Clinical Policy: Hospice Services

Reference Number: CP.MP.54 Coding Implications
Date of Last Revision: 08/24 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. Hospice care is an alternative treatment approach that is based on recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and support for the family. Palliative care focuses on comfort care and the alleviation of physical, emotional and spiritual suffering. Instead of hospitalization, its focus is on maintaining the terminally ill patient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible. This policy describes the medical necessity criteria for hospice services.

Policy
Initial Request
It is the policy of Louisiana Healthcare Connections that hospice is considered **medically necessary** when the *requirements in Criteria sections I, II, and III are met:*

I. The Required Documentation has been submitted, and
II. The member/enrollee has a terminal illness with a life expectancy of six months or less. Please use the severity of illness criterion below for guidance:
  A. Cancer;
  B. ALS;
  C. Heart Disease;
  D. Pulmonary Disease;
  E. Dementia;
  F. HIV;
  G. Liver Failure;
  H. Acute or Chronic Renal Failure;
  I. Stroke;
  J. Coma;
  K. Non-Disease Specific Decline in Clinical Status.
III. The requested intensity of service is appropriate for one of the following:
  A. Routine Hospice Home Care;
  B. Continuous Hospice Home Care;
  C. Inpatient Respite Hospice Care;
  D. General Inpatient, Short Term (non-respite) Hospice Care.
IV. Not Medically Necessary Services

Note: Hospice room and board (long-term care/nursing home) coverage is based on the Benefit Plan Contract.

Criteria

I. Required Documentation

A. Documentation of hospice medical director certification of hospice appropriateness for the initial 90-day certification period.

1. BHSF FORM HOSPICE-CTI (Certification of Terminal Illness)
   - The written certification must identify the terminal illness diagnosis that prompted the member/enrollee to seek hospice care, including a statement that the member/enrollee'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 six months or less;
   - The documentation also includes a hospice election statement signed by the member/enrollee or the member/enrollee's healthcare proxy stating they understand the nature of hospice care.
2. BHSF FORM HOSPICE-NOE (Notice of Election/Revocation/Discharge/Transfer)
   - An election statement for hospice care must be filed by the member/enrollee or by a person authorized by law to consent to medical treatment for the member/enrollee and they understand the nature of hospice care.
3. Plan of Care (POC) include the following:
   - Corroborating referral documentation (progress notes from hospital, home health, physician's office, etc.)
   - Physician orders for plan of care (POC); and
   - Include Minimum Data Set (MDS) form (original and current) if beneficiary is in a facility; weight chart; laboratory tests; physician and nursing progress notes. The MDS form (original and current) is not required if the beneficiary has been in a long-term care facility less than 30 days. The MDS form must be provided upon the subsequent request for continuation of hospice services.
4. Documentation to support beneficiary's hospice appropriateness include the following
   - Paint picture of beneficiary's condition
   - Illustrate why beneficiary is considered terminal and not chronic
   - Explain why his/her diagnosis has created a terminal prognosis; and
   - Show how the body systems are in a terminal condition.
   - A cover letter attached to the required information will not suffice for supporting documentation. The supporting information must be documented within the clinical record with appropriate dates and signatures.

II. Severity of Illness

The presence of significant comorbidities should be considered when using these criteria to determine hospice appropriateness. Please see guidance below:

A. *Cancer* – meets all of the following:
   1. Palliative performance scale (PPS) (Appendix A) or Karnofsky performance status scale (KPS) (Appendix B) score < 70%;
   2. Dependence for at least two activities of daily living (ADLs) (e.g. ambulation, continence, transfers, dressing, feeding, bathing);
   3. Disease status is one of the following:
      a. Metastatic cancer at presentation, deferring therapy,
      b. Progression to metastatic disease with decline despite therapy or deferring therapy,
      c. Brain, pancreatic, or small cell lung cancer;

B. *ALS* (amyotrophic lateral sclerosis) – meets all of the following:
   1. PPS (Appendix A) or KPS (Appendix B) score < 70%;
   2. Dependence for at least two ADLs (e.g. ambulation, continence, transfers, dressing, feeding, bathing);
   3. Disease status is one of the following:
      a. Signs or symptoms of impaired respiratory function, not electing tracheostomy or invasive ventilation, and forced vital rety (FVC) < 30% (if results available);
      b. Rapid progression with critical nutritional impairment indicated by at least 5% loss of body weight (with or without tube feeding);
      c. Rapid progression with other life-threatening complications (sepsis, recurrent aspiration, pyelonephritis, stage 3-4 decubiti);

C. *Heart Disease* – meets all of the following:
   1. PPS (Appendix A) or KPS (Appendix B) score < 70%;
   2. Dependence for at least two ADLs (e.g. ambulation, continence, transfers, dressing, feeding, bathing);
   3. Disease status is one of the following:
      a. Congestive Heart Failure (CHF), both of the following:
         i. Symptomatic at rest (NYHA Class IV), with ejection fraction (EF) $\leq$ 20% (if results available);
         ii. Presently optimally treated with diuretics and vasodilators or has failed therapy with IV inotropes;
      b. Coronary Artery Disease (CAD), all of the following:
         i. Elderly member/enrollee with intractable angina who is not a candidate for coronary revascularization;
         ii. No longer responding well to nitrates, beta- and calcium-channel blockers and other appropriate medications;
         iii. Not a candidate for cardiac transplant;

D. *Pulmonary Disease* – has fixed obstructive disease OR restrictive disease and meets all of the following:
   1. PPS (Appendix A) or KPS (Appendix B) score < 70%;

2. Dependence for at least two ADLs (e.g. ambulation, continence, transfers, dressing, feeding, bathing);
3. Severity, all:
   a. Disabling symptoms at rest or with minimal exertion;
   b. Diminished functional capacity, e.g., bed-to-chair existence;
   c. Forced expiratory volume in 1 second (FEV1) < 30% predicted, after bronchodilator (if able to obtain);
4. Progressiveness, both:
   a. Two ED visits in prior six months or one hospitalization in last year for pulmonary infection and/or respiratory failure with intubation or BiPAP (bi-level positive airway pressure);
   b. Member/enrollee states they do not want to be intubated;
5. Partial pressure of oxygen in arterial blood (PaO2) ≤ 55 mmHg or arterial oxygen saturation (SaO2) ≤ 88% at rest on room air; or partial pressure of carbon dioxide in arterial blood (PaCO2) ≥ 50 mmHg;

E. *Dementia* – meets all of the following:
1. Increasing severity indicated by FAST (Appendix C) stage 7 or beyond; and
2. Increasing medical complications indicated by one of the following in the past 12 months:
   a. Aspiration pneumonia;
   b. Pyelonephritis or other upper urinary tract infection;
   c. Septicemia;
   d. Multiple stage 3-4 decubiti;
   e. Fever recurrent after a course of antibiotics;
   f. Weight loss > 10% during the previous six months;
   g. Albumin < 2.5 g/dl;

F. *HIV* – meets all of the following:
1. CD4+ (T-cell) count < 25 or viral load > 100,000 copies/ml;
2. PPS or KPS score < 50%;
3. At least one of the following AIDS-related conditions:
   a. Central nervous system or poorly responsive systemic lymphoma;
   b. Wasting: loss of at least 10% lean body mass;
   c. Mycobacterium avium complex (MAC) bacteremia;
   d. Progressive multifocal leukoencephalopathy (PML);
   e. Refractory visceral Kaposi's sarcoma (KS);
   f. Renal failure in the absence of dialysis;
   g. Refractory cryptosporidium infection;
   h. Refractory toxoplasmosis;

G. *Liver Disease* – meets all of the following:
1. PPS (Appendix A) or KPS (Appendix B) score < 70%;
2. Dependence for at least two ADLs (e.g. ambulation, continence, transfers, dressing, feeding, bathing);
3. Member/enrollee has end-stage liver disease and is not on the transplant list;
4. Prothrombin time (PT) > five seconds or International Normalized Ration (INR) > 1.5;

5. Albumin < 2.5 g/dl;
6. And at least one of the following:
    a. Recurrent bleeding esophageal varices despite therapy;
    b. Refractory ascites;
    c. Episode of spontaneous bacterial peritonitis;
    d. Hepatorenal syndrome;
    e. Hepatic encephalopathy;

H. *Acute or Chronic Renal Failure* – meets all of the following:
1. PPS (Appendix A) or KPS (Appendix B) score < 70%;
2. Dependence for at least two ADLs (e.g. ambulation, continence, transfers, dressing, feeding, bathing);
3. Member/enrollee is in renal failure, not receiving dialysis and one of the following:
    a. Serum Creatinine > 8 mg/dl (> 6 diabetes);
    b. Creatinine clearance < 15 ml/minute;

I. *Stroke* – meets all of the following:
1. PPS or KPS < 40%;
2. Inadequate oral intake with one of the following:
    a. Weight loss of > 10% body weight in the last six months, or > 7.5% in to the last three months;
    b. Serum albumin < 2.5 g/dl;
    c. Recurrent aspiration;
    d. Dysphagia and declining tube feeding and hydration;

J. *Coma* – member/enrollee is comatose with at least three of the following on day three of coma:
1. Abnormal brain stem response;
2. Absent verbal response;
3. Absent withdrawal to painful stimuli;
4. Creatinine > 1.5 mg/dl;

K. *Non-Disease Specific Decline in Clinical Status* (the presence of significant comorbidities should be considered when using these criteria), all of the following:
1. Irreversible decline, based on both baseline and follow-up determinations; and
2. Clinical deterioration of one or more of the following:
    a. Progressive dependence for ADLs;
    b. KPS or PPS score < 70%;
    c. Increasing frequency of ER visits or hospitalizations;
    d. Worsening of one or more of the following:
        i. Clinical status - such as recurrent infections, inanition with progressive weight loss, dysphagia, or decreasing albumin;
        ii. Signs - such as hypotension, ascites, edema, pleural or pericardial disease, or decreased consciousness;
        iii. Symptoms - such as intractable dyspnea, cough, nausea, diarrhea, or pain;
        iv. Laboratory results - arterial blood gases, tumor markers, electrolytes, creatinine, or liver function tests;
    e. Progressive or stage 3 to 4 decubiti.

III. 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* (HCPCS T2042 or rev code 0651)
Routine hospice home care is medically necessary when < eight 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* (HCPCS T2043 or rev code 0652)
Continuous hospice home care is medically necessary to maintain the member/enrollee at home when the member/enrollee requires ≥ eight hours of nursing care in a 24-hour period (begins and ends at midnight). Up to five days of continuous home hospice care may be approved with ongoing concurrent review for additional days requested.

C. *Inpatient Respite Hospice Care* (HCPCS T2044 or rev code 0655)
Respite hospice care is medically necessary to relieve family members/enrollees or other primary caregivers of care duties for no more than five consecutive days per episode. Respite care is short-term inpatient care, and not residential or custodial care. Up to five days per episode of inpatient respite care may be approved.

D. *General Inpatient, Short Term (non-respite) Hospice Care* (HCPCS T2045 or 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/enrollee's care team;
   2. The individual treatment plan is specifically directed at acute symptom management and/or pain control.
   3. A cap is placed on the number of allowable inpatient hospice days that can be provided by a hospice facility to fee-for-service beneficiaries during the twelve-month period beginning November 1st of each year to October 31st of the following year. This cap is calculated as twenty percent (20%) of the total number of hospice days provided by the facility.

IV. Not Medically Necessary Services

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

A. Members/enrollees with any of the following as the primary diagnosis:
   1. Debility or unspecified debility;
   2. Failure to thrive;

B. The member/enrollee is no longer considered terminally ill as evidenced by a review of the medical documentation;

C. Services, supplies or procedures that are directed towards curing the terminal condition, except for children covered under Medicaid or CHIP;

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

E. Member/enrollee is discharged from hospice services; e.g. member/enrollee is no longer considered terminally ill, member/enrollee refuses services or is uncooperative, moves

out of the area, or transfers to a non-covered hospice program. In the event a member/enrollee is discharged from hospice, benefit coverage would be available as long as the member/enrollee 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/enrollee. *The appropriate HCPCS or revenue (rev) code must be billed according to applicable contract provisions*.

It is the policy of health plans associated with Louisiana Healthcare Connections 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* (HCPCS T2043 or rev code 0652)
Continuous hospice home care is medically necessary to maintain the member/enrollee at home when the member/enrollee requires ≥ eight hours of nursing care in a 24-hour period (begins and ends at midnight). Up to five days of continuous home hospice care may be approved with ongoing concurrent review for additional days requested.

B. *Inpatient Respite Hospice Care* (HCPCS T2044 or rev code 0655)
Respite hospice care is medically necessary to relieve family members/enrollees or other primary caregivers of care duties for no more than five consecutive days per episode. Respite care is short-term inpatient care, and not residential or custodial care. Up to five days per episode of inpatient respite care may be approved.

C. *General Inpatient, Short Term (non-respite) Hospice Care* (HCPCS T2045 or 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/enrollee's care team;
2. The treatment plan is specifically directed at acute symptom management and/or pain control.
3. A cap is placed on the number of allowable inpatient hospice days that can be provided by a hospice facility to fee-for-service beneficiaries during the twelve-month period beginning November 1st of each year to October 31st of the following year. This cap is calculated as twenty percent (20%) of the total number of hospice days provided by the facility.

III. All the following documentation must be submitted:

a. MDS forms (original and current) are required; weight chart; laboratory tests; physician and nursing progress notes if the beneficiary resides in a nursing facility
b. An updated Hospice CTI form (BHSF Form Hospice-CTI) and a face-to-face encounter signed and dated by the hospice provider's medical director or

physician member of the interdisciplinary group (IDG) for the third and subsequent requested PA periods

c. An updated POC
d. Updated physician's orders
e. List of current medications (within last 60 days)
f. Current laboratory/test results (within last 60 days if available)
g. Description of hospice diagnosis
h. Description of changes in diagnoses
i. Progress notes for all services rendered (daily/weekly physician, nursing, social worker, aide, volunteer and chaplain)
j. A social evaluation
k. An updated scale such as: Karnofsky Performance Status Scale, Palliative Performance Scale or the Functional Assessment Tool (FAST)
l. The beneficiary's current weight, vital sign ranges, lab tests and any other documentation supporting the continuation of hospice services. Documentation must illustrate the beneficiary's decline in detail. Compare last month's status to this month's status

This information must be submitted for all subsequent benefit periods and must show a decline in the beneficiary's condition for the authorization to be approved.

For prior authorization, the prognosis of terminal illness will be reviewed. A recipient must have a terminal prognosis in addition to a completed Hospice Certification of Terminal Illness form and proof of the face-to-face encounter. Authorization will be made on the basis that a recipient is terminally ill as defined in Federal Regulations. These regulations require certification of the prognosis, rather than diagnosis. Authorization will be based on objective clinical evidence in the clinical record about the recipient's condition and not simply on the recipient's diagnosis.

IV. 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/enrollee's home and is related to the terminal diagnosis and plan of care written for the member/enrollee. 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 and only as necessary to maintain the member/enrollee at home. Continuous

care must provide a minimum of eight 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 paid caregivers or placement in another setting. 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 five consecutive days per episode. It is allowed to relieve family members/enrollees or other primary caregivers of the primary caregiving duties. A primary caregiver is an individual, designated by the member/enrollee, who is responsible for the 24-hour care and support of the member/enrollee 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/enrollee is safe at home alone at the time of the election.

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/enrollee 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.

E. *Service Intensity Add-On Rate (SIA)* (Revenue Code 659)
A service intensity add-on (SIA) payment will be reimbursable for a visit by a registered nurse (RN) or a social worker, when provided during routine home care (HR651) in the last seven days of a patient's life. The SIA payment is in addition to the routine home care rate. Claims for SIA services must be billed in units. Each unit is equal to 15 minutes. The maximum number of reimbursable units per day is 16 units. The seven-day maximum number of reimbursable units is 112 units. Documentation submitted should reflect the arrival and departure time of the professional providing the services. Visits for the pronouncement of death only will not be reimbursed as an eligible visit.

Certification Periods

Hospice services are covered based on periods and requires prior authorization (PA). PA requests must be submitted within 10 calendar days of the hospice election date. A member may elect to receive hospice care during one or more of the following election periods:

- An initial 90-day period;
- A subsequent 90-day period; and
- Subsequent periods of 60 days each.

The periods of care are available in the order listed and may be used consecutively or at different times during the member's life span.

Discontinuation of Hospice
If a member/enrollee revokes or is discharged from hospice care, the remaining days in the benefit period are lost. If/when the member/enrollee 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);
J. Consumable medical supplies (e.g., bandages, catheters) used by the hospice team.

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/enrollee 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, except for children enrolled in Medicaid or CHIP who are receiving concurrent care;
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
Responsibilities of the hospice provider include:

A. Verifying member/enrollee 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/enrollee'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.

Appendices

Appendix A: Palliative Performance Scale (PPS)

PPS Level	Ambulation	Activity & Evidence of Disease	Self-care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable normal job/work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/housework Significant disease	Occasional assistance needed	Normal or reduced	Full or confusion
50%	Mainly sit/lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or confusion
40%	Mainly in bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or drowsy +/- confusion
30%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Normal or reduced	Full or drowsy +/- confusion
20%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Minimal to sips	Full or drowsy +/- confusion
10%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Mouth care only	Drowsy or Coma
0%	Death				

Appendix B: Karnofsky Performance Status Scale (KPS) Definitions Rating (%) Criteria

Activity Level	Score	Detailed Activity Level
Able to carry on normal activity and to work; no special care needed.	100	Normal no complaints; no evidence of disease.
	90	Able to carry on normal activity; minor signs or symptoms of disease.
	80	Normal activity with effort; some signs or symptoms of disease.
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.	70	Cares for self; unable to carry on normal activity or to do active work.
	60	Requires occasional assistance but is able to care for most personal needs.
	50	Requires considerable assistance and frequent medical care.
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.	40	Disabled; requires special care and assistance.
	30	Severely disabled; hospital admission is indicated although death not imminent.
	20	Very sick; hospital admission necessary; active supportive treatment necessary.
	10	Moribund; fatal processes progressing rapidly.

Appendix C: Functional Assessment Staging Test (FAST) for Alzheimer's disease

Stage	Stage Name	Characteristic
1	Normal aging	No deficits
2	Possible mild cognitive impairment	Subjective functional deficit
3	Mild cognitive impairment	Objective functional deficit interferes with a person's most complex tasks
4	Mild dementia	IADLs become affected, such as bill paying, cooking, cleaning, traveling
5	Moderate dementia	Needs help selecting proper attire
6a	Moderately severe dementia	Needs help putting on clothes
6b	Moderately severe dementia	Needs help bathing
6c	Moderately severe dementia	Needs help toileting
6d	Moderately severe dementia	Urinary incontinence
6e	Moderately severe dementia	Fecal incontinence
7a	Severe dementia	Speaks 5 to 6 words during day
7b	Severe dementia	Speaks only 1 word clearly
7c	Severe dementia	Can no longer walk
7d	Severe dementia	Can no longer sit up
7e	Severe dementia	Can no longer smile
7f	Severe dementia	Can no longer hold up head

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.

NOTE: Coverage is subject to each requested code's inclusion on the corresponding LDH fee schedule. Non-covered codes are denoted (*) and are reviewed for Medical Necessity for members under 21 years of age on a per case basis.

HCPCS Codes	Description
T2042	Hospice routine home care; per diem
T2043	Hospice continuous home care; per hour
T2044	Hospice inpatient respite care, per diem
T2045	Hospice general inpatient care; per diem
T2046	Hospice long-term care, room and board only; per diem
G0337	Hospice evaluation and counseling services, pre-election

Revenue Code	Description
0651	Hospice routine home care; 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
0658*	Hospice room and board, nursing facility
0657*	Hospice charges for services furnished to patients by physician or nurse practitioner employees, or physicians or nurse practitioners receiving compensation from the hospice. Physician services performed by a nurse practitioner require the addition of the modifier GV in conjunction with revenue code 0657.
0659	Service Intensity Add-On (SIA)

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
Policy created.	12/22	4/3/23	
Annual review. References reviewed and updated. Reviewed by internal specialist. HCPCS table added. Changed member to member/enrollee.	08/23	10/30/23	
Annual Review. Added to Description. Reformatted and adjusted numbering throughout. Updated sections under Initial requests. Added "The documentation also includes a hospice election statement signed by the member/enrollee or the member/enrollee's healthcare proxy stating they understand the nature of hospice care." Under I.A.(1). Removed determining terminal illness and added section II. Severity of Illness for guidance. Added section III. Intensity of level of care. Added IV. Not Medically Necessary Services. Added section I. and II. under subsequent	08/24	10/23/24	11/22/24

Reviews, Revisions, and Approvals	Revision Date	Approval Date	Effective Date
requests. References reviewed and updated. Reviewed by external specialist.			

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. Accessed May 28, 2024. https://www.govinfo.gov/content/pkg/CPRT-111HPRT61643/pdf/CPRT-111HPRT61643.pdf
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. Accessed June 7, 2023. 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. LDH Hospice Provider Manual

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 LHCC 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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by the LHCC. 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. LHCC 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 LHCC 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 LHCC. 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.