Medical Coverage Policy

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Coverage Policy Number..... 0462

Hospice Care

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INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health

benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses hospice care. A hospice care 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.

Coverage Policy

Coverage for hospice care is subject to the terms, conditions and limitations of the applicable benefit plan. Please refer to the applicable benefit plan document to determine benefit availability and the terms, conditions and limitations of coverage. Please note that many benefit plans do not cover respite care.

While receiving hospice care services, non-hospice services may still be covered under other portions of the benefit plan.

If benefit coverage for hospice services is available, the following conditions of coverage apply.

Hospice care services are considered medically necessary when ALL of the following criteria are met:

- The individual is terminally ill and expected to live twelve months or less.
- Potentially curative treatment for the terminal illness may be part of the prescribed plan of care.
- The individual or appointed designee has formally consented to hospice care (i.e., care which is directed mostly toward 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.

When the above medical necessity criteria have been met, hospice care may include any of the following levels of care:

- Home care when less than eight hours of primarily 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 eight hours of primarily skilled care, which may be intermittent, is required in a 24-hour period.
- Inpatient hospice care when the intensity or scope of care needed is not practical in the home setting.

When the above medical necessity criteria above are met, hospice services may include:

- physician services
- intermittent skilled nursing services
- home health aide services

- physical and/or occupational therapy
- speech therapy services for dysphagia/feeding therapy
- medical social services
- counseling services (e.g., dietary and bereavement)
- short-term inpatient care
- prescription drugs
- consumable medical supplies (e.g., bandages, catheters) used by the hospice team

Each of the following hospice care services is specifically excluded from coverage or considered not medically necessary as hospice care:

- services for an individual no longer considered terminally ill
- services to primarily aid in the performance of activities of daily living (e.g., personal hygiene, feeding, dressing, transfers)
- nutritional supplements, vitamins, minerals and non-prescription drugs
- medical supplies unrelated to the palliative care to be provided
- services for which any other benefits apply

General Background

Hospice services are considered as a philosophy or concept of care; it is not a specific place of care or an evidence-based standard. The focus of treatment is palliative, not curative, and is based on a biopsychosocial model rather than a disease model of care (Fine and Davis, 2006). Palliative care may be defined as treatment for the relief of pain and other uncomfortable symptoms through the appropriate coordination of all aspects of care to maximize personal comfort and relieve distress (Department of Health and Human Services, Centers for Medicare and Medicaid Services [CMS], Federal Register, 2005). Hospice care is comprehensive and coordinated palliative care that is provided in the final stages of life and allows the patient to remain at home for as long as possible by providing support to the patient and family and keeping the patient as comfortable as possible while maintaining the patient's dignity and quality of life. Hospice programs consider both the patient and the family as the unit of care. Services that are provided generally include nursing care, physicians' services, nurse practitioner services, medical social services and other supportive services (Meier, et al., 2023).

Racial disparities in the use of hospice care have been identified. In a study of 1,212 individuals by Ornstein et al. (2020) on the the utilization of hospice care in the last six months of life, 34.9% black decedents used Hospice care compared to 46.2% by white decedents. It was also found that black decedents were far more likely to receive aggressive care at the end of life which included multiple hospitalizations, emergency department visits, and use of intensive procedures.

Most hospice care services are provided in the home or in inpatient settings (e.g., hospital, freestanding hospice facility, nursing home) and are provided to patients in all age groups. Inpatient care is generally short-term and is provided for control of pain and management of acute symptoms (e.g., intractable nausea, vomiting, seizures), or to provide respite care for relief of the patient's primary caregivers. Short-term inpatient hospice care may also be provided in order to prepare the patient and family for home-care services.

Determining the Need for Services
Assessment tools for determining prognosis and hospice eligibility may include general guidelines for noncancer diseases, published by the National Hospice and Palliative Care Organization (NHCPO), (previously referred to as the National Hospice Organization [NHO], 1996), the Functional Assessment Staging Scale (FAST), and the Karnovsky Performance Scale score.

Eligibility for or election of hospice services does not require the patient have a do-not-resuscitate order, a living will, or that any specific intervention such as tube-feedings, transfusions, or chemotherapy be terminated. In some cases, pre-election evaluation or consultation for hospice care may be helpful to inform members and their family of the healthcare choices available.

Documentation of hospice eligibility includes the following information:

- history of recent progression of the disease, including treatment and indications of disease severity, decline in functioning, or increased need for emergency room visits or hospitalization
- physical examination that is focused on evidence of disease severity and specific disease criteria listed in the NHCPO guidelines
- indications of the patients physical functioning (e.g., Karnovsky score of 50% or less), ability to ambulate, and ability to complete activities of daily living
- nutritional indicators of disease severity are recommended but not required to confirm hospice eligibility
- mental status assessment, particularly for patients with dementia

Levels of Hospice Care
Hospice care is defined by the services and care provided, in addition to the setting in which these services are delivered. Four levels of hospice care are available: routine home care, continuous home care, inpatient respite care, and general inpatient care (CMS, 2021; NHPCO, 2022). A majority of hospice services in the United States are provided in the patient's home (NHPCO, 2022).

Routine Home Care: Routine home care is the basic level of care provided, often by an interdisciplinary hospice team to support a patient with a terminal illness. It may be provided in a private residence, a hospital residential care facility, or an adult care home. It may also be provided in a nursing facility when the facility has a contractual agreement with the hospice agency. This level of care typically requires fewer than eight hours of primarily nursing care per day and is based on the patient's individual needs. The nursing care need not be continuous. Often the family members and the hospice team work together to facilitate the role of family and friends as healthcare providers. Caregivers are taught how to care for the patient along with care that is provided by home health aides and skilled nurses. Typically, with this level of care, the nurse monitors the comfort level of the patient and works closely with the physician to adjust the treatment plan as needed. An on-call registered nurse is usually available to provide phone support and make home visits as necessary.

Continuous Home Care: Continuous home care is provided in the patient's home and is often provided during a medical crisis that would otherwise require inpatient admission. For example, patients with dyspnea, delirium, or pain may receive 24-hour nursing services temporarily until they are stable. A minimum of eight hours of primarily nursing care is required, half of which must be provided by a registered nurse, licensed practical nurse or nurse practitioner. The nursing care need not be continuous. Homemaker or home health aide services may also be provided to supplement nursing care. Nursing care in the hospice setting includes but is not limited to skilled care for pain and symptom control. Hospice medical directors can make home visits during this time as needed.

Inpatient Respite Care: Inpatient respite care is short-term care (i.e., five days or less per benefit period) that may be provided to relieve family members and other unpaid caregivers who care for the patient in their private residence. Respite care may be provided in a hospice facility, hospital or nursing home.

General Inpatient Care: General inpatient hospice care is provided in an inpatient setting for the purpose of managing symptoms or to perform procedures for pain control that cannot be performed in other settings. The inpatient services may be provided in a hospice inpatient facility, hospital facility, or nursing facility under the arrangement of a hospice agency.

Hospice Services
Patients who may benefit from hospice services include those who are terminally ill (i.e., life expectancy is 12 months or less) and who require services for the palliation or management of the terminal illness and related conditions. The physician must certify (i.e., validate) that the patient is terminally ill and has a life expectancy of 12 months or less to live, if the disease follows its expected course. Certification from the physician is generally based on the physician's or medical director's clinical judgment regarding the normal course of the patient's illness. Additionally, since making medical prognostications is not always exact, documentation in the medical records must support the physician's clinical judgment. The following clinical prognostic indicators have been identified as general predictors of end-stage illness (Meier, 2023) and may be included in the medical record:

- multiple comorbidities with no primary diagnosis
- greater than 10% weight loss over six months
- general physical decline
- decreasing serum albumin or cholesterol
- reduced performance status (e.g., Karnovsky score < 50%)
- dependence in most activities of daily living

If the patient lives longer than 12 months duration, it is not necessary to terminate coverage of hospice services. In the event patient survival is longer than 12 months, the physician recertifies that the patient is terminally ill in order for hospice benefits to continue.

Once a patient is certified as terminally ill with 12 months or less to live and elect's hospice services, an initial plan of care is established, and all treatment of the patient's terminal illness is provided by or through the hospice. Appropriate, qualified personnel perform all services.

Hospice programs use medications for symptom control and pain relief, in addition to medical equipment and supplies to assist in making the patient as comfortable and pain-free as possible. Hospice care services may include treatment that is curative or life-prolonging (i.e., life-sustaining), or treatment that is not related to the terminal illness. Hospice care services may include any of the following:

Nursing Care: These services must require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse and must be reasonable and necessary for treatment of the patient's illness or injury. Nursing care also includes services provided by a nurse practitioner who is not considered the patient's attending physician.

Medical Social Services: These services are provided by a social worker who is working under the direction of the physician.

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 a 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 12 months or less.

Counseling Services: Counseling services, including dietary counseling and bereavement, may be provided.

Short-term Inpatient Care: General inpatient care may be required for symptom management and pain control that cannot be provided in other settings. Inpatient care may be required for medication adjustment, observation or stabilizing treatment, such as psychosocial monitoring, or for a patient whose family is unwilling to permit needed care to be furnished in the home.

Medical Appliances and Supplies: These services include medical appliances and supplies, drugs and biologicals used by the hospice team primarily for the relief of pain and symptom control related to the patient's terminal illness.

Home Health Aide Services: Trained home health aides, under the supervision of a registered nurse, may provide personal care services and/or perform household services to ensure a safe and sanitary environment in the home.

Physical, Occupational and Speech Therapy: These services may be provided for purposes of symptom control or to enable the patient to maintain basic functional skills and activities of daily living.

In addition to hospice care services, specific disease treatment may be required for a secondary illness. 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 (Smucker, 2004). Hospice organizations may allow patients to receive treatments such as palliative radiation or chemotherapy, blood transfusion or even surgery, if necessary to control symptoms.

Discharge from Hospice Services
Discharge from hospice may be appropriate in some situations. If the hospice team determines the patient is no longer considered terminally ill, discharge from hospice is appropriate. In addition, hospice discharge may also be appropriate if the patient refuses services or is uncooperative, moves out of the area, or transfers to another hospice program. In the event a patient is discharged from hospice, benefit coverage would be available under core medical benefits as long as the patient remained eligible for coverage of medical services. It is recommended that the hospice program have a discharge planning process taking into account the possibility a patient's condition may stabilize or change, and hospice services would no longer be required. It is recommended that the patient and family are notified that a discharge is being considered in order to allow for necessary arrangements. Prior to discharge, the hospice must obtain a written physician discharge order from the hospice medical director.

Medicare Coverage Determinations

	Contractor	Determination Name/Number	Revision Effective Date
NCD		No National Determination found	
LCD	CGS Administrators	Hospice Determining Terminal Status/L34538	

	Contractor	Determination Name/Number	Revision Effective Date
LCD	National Government Services	Hospice - Determining Terminal Status/L33393	11/14/2019

Note: Please review the current Medicare Policy for the most up-to-date information.
(NCD = National Coverage Determination; LCD = Local Coverage Determination)

Coding Information

Notes:

1. This list of codes may not be all-inclusive since the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) code updates may occur more frequently than policy updates.
2. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
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 care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

HCPCS Codes	Description
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
G0155	Services of clinical social worker in home health or hospice setting, each 15 minutes
G0156	Services of home health/hospice aide in home health or hospice settings, each 15 minutes
G0162	Skilled services by a registered nurse (RN) for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieve its purpose in the home health or hospice setting)
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 license practical nurse (LPN) in the home health or hospice setting, each 15 minutes
G0337	Hospice evaluation and counseling services, pre-election

HCPCS Codes	Description
G0493	Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
G0494	Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
G0495	Skilled services of a registered nurse (RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes
G0496	Skilled services of a licensed practical nurse (LPN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes
Q5001	Hospice or home health care provided in patient's home/residence
Q5002	Hospice or home health care provided in assisted living facility
Q5003	Hospice care provided in nursing long-term care facility (LTC) or nonskilled nursing facility (NF)
Q5004	Hospice care provided in skilled nursing facility (SNF)
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 or home health care provided in place not otherwise specified (NOS)
Q5010	Hospice home care provided in a hospice facility
S0255	Hospice referral visit (advising patient and family of care options) performed by nurse, social worker, or other designated staff
S0257	Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)
S9126	Hospice care, in the home, per diem

Revenue Codes†	Description
0651	Hospice service - Routine home care
0652	Hospice service - Continuous home care
0657	Hospice service - Physician service
0658	Hospice service - Hospice room & board-nursing facility
0659	Hospice service - Other hospice service

Excluded and Not Covered when respite care is specific to hospice:

HCPCS Codes	Description
S9125	Respite care, in the home, per diem

References

1. American Cancer Society. What is hospice care? Making treatment decision. Revised May 10, 2019. Copyright 2023 © American Cancer Society, Inc. Accessed Dec 6, 2023. Available at URL address: https://www.cancer.org/treatment/finding-and-paying-for-treatment/choosing-your-treatment-team/hospice-care/what-is-hospice-care.html

2. Centers for Medicare and Medicaid. Medicare Benefit Policy Manual. Ch. 9. Coverage of hospice services under hospital insurance. Revision 11056, Oct 21, 2021. Accessed Dec 4, 2023. Available at URL address: http://www.cms.hhs.gov/manuals/Downloads/bp102c09.pdf

3. Centers for Medicare and Medicaid Services (CMS). Local Coverage Determinations (LCDs) alphabetical index. Accessed Dec 6, 2023. Available at URL address: https://www.cms.gov/medicare-coverage-database/indexes/lcd-alphabetical-index.aspx

4. Centers for Medicare and Medicaid Services (CMS). National Coverage Determinations (NCDs) alphabetical index. Accessed Dec 6, 2023. Available at URL address: https://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx

5. Department of Health and Human Services. Centers for Medicare and Medicaid. 42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation. Federal Register. Vol 70, No. 224. November 22, 2005. Final rule. Accessed Dec 4, 2023. Available at URL address: http://edocket.access.gpo.gov/2005/pdf/05-23078.pdf

6. Fine PG, Davis D. Hospice: Comprehensive care at the end of life. Anesthesiology Clin N Am. 2006 Mar;24(1):181-204.

7. Fischberg D, Meier DE. Palliative care in hospitals. Clin Geriatric Med. 2004 Nov;20(4):735-51, vii.

8. Gruenewald DA, White EJ. The illness experience of older adults near the end of life: a systematic review. Anesthesiol Clin North America. 2006 Mar;24(1):163-80.

9. Herbst L. Hospice care at the end of life. Clin Geriatr Med. 2004 Nov;20(4):753-65,vii.

10. Meier DE, McCormick E, Lagman RL. Hospice: Philosophy of care and appropriate utilization in the United States. In: UpToDate, Givens J, editor. Sep 14, 2023. UpToDate, Waltham, MA. Accessed Dec 4, 2023.

11. Miller SC, Teno JM, Mor V. Hospice and palliative care in nursing homes. Clin Geriatric Med. 2004 Nov;20(4):717-34.

12. Mo L, Urbauer DL, Bruera E, Hui D. Recommendations for Palliative and Hospice Care in NCCN Guidelines for Treatment of Cancer. Oncologist. 2021 Jan;26(1):77-83. doi: 10.1002/ONCO.13515. Epub 2020 Sep 23. PMID: 32915490.

13. National Consensus Project for Quality Palliative Care. Clinical practice guidelines for quality palliative care, 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018. Accessed Dec 6, 2023. Available at URL address: https://www.nationalcoalitionhpc.org/ncp/

14. National Hospice and Palliative Care Organization (NHPCO). Facts and Figures: Hospice Care in America. Alexandria, VA: National Hospice and Palliative Care Organization, Dec 15, 2022. Accessed Dec 4, 2023. Available at URL address: https://www.nhpco.org/hospice-facts-figures/

15. National Hospice and Palliative Care Organization (NHPCO). Standards of practice for hospice programs: professional development and resource series. 2022. Accessed Dec 4, 2023. Available at URL address: https://www.nhpco.org/regulatory-and-quality/quality/

16. Ngo-Metzger Q, McCarthy EP, Burns RB, Davis RB, Li FP, Phillips RS. Older Asian Americans and Pacific Islanders dying of cancer use hospice less frequently than older white patients. Am J Med. 2003 Jul;115(1):47-53.

17. (No authors listed). Medical guidelines for determining prognosis in selected non-cancer diseases. The National Hospice Organization (NHO). Hosp J. 1996;11(2):47-63.

18. Ornstein KA, Roth DL, Huang J, Levitan EB, Rhodes JD, Fabius CD, Safford MM, Sheehan OC. Evaluation of Racial Disparities in Hospice Use and End-of-Life Treatment Intensity in the REGARDS Cohort. JAMA Netw Open. 2020 Aug 3;3(8):e2014639. doi: 10.1001/jamanetworkopen.2020.14639. PMID: 32833020; PMCID: PMC7445597.

19. Royal College of General Practitioners. RCGP Position Statement on palliative and end of life care. May 2016. Accessed Dec 6, 2023. Available at URL address: https://www.rcgp.org.uk/policy/rcgp-policy-areas/palliative-and-end-of-life-care.aspx

20. Shepperd S, Gonçalves-Bradley DC, Straus SE, Wee B. Hospital at home: home-based end-of-life care. Cochrane Database of Systematic Reviews 2021, Issue 3. Art. No.: CD009231. DOI: 10.1002/14651858.CD009231.pub3.

21. Shugarman LR, Lorenz K, Lynn J. End-of-life-care: An agenda for policy improvement. Clin Geriatric Med. 2005 Feb;21(1):57-78, vii.

22. Smucker D. Hospice and the continuum of primary care. Clin Fam Pract. 2004 Jun;6(2):299.

23. Stoneberg JN, von Guten CF. Assessment of palliative care needs. Anesthiol Clin North America. 2006 Mar;24(1):1-17.

Revision Details

Type of Revision	Summary of Changes	Date
Annual review	• No policy statement changes	2/15/2024