Clinical Policy: Hospice Services

Reference Number: WA.CP.MP.54
Date of Last Revision: 9/24
Effective Date: 02/01/25

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.

Pediatric Palliative Care, including curative medically necessary services, may be offered to members aged 20 and younger and is not addressed in this policy.

Policy

Initial Request

It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority billing guidelines, that hospice is considered **medically necessary** when the *requirements in Criteria sections I, and II are met*.

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 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, and
2. The documentation also includes a hospice election statement signed by the member/enrollee or the member/enrollee's healthcare proxy stating they are fully informed and understand hospice care and waiver of other Medicaid or Medicare services, or both.

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/enrollee. *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. This maybe billed with Nursing Facility (rev codes 0115, 0125, 0135) and Hospice Care Center (rev code 0145) room and board charges.

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). Care may include homemaker services and home health aide services, but must be predominantly nursing care. 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. Up to 5 days of continuous home hospice care may be approved with ongoing concurrent review for additional days requested. Coordinated Care does not reimburse for continuous home care provided to a client in a nursing facility, hospice care center or hospital.

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, provided on an intermittent, non-routine and occasional basis. It is not residential or custodial care.

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. This benefit is limited to brief periods of care delivered in approved: Hospitals, Nursing facilities, or Hospice care centers.

III. Not Medically Necessary Services

Hospice services are considered **NOT medically necessary** under the following circumstances:

A. The member is no longer considered terminally ill as evidenced by a review of the medical documentation; or
B. Services, supplies or procedures that are directed towards curing the terminal condition, with the exception of children under the age of 21 per WAC 182-551-1860, or

C. Member chooses to revoke the hospice election by submitting a signed, written statement with the effective date of the revocation; or
D. Member is discharged from hospice services. A hospice agency may discharge a member/enrollee from hospice care when the member/enrollee is any of the following: No longer certified for hospice care, No longer appropriate for hospice care (i.e. no longer considered terminally ill), or Seeking treatment for the terminal illness outside the hospice treatment plan.

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/enrollee. 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 an additional 90-day benefit period, followed by an unlimited number of 60-day benefit periods with submission of a renewed hospice medical director certification of terminal illness. Hospice care is continuous from one period to another, unless the member revokes, or the hospice provider discharges or does not recertify.

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). Care may include homemaker services and home health aide services, but must be predominantly nursing care. 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. Up to 5 days of continuous home hospice care may be approved with ongoing concurrent review for additional days requested. Coordinated Care does not reimburse for continuous home care provided to a client in a nursing facility, hospice care center or hospital.
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. This benefit is limited to brief periods of care delivered in approved: Hospitals, Nursing facilities, or Hospice care centers.

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 certification period.

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 and included in the appropriate hospice daily rate:

- **A.** Physician services
- **B.** Appropriate skilled nursing services
- **C.** Home health aide services, homemaker, or personal care services, or all three that are ordered by a member/enrollee's physician and documented in the plan of care. These services must be provided by a qualified home health aide and are an extension of skilled nursing or therapy services.
- **D.** Physical therapy,occupational therapy, and speech-language therapy to manage symptoms or enable the client to safely perform activities of daily living (ADLs) and basic functional skills
- **E.** Adult day health
- **F.** Medical social services
- **G.** Counseling services (e.g., dietary, bereavement) provided to a member/enrollee and the member/enrollee's family members or caregivers
- **H.** Short-term inpatient care for general or respite care provided in a Medicare-certified hospice care center, hospital or nursing facility
- **I.** Drugs, biologicals, and over-the-counter medications used for the relief of pain and symptom control of a member/enrollee's terminal illness and related conditions (enteral/parenteral supplies for a pre-existing diagnosis requiring enteral/parenteral support may be billed separately. This pre-existing diagnosis must not be related to the diagnosis that qualifies the client for hospice)
- **J.** Durable medical equipment and related supplies, prosthetics, orthotics, medical supplies, related services, or related repairs and labor charges that are medically necessary for palliation and management of the member/enrollee's terminal illness and related conditions
- **K.** Interpreter services
- **L.** Medical transportation services, including ambulance, related to terminal illness
- **M.** Communication with non-hospice providers about care not related to the member/enrollee's terminal illness to ensure needs are met and not compromised
- **N.** Coordination of care, including coordination of medically necessary care not related to the member/enrollee's terminal illness

O. Other services or supplies that are documented as necessary for the palliation and management of the member/enrollee's terminal illness and related conditions

Non-covered Services
The following services are *not* included in the hospice daily rate:

A. Any services not related to the terminal condition
B. Dental care, eyeglasses, hearing aids, podiatry, and chiropractic services
C. Ambulance transportation or brokered transportation, if not related to the member/enrollee's terminal illness
D. Home and Community Based Long-Term Services and Supports (HCB LTSS) or Title XIX Personal Care Services

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
Most hospice services are provided at home[4] 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 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.

Revenue Code	Description
0115	Hospice, room and board, private (nursing facility)
0125	Hospice, room and board, semi-private (nursing facility)
0135	Hospice, room and board, 3-4 beds (nursing facility)

Revenue Code	Description
0145	Hospice Care Center, room and board
0551	Skilled Nursing Visit (service intensity add-on)
0561	Medical Social Service Visit (service intensity add-on)
0651	Hospice routine home care (RHC); 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

HCPCS Codes & Modifiers	Assoc. Rev. Code	Description
G0155	0561	Services of Social Worker in hospice setting, each 15 minutes (service intensity add-on)
Q5001	0651	Hospice care provided in client's home/residence
Q5002	0651	Hospice care provided in assisted living facility
Q5003	0651	Hospice care provided in non-skilled nursing facility
Q5010	0651	Hospice home care provided in a hospice facility
-TG	0651	Complex/high tech level of care (for RHC days 1-60)
-TF	0651	Intermediate level of care (for RHC days 61+)

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy adopted. Previously WA.UM.21	06/19	06/19
Added Investigational Services clarification	07/19	07/19
Annual review, references updated. Inclusion of transportation services added. Associated revenue code added to HCPCS table.	05/20	06/20
Switched order of Revenue Code and HCPCS tables. Moved hospice description from background section to policy description section. Replaced all instances of "member" with "member/enrollee". Codes reviewed. Reviewed and updated references.	05/21	06/21
Annual review. Changed "review date" in the header to "date of last revision" and "date" in the revision log header to "revision date." References updated.	01/22	02/22
Annual review. References updated. Reworded description of Pediatric Palliative Care.	12/22	01/23
References updated. Background information updated. Removed statement regarding previous investigational treatment from Initial Request paragraph. Updated Initial Request Section I. language to correspond to HCA billing guidelines. Updated Initial and Subsequent Request sections II. Continuous Homecare and General Inpatient descriptions to correspond to HCA billing guidelines. Removed debility and failure to thrive exclusion from section III. Updated section III. D. language re: hospice discharge per HCA billing guidelines. Covered and non-covered services sections updated to correspond to HCA billing guidelines.	08/23	08/23
Annual review. References reviewed and updated. Background updated per corporate policy. *Initial Request* Section II. B. and *Subsequent Requests* Section II. A. verbiage updated to align with HCA billing guidelines. *Subsequent Requests* section I. verbiage updated to reflect the length election periods per HCA billing guidelines. *Subsequent Requests* section III. removed length of certification period. Section III. Not Medically Necessary services, added reference to WAC for concurrent care < age 21. Levels of Care Definitions and Certification Periods sections removed. Covered Services section I. verbiage updated and section O. added to align with HCA billing guidelines. Non-covered Services section updated to list services not included in the hospice daily rate per HCA billing guidelines. Removed G0299 from coding table.	07/24	09/24

References

1. American Cancer Society. Hospice care. https://www.cancer.org/cancer/end-of-life-care/hospice-care.html?sitearea=ETO. Accessed May, 28, 2024
2. Compilation of Patient Protection and Affordable Care Act. 2010, section 2302. Accessed May 28, 2024. http://www.hhs.gov/healthcare/rights/law/index.html
3. Medicare Benefit Policy Manual, Chapter 9-Coverage of Hospice Services Under Hospital Insurance, (Rev. 11056 10-21-21) Accessed May 28, 2024. http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf

4. National Hospice and Palliative Care Organization, Facts and Figures: Hospice Care in America, 2020 Edition. Published August 20, 2020. Accessed May 28, 2024.
5. Palliative Performance Scale (PPS). Version 2. Victoria Hospice Society. May 28, 2024. http://www.npcrc.org/files/news/palliative_performance_scale_PPSv2.pdf
6. Karnofsky Performance Status Scale Definitions Rating (%) Criteria. Accessed May 28, 2024. http://www.npcrc.org/files/news/karnofsky_performance_scale.pdf
7. End-Stage Indicators. Montgomery Hospice. Accessed May 28, 2024. http://www.montgomeryhospice.org/health-professionals/end-stage-indicators/end-stage-indicators
8. Local coverage determination: Hospice Determining Terminal Status (L34538). Centers for Medicare and Medicaid Services. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=34538&ver=15&bc=0. Published October 1, 2015 (revised July 6, 2023). Accessed May 28, 2024.
9. Medicare Claims Processing Manual. Chapter 11 – Processing Hospice Claims. (Rev. 11286, 03-03-22). Accessed May 28, 2024.
10. Local coverage determination. Hospice – HIV Disease (L34566). Centers for Medicare and Medicaid Services. http://www.cms.hhs.gov/mcd/search.asp. Published October 1, 2015 (revised November 16, 2023). Accessed May 28, 2024.
11. Meier DE, McCormick E, Lagman RL. Hospice: Philosophy of care and appropriate utilization in the United States. UpToDate. www.uptodate.com. Published May 5, 2023. Accessed May 28, 2024.
12. Local coverage determination: Hospice - determining terminal status (L33393). Centers for Medicare and Medicaid Services. http://www.cms.hhs.gov/mcd/search.asp. Published October 1, 2015 (revised November 14, 2019). Accessed May 28, 2024.
13. Washington State Health Care Authority. Hospice Services Billing Guide. https://www.hca.wa.gov/assets/billers-and-providers/Hospice-bg-20240701.pdf. Revision July 1, 2024.

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.