Clinical Policy: Hospice Services

Description
Medical necessity criteria for hospice services.

Policy

Initial Request
It is the policy of health plans associated with Centene Corporation® 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 meets one of the severity of illness criterion
   A. Cancer, or
   B. ALS, or
   C. Heart Disease, or
   D. Pulmonary Disease, or
   E. Dementia, or
   F. HIV, or
   G. Liver Failure, or
   H. Acute or Chronic Renal Failure, or
   I. Stroke, or
   J. Coma, or
   K. Non-Disease Specific Decline in Clinical Status; and
III. The requested intensity of service is appropriate
   A. Routine Hospice Home Care, or
   B. Continuous Hospice Home Care, or
   C. Inpatient Respite Hospice Care, or
   D. General Inpatient, Short Term (non-respite) Hospice Care

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. The written certification must identify the terminal illness diagnosis that prompted the member to seek hospice care, includes a statement that the member’s life expectancy is six months or less if the terminal diagnosis runs its normal course; details specific clinical findings supporting a life expectancy of 6 months or less; and
2. The documentation also includes a hospice election statement signed by the member or the member’s healthcare proxy stating they understand the nature of hospice care.

II. Severity of Illness
The presence of significant comorbidities should be considered when using these criteria to determine hospice appropriateness.

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

B. ALS (amyotrophic lateral sclerosis)– meets 1, 2, and 3:
   1. PPS (Appendix A) or KPS (Appendix B) score < 70%; and
   2. Dependence for at least 2 ADLs (i.e. ambulation, continence, transfers, dressing, feeding, bathing); and
   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 capacity (FVC) < 40% (if results available), or
      b. Rapid progression with critical nutritional impairment indicated by at least 5% loss of body weight (with or without tube feeding), or
      c. Rapid progression with other life-threatening complications (sepsis, recurrent aspiration, pyelonephritis, stage 3-4 decubiti).

C. Heart Disease – meets 1, 2, and 3:
   1. PPS (Appendix A) or KPS (Appendix B) score < 70%; and
   2. Dependence for at least 2 ADLs (i.e. ambulation, continence, transfers, dressing, feeding, bathing); and
   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) ≤ 20% (if results available), and
         ii. Presently optimally treated with diuretics and vasodilators or has failed therapy with IV inotropes; or
      b. Coronary Artery Disease (CAD), all of the following:
         i. Elderly member with intractable angina who is not a candidate for coronary revascularization, and
         ii. No longer responding well to nitrates, beta- and calcium-channel blockers and other appropriate medications, and
         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%; and
2. Dependence for at least 2 ADLs (i.e. ambulation, continence, transfers, dressing, feeding, bathing); and
3. Severity, all
   a. Disabling symptoms at rest or with minimal exertion, and
   b. Diminished functional capacity, i.e., bed-to-chair existence, and
   c. Forced expiratory volume in 1 second (FEV1) < 30% predicted; and
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), and
   b. Member states they do not want to be intubated; and
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, or
   b. Pyelonephritis, or
   c. Septicemia, or
   d. Multiple stage 3-4 decubiti, or
   e. Fever recurrent after a course of antibiotics, or
   f. Weight loss > 10% over six months, or
   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; and
2. PPS or KPS score < 50%; and
3. At least one of the following AIDS-related conditions:
   a. Central nervous system or poorly responsive systemic lymphoma, or
   b. Wasting: loss of > 33% of lean body mass, or
   c. Mycobacterium avium complex (MAC) bacteremia, or
   d. Progressive multifocal leukoencephalopathy (PML), or
   e. Refractory visceral Kaposi’s sarcoma (KS), or
   f. Renal failure in the absence of dialysis, or
   g. Refractory cryptosporidium infection, or
   h. Refractory toxoplasmosis.

G. *Liver Failure* – meets ALL of the following:
1. PPS (Appendix A) or KPS (Appendix B) score < 70%; and
2. Dependence for at least 2 ADLs (i.e. ambulation, continence, transfers, dressing, feeding, bathing); and
3. Member has end-stage liver disease and is not on the transplant list; and
4. Prothrombin time (PT) > 5 seconds or international normalized ration (INR) > 1.5; and
5. Albumin < 2.5 g/dl; and
6. And at least one of the following:
   a. Recurrent bleeding esophageal varices despite therapy, or
   b. Refractory ascites, or
   c. Episode of spontaneous bacterial peritonitis, or
   d. Hepatorenal syndrome, or
   e. Hepatic encephalopathy.

H. Acute or Chronic Renal Failure – meets ALL of the following:
   1. PPS (Appendix A) or KPS (Appendix B) score < 70%; and
   2. Dependence for at least 2 ADLs (i.e. ambulation, continence, transfers, dressing, feeding, bathing); and
   3. Member is in renal failure, not receiving dialysis and one of the following:
      a. Serum Creatinine > 8 mg/dl (> 6 diabetes), or
      b. Creatinine clearance < 10 (or < 15 with diabetes), or
      c. Creatinine clearance < 15 with CHF (or < 20 with diabetes and CHF).

I. Stroke – meets ALL of the following:
   1. PPS or KPS < 40%; and
   2. Inadequate oral intake with one of the following:
      a. Weight loss of > 10% body weight in up to 6 months, or > 7.5% in up to three months, or
      b. Serum albumin < 2.5 g/dl, or
      c. Recurrent aspiration, or
      d. Dysphagia and declining tube feeding and hydration.

J. Coma – member is comatose with at least three of the following on day 3 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 based on:
      a. Progressive dependence for ADLs, or
      b. KPS or PPS score < 70%, or
      c. Increasing frequency of ER visits or hospitalizations, or
      d. Worsening of:
i. Clinical status - such as recurrent infections, inanition with progressive weight loss, dysphagia, or decreasing albumin, or
ii. Signs - such as hypotension, ascites, edema, pleural or pericardial disease, or decreased consciousness, or
iii. Symptoms - such as intractable dyspnea, cough, nausea, diarrhea, or pain, or
iv. Laboratory results - arterial blood gases, tumor markers, electrolytes, creatinine, or liver function tests; or

e. Progressive or stage 3-4 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. 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 < 8 hours of nursing care, which may be intermittent, is required in a 24-hour period. 90 days of routine hospice care may be approved.

B. Continuous Hospice Home Care (HCPCS T2043 or rev code 0652)
Continuous hospice home care is medically necessary to maintain the member at home, when the member requires ≥ 8 hours of nursing care in a 24 hour period (begins and ends at midnight). Up to 5 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 or other primary caregivers of care duties for no more than 5 consecutive days per episode. Respite care is short term inpatient care, and not residential or custodial care. Up to 5 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's care team; and
2. The individual treatment plan is specifically directed at acute symptom management and/or pain control.
Up to 5 days of general inpatient, short term care may be approved with ongoing concurrent review for additional days requested.

IV. Not Medically Necessary Services
Hospice services are considered NOT medically necessary under the following circumstances:

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

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

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

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

E. 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.

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. The appropriate HCPCS or revenue (rev) code must be billed according to applicable contract provisions.

It is the policy of health plans associated with Centene Corporation 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 at home, when the member requires ≥ 8 hours of nursing care in a 24 hour period (begins and ends at midnight). Up to 5 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 or other primary caregivers of care duties for no more than 5 consecutive days per episode. Respite care is short term inpatient care, and not residential or custodial care. Up to 5 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 care team; and
      2. The treatment plan is specifically directed at acute symptom management and/or pain control.
I. Clinical Policy

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Up to 5 days of general inpatient, short term care may be approved with ongoing concurrent review for additional days requested.

III. Change to routine home care following higher intensity of service

Continuation of routine home care following a higher level of care is medically necessary for the duration of the current 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’s home and is related to the terminal diagnosis and plan of care written for the member. 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 at home. Continuous care 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.

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 5 consecutive days per episode. It is allowed to relieve family members or other primary caregivers of the primary caregiving duties. 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.

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 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.
Certification Periods
Certification (benefit) periods include an initial 90-day benefit period, followed by a second-90 day benefit period, followed by an unlimited number of 60-day benefit periods. Hospice care is continuous from one period to another, unless the member revokes, or the hospice provider discharges or does not recertify.

Discontinuation of Hospice
If a member revokes or is discharged from hospice care, the remaining days in the benefit period are lost. If/when the member meets the hospice coverage requirements, they can re-elect the hospice benefit, and will begin with the next benefit period.

Covered Services
When the above coverage criteria are met, the following hospice care services may be covered 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 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
The hospice provider is responsible for:

A. Verifying member eligibility
B. Obtaining authorization to provide hospice services before hospice care is initiated
C. Notifying the health plan of any significant change in the member’s status or condition including revisions to treatment plans and goals
D. Requesting each change in the level of hospice service including discharge from hospice.

**Background**
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. Most hospice services are provided at home, 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 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)**

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

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

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

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

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

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.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T2042</td>
<td>Hospice routine home care; per diem</td>
</tr>
<tr>
<td>T2043</td>
<td>Hospice continuous home care; per hour</td>
</tr>
<tr>
<td>T2044</td>
<td>Hospice inpatient respite care, per diem</td>
</tr>
<tr>
<td>T2045</td>
<td>Hospice general inpatient care; per diem</td>
</tr>
<tr>
<td>T2046</td>
<td>Hospice long-term care, room and board only; per diem</td>
</tr>
<tr>
<td>G0337</td>
<td>Hospice evaluation and counseling services, pre-election</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0651</td>
<td>Hospice routine home care; per diem</td>
</tr>
<tr>
<td>0652</td>
<td>Hospice continuous home care, per 15 minutes</td>
</tr>
<tr>
<td>0655</td>
<td>Hospice inpatient respite care, per diem</td>
</tr>
<tr>
<td>0656</td>
<td>Hospice general inpatient, non-respite care, per diem</td>
</tr>
<tr>
<td>0658</td>
<td>Hospice room and board, nursing facility</td>
</tr>
<tr>
<td>0657</td>
<td>Hospice charges for services furnish by physician or nurse practitioner employees, or physicians or nurse practitioners receivin compensation from the hospice. Physician services performed by a nurse practitioner require the addition of the modifier GV in conjunction with revenue code 0657.</td>
</tr>
</tbody>
</table>

Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
<th>Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy reorganized into severity of illness and intensity of service criteria; added appendices</td>
<td>07/14</td>
<td>07/14</td>
</tr>
<tr>
<td>Converted into new policy template, bibliography reviewed and updated</td>
<td>07/15</td>
<td>07/15</td>
</tr>
<tr>
<td>References reviewed and updated. Limited codes in Coding Implications to only those that should be billed for hospice services.</td>
<td>07/16</td>
<td>07/16</td>
</tr>
<tr>
<td>References reviewed and updated.</td>
<td>07/17</td>
<td>07/17</td>
</tr>
<tr>
<td>Removed requirement of documentation that member must no longer be seeking curative treatment, with the possible exception of CHIP. Intensity of Service (Initial): removed redundant language regarding requirement for authorization of each request. Added section for subsequent requests.</td>
<td>04/18</td>
<td>04/18</td>
</tr>
</tbody>
</table>
Section I.E Dementia: Removed “Inability to ambulate” from criteria as this is included in the FAST stage 7 criteria; added septicemia to list of medical complications (E.2.C). References reviewed and updated. Specialist reviewed.

03/19 04/19

Noted in “non-covered services” section that exclusion of coverage for concurrent treatment does not apply to children in Medicaid or CHIP.

07/19

Replaced “glomerular filtration rate” with creatinine clearance in H.3.b and H.3.c. References reviewed and updated.

03/20 04/20

References


**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.
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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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