PAYMENT AND REIMBURSEMENT POLICY

Title: PRP-04 Hospice Services

Category: Compliance

Effective Date: 08/31/2021

Physicians Health Plan
PHP Insurance Company
PHP Service Company

1.0 Guidelines:

This policy applies to all network and non-network providers, including but not limited to percent of charge contract providers. This policy does not guarantee benefits or solely determine reimbursement. Benefits are determined and/or limited by an individual member's benefit coverage document (COC, SPD, etc.). The Health Plan reserves the right to apply clinical edits to all medical claims through coding software and accuracy of claim submission according to industry billing standards. Clinical edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI), the American Medical Association (AMA), and specialty societies. The Health Plan may leverage the clinical rationale of CMS or other nationally sourced edits and apply this rationale to services that are not paid through CMS but which are covered by the Health Plan to support covered benefits available through one of the Health Plan's products. Prior approval does not exempt adherence to the following billing requirements. The provider contract terms take precedence if there is a conflict between this policy and the provider contract.

2.0 Description:

Hospice services are considered by most as a philosophy or concept of care; it is not a specific place of care. A Hospice program is 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 Policy:

Health Plan covers hospice care as a medical benefit when established criteria are met and supported by clinical documentation. Hospice services are provided in either an inpatient or outpatient setting.

A. Services considered for reimbursement under the hospice benefit are included in the per diem rate as follows:

    1. Skilled nursing care provided by or under the supervision of a registered nurse.

    2. Medical social services.

    3. Physician and mid-level practitioner services.

    4. Counseling services, including:

        a. Bereavement counseling.

b. Dietary counseling.

c. Spiritual counseling.

d. Other additional counseling.

5. Physical, occupational, and speech/language therapy.

6. Homemaker/home health aide services.

7. Drugs/durable medical equipment/medical supplies.

8. Short-term inpatient care other services covered by the Benefit plan that are not related to Hospice but would otherwise be covered, as long as such services do not exclude the member from electing hospice care.

9. Volunteer services.

10. Prescription medications for symptom control and pain relief.

11. Medical equipment recommended by the hospice team (e.g., hospital beds).

12. Medical supplies (e.g., bandages, catheters) used by the hospice team.

B. Services **excluded** from coverage or 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 .

4.0 Coding and Billing:

Prior Approval Legend: Y = All lines of business; N = None required; 1 = HMO/POS; 2 = EPO/PPO; 3 = SHS 264; 4 = SHS 1269 non-union & union; 5 = LBWL; 6 = Dart; 7 = SHS 1269 union only; 8 = ASO group L0002184.

PROFESSIONAL SERVICES 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	N	Professional fees for surgical and medical services

PROFESSIONAL SERVICES COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
	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		
G0156	Services of home health/health aide in home health or hospice settings, each 15 minutes	N	Professional fees for surgical and medical services
G0337	Hospice evaluation and counseling services	N	Physician office visit for sickness or injury; Professional fees for medical and surgical services
Q5001	Hospice or home health care provided in patient's home/residence		Professional fees for surgical and medical services
Q5002	Hospice or home health care provided in assisted living facility		Professional fees for surgical and medical 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

PROFESSIONAL SERVICES COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
Q5009	Hospice or home health care provided in place not otherwise specified (NOS)	N	Professional fees for medical and surgical services
Q5010	Hospice home care provided in a hospice facility	N	Professional fees for medical and surgical services
S9126	Hospice care, in the home, per diem	N	Professional fees for medical and surgical services

PROFESSIONAL SERVICES 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	Exclusion for health services and medical supplies that do not meet the definition of a Covered Health Service.
T2042	Hospice routine home care; per diem	T codes not covered
T2043	Hospice continuous home care; per hour	T codes not covered
T2044	Hospice inpatient respite care; per diem	T codes not covered
T2045	Hospice general inpatient care; per diem	T codes not covered
T2046	Hospice long term care, room and board only; per diem	T codes not covered

FACILITY COVERED CODES			
Revenue Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
0650	General	N	Facility services (non-hospital)
0651	Routine home care	N	Facility services (non-hospital)
0652	Continuous home care	N	Facility services (non-hospital)
0655	Hospice Inpatient Respite Care	N	Facility services (non-

FACILITY COVERED CODES			
Revenue Code	**Description**	**Prior Approval**	**Benefit Plan Cost Share Reference**
			hospital)
0656	Hospice General Inpatient Care-Non Respite	N	Facility services (non-hospital)
0657	Physician service	N	Facility services (non-hospital)
0659	Other hospice	N	Facility services (non-hospital)

FACILITY NON-COVERED CODES		
Revenue Code	**Description**	**Benefit Plan Reference/Reason**
0658	Hospice Room and Board - nursing facility	Specific exclusion for custodial care

1. Bill facility hospice services as defined by provider contract via UB-04.

    a. Discharges/Transfers (Field 17).

        i. Discharge status codes are required for hospital inpatient claims including SARs.

        ii. A patient discharge status code is defined as “a two-digit code that identifies where the patient is being discharged to at the end of their facility stay, or where they will be transferred to such as an acute/post-acute facility.

        iii. The discharging facility should ensure that documentation supports the billed discharge status code.

        iv. Failure to submit the appropriate code can result in denial of claims, delayed payments, or even return of reimbursement.

    b. Condition Codes (Fields 18-28).

        i. Required if applicable.

        ii. Situational two-digit codes that are entered in numerical order to describe any of the pertinent conditions or events that apply to the billing period of the claim.

    c. Occurrence Codes (Fields 31-34).

        i. Required if applicable.

        ii. Codes and dates defining specific event(s) related to the billing period of the claim.

        iii. Event codes are two-digits and dates are six numeric digits (MMDDYY).

    d. Occurrence Span Code and Dates (Field 35-36).

i. Required for inpatient claims.

ii. The provider must enter codes and associated beginning and ending dates defining a specific event relating to the billing period of the claim.

iii. Event codes are two-digits and dates are six numeric digits (MMDDYY).

e. Value Codes and Amounts (Fields 39-41).

i. Required if applicable.

ii. Codes and related dollar amount(s) identifying data of a monetary nature that are necessary for the processing of claims.

iii. The codes are two-digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in Field 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so the provider must refer to specific codes for instructions.

iv. If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are four lines of data, line "a" through line "d." The provider uses FLs 39A through 41A before 39B through 41B (i.e., it uses the first line before the second).

Please note: out of network (OON) and CMS based contracted providers must bill in accordance with CMS regulations.

5.0 Verification of Compliance.

Claims are subject to audit, prepayment and post payment, to validate compliance with the terms and conditions of this policy.

6.0 Documentation Requirements:

Hospice providers must establish and maintain a clinical record for every individual receiving care and services.

1. The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval.

2. The record must include all services, whether furnished directly or under arrangements made by the hospice.

3. Medical records should contain enough clinical factors and descriptive notes to show the illness is terminal and progressing in a manner that a physician would reasonably have concluded that the beneficiary's life expectancy is six months or less.

4. Hospice benefit periods are unlimited as long as the above remains true and documentation of disease progression is evident.

5. Generally, a beneficiary will show decline from one certification period to the next; however, this may not be the case for some beneficiaries whose condition may not run the normal course of decline and remain temporarily unchanged. However, documentation in the medical record should still show that the beneficiary has a six month prognosis.

6. Documentation notes from multiple disciplines involved in the care of the beneficiary should demonstrate a picture of the beneficiary's terminal progression. Avoid vague statement such as

"slow decline" or "disease progressing" that do not clearly support the terminal progression requirements; the more objective the documentation, the better.

7. When receiving a beneficiary as a transfer from another agency in the middle of a benefit period, obtain a copy of the signed certification for that benefit period from the transferring agency to complete that benefit period. Remember that the benefit period does not change due to a transfer.

8. When a beneficiary's level of care changes, the documentation should show when the change occurred and the reason for the change.

7.0 Terms & Definitions:

Continuous Home Care (CHC) – 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.

Custodial Care - Non-covered services that:

- Are non-health related services.
- Do not seek to cure.
- Are provided when the medical condition of the patient is not changing.
- Do not require trained medical personnel.
- Are provided after stated clinical goals have been achieved.

Hospice Benefit Period – The 1st two 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.

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).

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 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 a RN or LPN and meets the following criteria for skilled nursing services:

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

8.0 References, Citations & Resources:

1. Centers for Medicare and Medicaid. Medicare Benefit Policy Manual. Chapter 9. Coverage of Hospice Services Under Hospital Insurance. Revision 209. 05/08/15. Available at URL address. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf.
2. American Academy of Hospice and Palliative Medicine. National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care. © 2009, National Consensus Project for Quality Palliative Care. Available at URL address: http://www.nationalconsensusproject.org/Guideline.pdf.
3. World Health Organization 2015. Definition of Palliative Care. http://www.who.int/cancer/palliative/definition/en/.
4. American Medical Association (AMA), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and associated publications
5. Associated Benefit Coverage Policy: BCP-22 Hospice Services.

9.0 Revision History:

Original Effective Date: 12/26/2018

Next Revision Date: 10/01/2022

Revision Date	Reason for Revision
12/18	PRP created.
9/19	Annual review; billing language added.
10/20	Annual review; removed prior approval requirement, approved by CCSC 12/1/20.
7/21	Annual review; covered services expanded and excluded services added Update the verbiage on the guidelines to be uniform