POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Hospice Coverage
PAGE: 1 of 6	**REPLACES DOCUMENT:**
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Scope:
This policy is to be used as a guideline to determine the appropriateness of Hospice, as well as the level of Hospice, for members needing end-of-life care.

Subject:
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. Members under age 21 may receive hospice services without waiving their right to seek curative treatments at the same time. Most hospice services are provided at home,[1] 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. Hospice includes drugs related to the management of the terminal illness, to relieve pain, provide hydration and to deliver enteral feedings 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.

Description:

Levels of Care
Hospice includes four distinct levels of care which are defined as: Routine Hospice Home Care, Continuous Hospice Home Care, Inpatient Respite Hospice Care and General Inpatient, Short Term (Non-Respite) Hospice Care. **(NOTE: Palliative Care is *not* Hospice – this should be authorized using HHC criteria as a HHC authorization). For Pediatric Palliative Care see WA.UM.21.01.**

Routine Hospice Home Care: Care provided in the member's home, which may include any of the services previously identified in the subject of this policy, when the care is related to the terminal diagnosis and included in the plan of care for the member. Routine Hospice Home Care may include up to 8 hours of skilled nursing care in a 24-hour period. Routine Hospice Home Care may be provided in a private residence, a hospice residential care facility, a nursing facility, or an adult care home.

Continuous Hospice Home Care: Care consisting primarily of nursing care and provided on a

[1] National Hospice and Palliative Care Organization, Facts and Figures: Hospice Care in America, 2011 Edition

continuous basis at home, during brief periods of crisis and only as necessary to maintain the member at home. Continuous Hospice Home Care may include home health aide or homemaker services, however, the hospice 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. (When fewer than 8 hours of nursing care are needed, the care is covered as Routine Hospice Home Care, rather than Continuous Hospice Home 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. Continuous Hospice Home Care may include any of the services provided in the Subject of this policy. Continuous Hospice Home Care is not intended to be respite care and cannot be provided in a nursing facility, hospice care center, or hospital.

Inpatient Respite Hospice Care: Short-term inpatient respite hospice care, only when provided in an approved inpatient hospice facility, hospital or nursing home, when necessary to relieve family members or other primary caregivers.[2] Inpatient Respite Hospice Care is limited to 6 consecutive days in a 30 day period.

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, specifically 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, Non-Respite Hospice Care includes all the services identified in the Subject of this policy. *See WA.UM.03 Post Acute Sub Acute Review and Coordination for further information about placement options.*

<u>**Medical Necessity Criteria:**</u>
In order for a member to be eligible to receive hospice services:

- Both the attending physician AND the hospice medical director must submit written documentation that the member is terminally ill and has a life expectancy of 6 months or less and is no longer seeking curative treatment for their terminal diagnosis (a signature from the hospice medical director is not required for Prior Authorization). *Exception: if the member is under 21 they may continue to seek curative treatment in accordance with the Patient Protection and Affordable Care Act in accordance with WAC 182-551-1860*; and

[2] 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.

- The written certification must identify the diagnosis of a terminal illness that prompted the member to seek hospice care; it must include a statement that the member's life expectancy is six months or less if the terminal diagnosis runs its normal course; it must include specific clinical findings and other documentation supporting a life expectancy of 6 months or less; and
- A licensed, hospice provider determines that the terminally ill member and his/her caregiver(s) understand the nature of hospice care which is evidenced by a hospice election statement signed by the member, which will be kept on file by the hospice agency; and
- Prior authorization has been obtained for services to be delivered through a contracted hospice provider

Authorization Protocols:

A. **Initial Authorization**

Authorization is required prior to the initiation of hospice services, and for *each change* in the level of hospice service for all members regardless of age or product. Requests for changes must be reviewed to determine medical necessity and clinical appropriateness of the proposed change. 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. A maximum of three months can be authorized upon initial request.

1. ***Routine Hospice Home Care***- Review to be conducted by a Prior Authorization Nurse Routine hospice home care is covered when the above medical necessity criteria have been met and
   - Less than eight hours of nursing care, which may be intermittent, is required in a 24-hour period.

2. ***Continuous Hospice Home Care*** - Review to be conducted by a Prior Authorization Nurse Continuous Hospice Home Care is covered during brief periods of acute medical crisis *or* the sudden loss of a caregiver and only as necessary to maintain the member at home, when the above medical necessity criteria are met and
   - Hospice must provide a minimum of eight hours of nursing care in a 24 hour period which begins and ends at midnight.
   - Nursing care need not be continuous. (When fewer than 8 hours of nursing care are needed, the care is covered as Routine Hospice Home Care, rather than Continuous Hospice Home Care.)

3. ***Inpatient Respite Hospice Care*** – Review to be conducted by a Prior Authorization Nurse
   Inpatient Respite Hospice Care services are covered when the above medical necessity criteria have been met and:
   - Respite care is short term, inpatient care, and not residential or custodial care; and
   - Respite care is limited to 6 consecutive days per 30 days.
   - Should be authorized under Hospice, not IP level of care.

4. ***General Inpatient, Short Term, (Non-Respite) Hospice Care*** Review to be conducted by a Prior Authorization Nurse
   General Inpatient, Short Term (Non-Respite) Care services are covered when the above medical necessity criteria have been met and 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 the
   - Individual treatment plan is specifically directed at acute symptom management and/or pain control.
   - Should be authorized under Hospice, not IP level of care.
   - After 7 days, should go to MD for secondary review

B. Continued Authorization

Continued authorization requests must be submitted at three (3) months, six (6) months and then every two (2) months following the initial request. These are considered the "benefit periods". Written documentation must be submitted by the hospice Medical Director only, meeting all other criteria listed above under Medical Necessity Criteria above.

C. 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.

D. Hospice services are not considered to be medically necessary under the following circumstances:

- Services do not meet the above medical necessity criteria; or
- The member is no longer considered terminally ill as evidenced by a review of the medical documentation; or
- Services, supplies or procedures that are directed towards curing the terminal condition; or
  Exception: if the member is under 21 they may continue to seek curative treatment in accordance with the Patient Protection and Affordable Care Act in accordance with WAC 182-551-1860; and
- Services primarily aid in the performance of activities of daily living; or

- Member chooses to revoke the hospice election by submitting a signed, written statement with the effective date of the revocation; or
- 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.

Provider Responsibilities

The hospice provider is responsible for:

- verifying member eligibility
- obtaining authorization to provide hospice services before hospice care is initiated
- notifying the health plan of any significant change in the member's status or condition including revisions to treatment plans and goals
- requests for each change in the level of hospice service including discharge from hospice

Acute Inpatient Care while in Hospice

When a member is admitted to an acute care facility *for a diagnosis that is unrelated to the terminal illness of the member*, the hospice is responsible for notifying the health plan of the admission.

During the period of admission, hospice care is not covered. Coverage may be available under the member's medical benefit once a determination is made that services are medically necessary. Upon discharge from acute inpatient care, hospice coverage will resume, as long as the medical necessity guidelines are met.

References:

Medicare Benefit Policy Manual, Chapter 9-Coverage of Hospice Services Under Hospital Insurance, (Rev. 141, 03/02/11)

Medicare Claims Processing Manual, Chapter 11-Processing Hospice Claims, (Rev. 2258, 07-29-11), (Rev. 2316, 10/07/11)

National Hospice and Palliative Care Organization, Facts and Figures: Hospice Care in America, 2011 Edition

Revision Log

Revision:	**Date**
Clarification Language	**10/13**
The definitions of hospice levels of care were update to reflect changes in the Health Care Authority Definitions of these levels. Respite care was changed to reflect a maximum of 6 days of coverage in 30 consecutive days per the Health Care Authority limits on respite care. Clarification as to responsibility for reviews within UM was added.	**9/14**
Annual review	**9/15**
Added statement that written signature is not required on CTI or from Hospice Medical Director.	**8/16**
Updated exception to include continued curative treatment for members under 21 and added that sudden loss of a caregiver could qualify member for continuous hospice services as per HCA Provider billing guide updates.	**8/17**
Added reference to Post Acute UM policy for inpatient care placement process.	**11/17**
Clarified that curative treatment is not an exclusion to hospice for members under age 21. Added reference to new pediatric palliative care policy.	**4/18**