University of Michigan Health Plan

BENEFIT COVERAGE POLICY

Title: BCP-22 Hospice Care Services

Payment Reimbursement Policy: PRP-04 Hospice Services

Effective Date: 01/01/2024

Important Information - Please Read Before Using This Policy

The following coverage policy applies to health benefit plans administered by UM Health Plan and may not be covered by all UM Health Plan plans. Please refer to the member's benefit document for specific coverage information. If there is a difference between this general information and the member's benefit document, the member's benefit document will be used to determine coverage. For example, a member's benefit document may contain a specific exclusion related to a topic addressed in a coverage policy.

Coverage determinations for individual requests require consideration of:

- The terms of the applicable benefit document in effect on the date of service.
- Any applicable laws and regulations.
- Any relevant collateral source materials including coverage policies.
- The specific facts of the particular situation.

Contact UM Health Plan Customer Service to discuss plan benefits more specifically.

1.0 Policy:

Health Plan covers hospice care as a medical benefit with services being provided either in an inpatient or outpatient setting.

For all non-network covered services to be paid at the network benefit level except for emergency/urgent services, prior approval is required.

Refer to the member's benefit coverage document for specific benefit description, guidelines, coverage, and exclusions.

2.0 Background:

Hospice services are considered by most as a philosophy or concept of care; it is not a specific place of care. Hospice programs are defined as a program of palliative and supportive care services providing physical, psychological, social, and spiritual care for dying persons, their families, and other loved ones. The treatment focus is palliative, not curative.

Hospice care is not necessarily appropriate for everyone who has a terminal illness. In order to qualify for entry into a hospice program, the patient, the family, and the attending physician must all accept the inevitability of the death process and relinquish all prospects of medical treatment that might aggressively prolong life, including artificial life support systems.

Patients who may benefit from hospice services include those who are terminally ill and who require services for the palliation or management of the terminal illness and related conditions.

3.0 Benefit Guidelines:

A. Hospice care services are covered when ALL the following indications are met:

1. The member or appointed designee has formally consented to hospice care (i.e., care, is directed toward palliative care and symptom management.); AND
2. Potentially curative treatment for the terminal illness is not part of the prescribed plan of care; AND

3. The hospice services are provided by a hospice agency with care available 24 hours per day, seven days per week; AND
4. Written certification by the physician that includes all the following:
    a. Statement that the member is terminally ill; and
    b. Member has a life expectancy of six months or less if the disease follows its expected course; and
    c. Specific clinical findings and other documentation supporting a life expectancy of six months or less; and
    d. Signature(s) of the physician(s); and
    e. If a patient lives longer than six months it is not a reason to terminate coverage of hospice services. In the event patient survival is longer than six months, the physician must re-certify that the patient is terminally ill every 60 days via a face-to-face assessment by the physician, PA, or NP in order for hospice benefits to continue.

B. The following levels of hospice care services are covered when the above criteria have been met:
1. Routine Home Hospice Care:
    a. Patient's medical condition is stable and does not require frequent intervention.
    b. Basic, intermittent skilled care which typically requires less than eight hours of nursing care and home health aide services per day.
    c. Most common level of hospice care.
    d. Care is provided in the patient's home, a long-term care facility, or an assisted living facility.
2. Continuous Home Hospice Care:
    a. Patient requires continuous skilled nursing care to achieve palliation or management of acute medical symptoms (e.g., uncontrolled pain, nausea and vomiting, CHF).
    b. Intensive care is provided up to 24 hours a day with at least eight hours of care provided from midnight to midnight by a hospice-employed nurse (RN, LPN, or LVN). Homemaker or hospice aide services may also be provided on a continuous basis to supplement nursing care.
    c. This level of care is intended to be provided short term (i.e., up to 3 days).
    d. Care is provided in the patient's home or an assisted living facility.
3. Inpatient General Hospice Care:
    a. Patient requires inpatient care for pain and symptom management that cannot effectively be provided in other settings.
    b. This level of care is intended to be provided short-term (i.e., up to three days).
    c. Care is provided in a hospital, hospice unit, or long-term care facility.
4. Inpatient Respite Hospice Care:
    a. Inpatient care is provided when necessary and if there is benefit coverage available under the plan, to provide a break in caregiving for the patient's caregiver(s).
    b. Care is short term for a maximum of five days approximately once every hospice benefit period.
    c. Care is provided in an assisted living facility, hospice unit, or long-term care facility.

C. When the above coverage criteria are met, the following hospice care services may be covered as part of the hospice treatment plan:

1. Hospice physician and nurse practitioners – provides medical direction of the patient's care. The physician can be either the patient's personal physician or a physician affiliated with a hospice program.
2. Intermittent skilled nursing services – regular home care visits by RNs or LPNs to monitor the patient's condition and to monitor symptoms and medication, maintain patient comfort, and help educate the patient and family about the end-of-life process.
3. Home health aides – provide personal care such as bathing, shaving, and nail care.
4. Homemakers – sitter companion for the patient who is ill or other members of the family, housecleaning, and meal preparation.
5. Chaplains – assist with the spiritual needs of the patient and/or loved ones.
6. Physical and/or occupational therapy – assist in developing new ways to perform tasks that may have become difficult, such as walking, dressing, or feeding.
7. Complementary therapists which may include massage therapy or music therapy.
8. Speech therapy services for dysphagia/feeding therapy.
9. Dietary counseling.
10. Social work and counseling services – provide emotional support, counseling, or assistance with community resources for families.
11. Trained Volunteer support – assist loved ones by running errands, carpooling, or companionship.
12. Bereavement counseling – to help patients and their loved ones with grief and loss.
13. Prescription medications for symptom control and pain relief.
14. Medical equipment recommended by the hospice team (e.g., hospital beds).
15. Medical supplies (e.g., bandages, catheters) used by the hospice team.

D. The following hospice care services are not covered because each is specifically excluded from coverage or is considered not medically necessary as hospice care (this list may not be all-inclusive):

1. Services for patients no longer considered terminally ill.
2. Services, supplies, or procedures that are directed towards actively treating or curing the terminal condition or judged to be life-prolonging (i.e., artificial life support systems).
3. Medical supplies unrelated to the palliative care to be provided.
4. Funeral arrangements.
5. Financial or legal counseling.
6. Room and board charges in facilities, including nursing homes and hospice facilities, unless there are skilled nursing needs as defined by the member's benefit plan document or for ASO group L0002184 member (see Section 5.0 below).

4.0 Coding:

Prior Approval Legend: Y = All lines of business; N = None required; 1 = HMO/POS; 2 = PPO; 3 = ASO group L0000264; 4 = ASO group L0001269 non-union & union; 5 = ASO group L0001631; 6 = ASO group L0002011; 7 = ASO group L0001269 union only; 8 = ASO group L0002184; 9 = ASO group L0002237, 10 = ASO group L0002193.

COVERED CODES

Code	Description	Prior Approval	Benefit Plan Cost Share Reference
99378	Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more	N	Professional fees for medical and surgical services
G0156	Services of home health/health aide in home health or hospice settings, each 15 minutes	N	Professional fees for medical and surgical services
G0337	Hospice evaluation and counseling services, pre-election	N	Professional fees for medical and surgical services
Q5001	Hospice or home health care provided inpatient's home/residence	N	Professional fees for medical and surgical services
Q5002	Hospice or home health care provided in assisted living facility	N	Professional fees for medical and surgical services
Q5003	Hospice care provided in nursing long-term care facility (LTC) or nonskilled nursing facility (NF)	N	Professional fees for medical and surgical services
Q5004	Hospice care provided in skilled nursing facility (SNF)	N	Professional fees for medical and surgical services
Q5005	Hospice care provided in inpatient hospital	N	Professional fees for medical and surgical services
Q5006	Hospice care provided in inpatient hospice facility	N	Professional fees for medical and surgical services
Q5007	Hospice care provided in long-term care facility	N	Professional fees for medical and surgical services
Q5008	Hospice care provided in inpatient psychiatric facility	N	Professional fees for medical and surgical services
Q5009	Hospice or home health care provided in place not otherwise specified (NOS)	N	Physician office visit for sickness or injury, Professional fees for medical and surgical services
Q5010	Hospice home care provided in a hospice	N	Physician office visit for sickness or injury,

COVERED CODES			
Code	Description	Prior Approval	Benefit Plan Cost Share Reference
	facility		Professional fees for medical and surgical services
S9126	Hospice care, in the home, per diem	N	Hospice care OR Facility services (non-hospital)

FACILITY COVERED CODES			
Revenue Code	Description	Prior Approval	Benefit Plan Cost Share Reference
0650	General	N	Hospice care, OR Facility services (non-hospital)
0651	Other hospice	N	Hospice care, OR Facility services (non-hospital)
0652	Continuous home care	N	Hospice care, OR Facility services (non-hospital)
0655	Inpatient respite care	N	Hospice care, OR Facility services (non-hospital)
0656	General inpatient care (non-respite)	N	Hospice care, OR Facility services (non-hospital)
0657	Physician service	N	Hospice care, OR Facility services (non-hospital)
0658	Hospice room and board – nursing facility	Y – 8 only, NC for all other plans	Hospice Care for L0002184; Specific exclusion for custodial care for all other plans
0659	Other hospice	N	Hospice care, OR Facility services (non-hospital)

NON-COVERED CODES		
Code	Description	Benefit Plan Reference/Reason
99377	Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes	General Limitations and Exclusions; Health services and medical supplies that do not meet the definition of a Covered Health Service.
T2042	Hospice routine home care; per diem	Not reimbursable for

NON-COVERED CODES		
Code	Description	Benefit Plan Reference/Reason
		commercial members
T2043	Hospice continuous home care; per hour	Not reimbursable for commercial members
T2044	Hospice inpatient respite care; per diem	Not reimbursable for commercial members
T2045	Hospice general inpatient care; per diem	Not reimbursable for commercial members
T2046	Hospice long term care, room and board only; per diem	Not reimbursable for commercial members

5.0 Unique Configuration/Prior Approval/Coverage Details:

Effective 01/01/2023, ASO group L0002184 will have an enhanced hospice benefit to include room and board facility charges with the following criteria:

- The member must be enrolled in an in-network hospice program that is medically necessary and preauthorized with UM Health Plan
- Members that are medically stable but unable to stay in their home due to:
  - Lack of caregiver
  - Caregiver inability
  - Needs cannot be met in the home
- Must use an in-network skilled nursing or hospice facility
- Prior authorization and continued stay reviews are required
- Covers room and board up to 45 days
- Does not take the place of inpatient hospice or respite care

6.0 Terms & Definitions:

Continuous Home Care – Care that is provided only during a period of crisis and is necessary to maintain an individual at home. If a patient's caregiver has been providing a skilled level of care for the patient and the caregiver is unable to continue providing care, this may precipitate a period of crisis because the skills of a nurse may be needed to replace the services that had been provided by the caregiver. However, regulations do not permit CHC to be provided in an inpatient facility (a hospice inpatient unit, a hospital, or SNF).

See http://www.cms.hhs.gov/manuals/downloads/bp102c09.pdf for additional information.

Hospice Benefit Period – The first 2 election periods are for 90 days. Starting with the third benefit period, each benefit period thereafter is for 60 days.

Hospice Care – Services available to patients with life-limiting illnesses who can no longer benefit from curative treatment and usually have a life expectancy of six months or less, as determined by a physician.

It is a team-oriented approach to expert medical care, pain management and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is extended to the patient's love ones, as well. At the center of hospice is the belief that each of us has the right to die pain-free and with dignity, and that our families will receive the necessary support to allow us to do so. Care is usually provided in the patient's home. Hospice services are available to patients of any age, religion, race, or illness.

Karnofsky Scale – A means to clinically estimate a patient's physical state, performance, and prognosis. The scale is from 100, perfectly well, to 0, dead. It is used in studying cancer and chronic illness.

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

Medical Crisis – A period in which a patient requires continuous care to achieve palliation or management of acute medical symptoms. If a patient's caregiver has been providing a skilled level of care for the patient and the caregiver is unwilling or unable to continue providing care, this may precipitate a period of crisis because the skills of a nurse may be needed to replace the services that had been provided by the caregiver

Non-skilled Services – Care that consists of training or assisting in personal hygiene and other activities of daily living that do not provide therapeutic treatment and can be safely and adequately provided by someone without technical skills of a health care provider (e.g., nurse).

Examples (not all inclusive):

1. Administration of routine and prn medications, eye drops, and ointments.
2. General maintenance and care of a colostomy or ileostomy.
3. Routine care to maintain satisfactory functioning of an indwelling catheter.
4. Dressing changes for non-infected post-operative wound or chronic conditions.

5. Routine skin care, including bathing and application of creams or treatment of minor skin conditions.
6. Routine care of incontinent patients, including use of diapers and protective sheets.
7. Routine care for a cast.
8. Routine care for use of braces and similar devices.
9. Routine use of palliative and comfort measures, such as heat or whirlpool.
10. Routine administration of oxygen after a therapy regimen has been established.
11. Assistance with dressing, eating, and toileting.
12. Periodic turning and repositioning in bed.
13. General supervision of a home exercise program that has been taught to the patient to improve gait or improve strength or endurance.
14. Custodial care (see member's COC for definition).

Long-Term Care Facility - A skilled nursing facility as defined by CMS requirement.

Palliative Care – Refers to any care that alleviates symptoms, even if there is hope of a cure by other means. Palliative care focuses on the pain relief, symptoms, and emotional stress brought on by a life-threatening illness. The illness does not have to be terminal to qualify for palliative care. Treatment may be used to relieve the side effects of a curative treatment, such as relieving nausea associated with chemotherapy, which may help to tolerate more aggressive or longer-term treatment.

Skilled Nursing Services – Care that consists of services that must be performed by an RN or LPN and meet the following criteria for skilled nursing services:

1. Ordered by a physician.
2. Must be provided on an intermittent basis.
3. Is not custodial in nature.
4. Must be reasonable and necessary for the treatment of the illness.

Examples (not all-inclusive):

1. Overall management and evaluation of a complex care plan.
2. Observation and assessment of a patient's changing condition.
3. Education to teach self-maintenance or self-administration of care.
4. Initiate administration and provide teaching to caregiver(s) for intravenous, intramuscular, or subcutaneous injections.
5. Education for new intravenous or gastric feedings.
6. Nasopharyngeal and/or tracheotomy suctioning.
7. Insertion and sterile irrigation and replacement of catheters.
8. Application of dressings using an aseptic technique and involving prescribed medication(s).
9. Treatment of extensive decubitus ulcers or other widespread skin disorders.

Terminally ill – A medical prognosis that indicates that life expectancy is six months or less if the illness runs its normal course.

7.0 References, Citations & Resources:

1. Centers for Medicare and Medicaid. Medicare Benefit Policy Manual. Chapter 9. Coverage of Hospice Services Under Hospital Insurance. Revision 11056. 10/21/21. Available at URL address. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf.

2. World Health Organization 2023. Definition of Palliative Care. http://www.who.int/cancer/palliative/definition/en/.

8.0 Associated Documents [For internal use only]:

Policy and Procedure (P&P) - MMP-09 Benefit Determinations, MMP-02 Transition and Continuity of Care.

Standard Operating Procedure (SOP) – MMS-03 Algorithm for Use of Criteria for Benefit Determinations; MMS-45 UM Nurse Review, MMS-52 Inpatient Case Process in CCA; MMS-53 Outpatient Case Process in CCA

Sample Letter – TCS Approval Letter; Clinically Reviewed Exclusion Letter; Specific Exclusion Letter; Lack of Information Letter

Form – Request Form: Out of Network/ Prior Authorization.

Payment Reimbursement Policies (PRPs) - PRP-04 Hospice Services.

9.0 Revision History

Original Effective Date: 10/11/2006

Next Review Date: 01/01/2025

Revision Date	Reason for Revision
2/16	Annual review and update: Title changes – removed references to Medical Resource Management with title changed to "Medical Policy" and Responsible Dept is now "Utilization Management." Converted to standardized policy format; removed references to Sparrow UM Health Plan, Healthy Michigan, MI Child, and MDHHS Product Application - added reference to COC definitions related to policy. Clinical Determination Guidelines - updated criteria for levels of hospice care. 2016 New Codes added – G0299 and G0300 Terms Associated with Hospice Services – added terminology.
2/17	Annual review – Changed from MRM Medical Policy MP 009 to Benefit Coverage Committee Policy formatting; no changes to criteria.
5/17	Annual review with updates: codes reviewed with Contracting.
11/18	Annual review and renewal by QI/MRM 12/12/18. Clarified D.6 and time limits
2/19	Annual review by BCC, codes added per gap analysis.
5/20	Off cycle review; removed prior approval requirement. Added note 12/14/20 that removal of PA delayed until 1/1/21.
7/21	Annual review; associated documents and cost share/denial references updated
7/22	Annual review; updated MMP-03 to MMP-09; added MMS-04 to associated documents
12/22	Off-cycle review; moved 0658 to Facility Covered Codes and added criteria in Section 5.0 for enhanced benefit for ASO group L0002184 effective 1/1/23
2/23	Off-cycle review; updated Section 5.0 to reflect change requested by ASO group L0002184 for enhanced hospice room and board benefits from 30 days to 45 days
10/23	Annual review, Moved benefit guidelines from 2.0 background section to 3.0 Changed name of section 3.0 from Clinical Determination Guidelines to "Benefit Guidelines", Added ASO group 2193 to section 4.0, updated benefit plan reference/reason for T codes listed in non-covered code section, updated references in section 7.0, updated associated documents in section 8.0.