

HOSPICE SERVICES

Policy

AllWays Health Partners reimburses participating providers for the provision of medically necessary hospice services which meet the criteria set forth in the Limitations of Coverage

Prerequisites

Authorization, Notification and Referral

Service	Requirement
Hospice Service	Prior Authorization Required
Respite Care	Prior Authorization Required

Limitations

Hospice is a covered benefit for: MassHealth Standard and Family Assistance Members, Commonwealth Care, Commonwealth Choice, and Commercial Members, only.

Respite care is limited to 14 days per calendar year.

Inpatient respite care is limited to no more than 5 consecutive days including date of admission, but not date of discharge and is authorized per episode. Reimbursement for day 6 and any subsequent days is made at the routine hospice home care rate. Unused days are forfeited.

Respite care is not reimbursed in addition to routine hospice home care.

AllWays Health Partners covers hospice care services when medically necessary when the following conditions are met:

- The individual is terminally ill and expected to live six months or less if the illness runs its normal course.
- Potentially curative treatment for the terminal illness is not part of the prescribed plan of care.
- The individual or appointed designee has formally consented to hospice care (e.g. care directed mostly at palliative care and symptom management).
- The hospice services are provided by a certified/accredited hospice agency with care available 24 hours per day, seven days per week.
- The hospice is responsible for providing any and all services indicated in the plan of care as necessary for the palliation and management of the terminal illness and related conditions.

Exceptions to Policy Criteria

Despite the election of hospice care, active treatment to address secondary illness may be required. These treatments may be considered life-prolonging; however, they often eliminate adverse symptoms such as shortness of breath, physical fatigue and edema. Essentially, some treatments may be both disease-modifying and palliative.

Hospice organizations may allow patients to receive treatments such as palliative radiation or chemotherapy, blood transfusion or even surgery, if necessary to control symptoms.

In some situations, it is appropriate to discharge a patient from hospice. If the hospice team determines the patient is no longer considered terminally ill, discharge from the hospice is deemed appropriate. Additionally, hospice discharge may be appropriate if the patient moves out of the area, transfers to another hospice program, or declines further hospice services.

MassHealth members under the age of 21 who have elected the hospice benefit will have coverage for **curative treatment** and all medically necessary services for which they are eligible.

Commercial members under the age of 21 have the option of services outside the hospice benefit.

Member Cost-Sharing

The provider is responsible for verifying at each encounter and when applicable for each day of care when the patient is hospitalized, coverage, available benefits, and member out-of-pocket costs; copayments, coinsurance, and deductible required, if any.

Definitions

Hospice: A program or facility that provides special care for people who are near the end of life and for their families.

Hospice Care: Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure. The goal is to enable patients to be comfortable and free of pain, so that they live each day as fully as possible. Aggressive methods of pain control may be used. Hospice programs generally are home-based, but they sometimes provide services away from home - in freestanding facilities, in nursing homes, or within hospitals. The philosophy of hospice is to provide support for the patient's emotional, social, and spiritual needs as well as medical symptoms as part of treating the whole person.

Hospice Inpatient Facility: A palliative-care facility that cares solely for hospice members requiring short-term, general inpatient, or respite care and is owned and operated directly by a licensed hospice pursuant to Department of Public Health 105 CMR 141.000, Licensure of Hospice Programs.

Physician Services: The physician services of the hospice medical director or physician member of the interdisciplinary team must be performed by a Doctor of Medicine or osteopathy.

Attending Physician Services: The attending physician is a Doctor of Medicine or osteopathy, or nurse practitioner and is identified by the patient at the time hospice care is elected as having the most significant determination and delivery of the patient's medical care. Nurse practitioners cannot certify or recertify a terminal illness or provide a prognosis of six months or less.

Primary Caregiver: A designated, patient selected person who is responsible for the patient's care and support in the home on a 24-hour basis.

Respite Care: Care provided to the patient to temporarily relieve the patient's family or other primary caregiver from the daily demands of caring for the patient. Respite care may be provided in the patient's home or in an inpatient facility.

Room and Board: Includes performance of personal care services, including assistance in activities of daily living, in socializing activities, administration and assistance in the use of durable medical equipment and prescribed therapies. This service is in addition to services provided by Routine Hospice Care or Continuous Hospice Care.

Terminally Ill: Recipient has a medical prognosis that his/her life expectancy is 6 months or less if the illness runs its normal course.

Levels of Hospice Care

ROUTINE HOSPICE HOME CARE (per diem) includes the following services:

- Skilled nursing care
- Up to **4 hours** of a home health aide/homemaker services, per day
- Physician's administrative and supervisory services per 105 CMR 141.204
- Medical Social Worker Services
- Counseling Services including Pastoral Counseling
- Nutritional Counseling
- Physical, occupational and speech therapies
- Respiratory equipment and therapies
- Durable Medical Equipment (DME)
- Medical and surgical supplies
- Venipuncture
- Volunteer services
- Bereavement counseling
- Medical supplies
- Drugs and biological related to the terminal illness, regardless of administration route, for pain relief, symptom management and hydration.
- Drugs obtained from the pharmacy by the member when covered by the prescription plan in effect at the time of service.
- Enteral formulas when used as the primary source of nutrition via a feeding tube and part of the treatment plan when provided by hospice.

CONTINUOUS HOME HOSPICE CARE (per diem) includes the following services:

- Predominately nursing care on a continuous basis at home.
- Home health aide or homemaker services or both may also be covered on a continuous basis.
- Continuous home care is only furnished during brief periods of crisis and only as necessary to maintain the member at home.
- A **minimum of 8 hours must be provided in a 24-hour period** beginning and ending at midnight. Care need not be continuous.
- Includes all services identified in Routine Hospice Home Care.

RESPITE HOSPICE CARE (per diem):

An inpatient stay **or** up to 24 hours home care provided for no greater than 14 consecutive days or non-consecutive days for a maximum of 14 days per calendar year, to relieve the primary caregiver.

- Includes all services identified in Routine Hospice Home Care.

GENERAL INPATIENT HOSPICE CARE (NON-RESPITE, SHORT TERM) (per diem):

- General inpatient hospice care provided in a hospital licensed per MGL CH. 111 §51 or in a long-term care facility licensed per MGL Ch 111 § 71, for acute short-term symptom management, and/or pain control related to the terminal illness that cannot be managed in the home.
- Includes all services identified in Routine Hospice Home Care.

OTHER HOSPICE CARE (RESIDENTIAL *inpatient* HOSPICE) (per diem):

- Residential care given when a primary caregiver is unavailable or unable to provide the care.

AllWays Health Partners Reimburses

- Home care when less than 8 hours of primary nursing care, which may be intermittent, are required in a 24-hour period.
- Continuous home care for the relief of acute medical symptoms, when at least a total of 8 hours of primary skilled care, which may be intermittent, is required in a 24-hour period.
- Inpatient respite care that is short term (i.e. up to 14 days per calendar year) and provided as part of the overall treatment plan, for the safety and supervision of a hospice patient to relieve the primary caregiver at home.
- Inpatient hospice care when the intensity or scope of care needed is not feasible in the home setting will be short term, and when the individual treatment plan is specifically directed at acute symptom management and/or pain control.
- A physician separately for services rendered during a hospice episode when such care is **unrelated** to the terminal illness.
- Radiation services outside the hospice contracted per diem to contracted providers.
- Services provided as a result of a subcontract arrangement with the hospice will be reimbursed to the hospice directly and paid as a component of the hospice per diem.

AllWays Health Partners Does Not Reimburse

- Hospice services for individuals no longer considered terminally ill.
- Services, supplies, or procedures that are directed at curing the terminal condition or deemed to be life-prolonging (e.g. life sustaining) unless said services are part of the palliative plan of care.
- Services to solely aid in the performance of activities of daily living (ADLs).
- Nutritional supplements, vitamins, and drugs not covered by the pharmacy benefit.

Medical supplies unrelated to the palliative care to be provided.

- Services outside of the hospice benefit.
- Inpatient care other than the services described above.
- Subcontracted hospice services which must be billed directly to the hospice provider

Procedure Codes Applicable to Guideline

Note: This list of codes may not be all-inclusive.

Rev Code	Descriptor	Comment
0651	Hospice Service-Routine Home Care	For billing less than 8 hours of care. Enter number of hours in UB- 04 Form Locator 46 Submit the appropriate “Q” code to indicate rendering location.
0652	Hospice Service-Continuous Home Care	Enter the number of hours in UB-04 Form Locator 46 Submit the appropriate “Q” code to indicate rendering location.
0655	Hospice Service-Inpatient Respite Care	Enter the number of days in UB-04 Form Locator 46 Submit the appropriate “Q” code to indicate rendering location.
0656	Hospice Service-Inpatient General Care (non-respite)	Enter the number of days in UB-04 Form Locator 46 Submit the appropriate “Q” code to indicate rendering location.
0657	Hospice-Physician Services	Provide CPT/HCPCS Level II code detail Submit the appropriate “Q” code to indicate rendering location.
0658	Hospice- Room and Board-Nursing Facility	Enter the number of days, in addition to Rev Code 0651 or 0652. Submit the appropriate “Q” code to indicate rendering location.
0659	Hospice-Other	Enter the number of hours in UB-04 form Locator 46 Submit the appropriate “Q” code to indicate rendering location.

HCPCS Code	Descriptor
Q5001	Hospice care provided in patient’s home/residence
Q5002	Hospice care provided in assisted living facility
Q5003	Hospice care provided in nursing long term care facility or non-skilled nursing facility
Q5004	Hospice care provided in skilled nursing facility
Q5005	Hospice care provided in inpatient hospital
Q5006	Hospice care provided in inpatient hospice facility
Q5007	Hospice care provided in long-term care facility
Q5008	Hospice care provided in inpatient psychiatric facility
Q5009	Hospice care provided in place not otherwise specified
Q5010	Hospice home care provided in a hospice facility

Provider Payment Guidelines and Documentation

All subcontracted services must be billed by the hospice agency and must not be billed by a subcontractor. All services billed as a result of a subcontract arrangement will be paid as a component of the hospice per diem and not reimbursed separately.

Bill for hospice services on an Institutional UB-04 Form using the appropriate revenue code(s), per your contractual agreement with AllWays Health Partners.

Submit HCPCS Level II codes (Q5001-Q5010) with the revenue code to indicate the location where the hospice care was rendered.

It is the level of care, and not the place of service that determines reimbursement. Bill other services on a CMS-1500 FORM.

Submit only one revenue code per date of service. Submit an individual date on each service line.

If submitting date ranges on a one-line-only claim, the count must match the number of days in the date range.

Enter the AllWays Health Partners Authorization number in the UB-04 Form Locator 63.

Please refer to your contract with AllWays Health Partners for information regarding specific coding requirements.

Reference

CMS Coverage of Hospice Services Manual 40.1.9; 40.3; 40.4.1

Division of Medical Assistance 130 CMR; 437:000 Hospice Services Mass.

Division of HCFA, 114.3 CMR 43.00 Hospice Services

MassHealth Transmittal Letters **HOS-14**, 04/01/2010; **HOS-15**, March 2011

US-DHHS SMD # 10-018, ACA # 8, Hospice Care for Children in Medicaid and CHIP

Publication History

Topic: Hospice	Owner: Network Management
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<i>May 25, 2010</i>	<i>Original documentation</i>
<i>May 15, 2012</i>	<i>Authorization grid, limitations and exceptions, definitions, guideline and documentation, references and disclaimer updated, new Q code added.</i>
<i>January 1, 2019</i>	<i>Document restructure, Disclaimer</i>

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider’s agreement, the terms and conditions of the provider’s agreement shall prevail. Payment policies are intended to assist providers in obtaining AllWays Health Partners ' payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers ‘contract(s); scope of benefits included in a given member’s benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

AllWays Health Partners includes AllWays Health Partners, Inc. and AllWays Health Partners Insurance Company.