Medical Policy & Procedure

Policy Name:	Medical Policy: Hospice Care	Policy #:	MP-321

Policy Information

Owner Department:	Medical UM & Systems Department
Owner:	Assigned Medical Director
Electronic Signature/Date:	Krystal Revai (08/08/2023), Lori Slaughter (08/08/2023)

If there is a discrepancy between a medical policy and a patient's policy or plan document/summary plan description, the policy or plan document/summary plan descriptions provisions and limitations will govern the determination of benefits.

Purpose of the Policy

To make utilization decisions, Health Alliance uses written criteria based on sound clinical evidence for appropriately applying the criteria.

Statement of the Policy

A hospice care program provides a coordinated, interdisciplinary program for meeting the special physical, psychological, spiritual, and social needs of a terminally ill member and his or her family by providing palliative and supportive medical, nursing, and other services through at-home or inpatient care for select SF plans only.

NOTE: Please refer to plan documents for prior authorization necessity/status.

Interpretations

1. Hospice program Per Diem charges are covered when:

1.1 Ordered by a Physician for a member expected to live less than six months as a result of their illness,
1.2 Potentially curative treatment is not part of the plan of care, and
1.3 The individual or appointed decision maker has formally agreed to hospice care, and
1.4 The member has a diagnosis of:
   a. Cancer; or
   b. Amyotrophic Lateral Sclerosis (ALS); or
   c. Dementia due to Alzheimer's disease and related disorders; or
   d. Heart disease; or
   e. HIV disease; or
   f. Liver disease; or
   g. Pulmonary disease; or
   h. Renal disease (acute renal failure or chronic kidney disease); or
   i. Stroke; or
   j. Coma

2. Short-Term Respite Care at a contracted Facility requires prior-authorization and is covered for:

2.1 Short-term relief of member's caregivers, no more often than two times after admission to the Hospice program and for no more than five consecutive days at a time.

NOTE: For Health Alliance Medicare Advantage members entering a hospice program, hospice related charges revert to standard CMS payment.

Medicare details:

- No NCDs are available. Medicare benefits policy manual –Chapter 9 hospice coverage information is available at Internet-Only Manuals (IOMs) | CMS
- Enter Regional LCD/LCA ID in Medicare website/link below for criteria details.
- MCD Search (cms.gov)

Medicare Admin Contractor (MAC) (HHH) – Member's state	Regional LCD/LCA Identifier	Applicable criteria
Palmetto (IL, IN, OH, NC)	• L34566/A56677 (Hospice –HIV Disease) • L34547/A56502 (Hospice-Neurological Conditions) • L34544/A56669 (Hospice – Liver Disease) • L34559/A56545 (Hospice – Renal Care) • L34567/A56639 (Hospice – Alzheimer's Disease & Related Disorders) • L34548/A56610 (Hospice – Cardiopulmonary Conditions) • A53054 (Going Beyond Diagnosis – Hospice Cardiopulmonary Conditions) • L34588/A56679 (Hospice – The Adult Failure to Thrive Syndrome) • A53056 (Hospice – Documenting Weigh Loss for Beneficiaries with Non-Neoplastic Conditions)	Applicable Palmetto LCD/LCA
CGS (IA)	L34538 (Hospice – Determining Terminal Status)	Applicable CGS LCD
NGS (WA)	L33393/A52830 (Hospice - Determining Terminal Status)	Applicable NGS LCD/LCA

Codes

*Codes listed are for informational purposes only and do not necessarily indicate that prior authorization is or is not required or coverage is guaranteed.

99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional, each additional 30 minutes (List separately I addition to code for primary procedure)
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes

Providers are required to indicate the diagnosis and procedure codes when requesting review of coverage.

References

1. Meier DE. Hospice: Philosophy of care and appropriate utilization in the United States. In: UpToDate, Post TW (Ed), Waltham, MA. (Accessed on May 7, 2018.)

History			
Created Date:	09/20/18		
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Next Review Date:	08/08/2024		
Revision Date:	11/30/18 – C. Kunka-Updated language for select SF plans.		
	09/17/19 – MDC-Annual review, no changes.		
	09/30/20 – MDC-Annual review, no changes.		
	09/21/21 – MDC-Annual review, no change.		
	08/16/22 – MDC-Annual review, no changes.		
	07/18/23 – MDC-Annual review, Medicare information updated, no changes.		