



HOSPICE

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Overview

Hospice care is a coordinated program of palliative and supportive care provided to patients who are terminally ill and their families. Rather than trying to cure the illness, the goal of hospice is to make the patient as comfortable as possible, ease pain and other troublesome symptoms and support the family through a difficult time.

Hospice care is provided by an interdisciplinary hospice team who understand the needs of patients who are terminally ill. The team includes doctors, nurses, social workers, spiritual counselors, home health aides, bereavement counselors and volunteers. Most hospice patients receive hospice care while continuing to live in the comfort of their own home. The hospice team visits the home regularly to provide medical and nursing care, emotional support and counseling, instruction and practical help.

Definitions

Attending physician – Each commercial plan member who elects hospice must designate an attending physician at the time he or she elects to receive hospice care. The attending physician will maintain primary responsibility for the plan member's care while the plan member is enrolled in hospice. The attending physician can be the plan member's PCP or another plan provider (including the hospice medical director).

Hospice – A hospice is an agency that will provide or arrange for hospice care. In Massachusetts, hospice agencies must be licensed by the Massachusetts Department of Public Health, pursuant to Title 105, Chapter 141 of the Code of Massachusetts Regulations.

Hospice care - A coordinated program of palliative and supportive care and other services provided by a licensed hospice agency to patients who are terminally ill and their families.

Hospice inpatient facility – A facility that cares solely for hospice patients requiring short-term, general inpatient, residential or respite care, and is owned and operated by a hospice. A hospice inpatient facility may also be referred to as a residential hospice.

Hospice patient – an individual in the terminal stage of an illness who alone or in conjunction with a family member or members has voluntarily requested admission and been accepted into a hospice. Terminal illness is defined as a life expectancy of 6 months or less.

Palliative care – care provided to patients diagnosed with a progressive disease for which the focus of treatment is relief from suffering. Palliative care promotes relief of pain and other physical symptoms with the goal of enhancing the patient's quality of life.

Primary care giver – The individual designated by the hospice patient who is responsible for the patient's care and support in the home on a 24-hour basis.

Respite care – Temporary care provided to a hospice patient, to relieve the patient’s family or other caregiver from the daily demands of caring for the patient or in unforeseen emergencies. Respite care may be provided in (1) a residential hospice owned and operated by the hospice, or (2) a general hospital or long-term care facility with whom the hospice has entered into a written contract, or (3) the patient’s home.

Short-term inpatient care – Inpatient care for the control of pain and management of acute and severe clinical problems that cannot be managed in a home setting. Short-term inpatient care may be provided in (1) a residential hospice owned and operated by the hospice, or (2) a licensed general hospital or long-term care facility with whom the hospice has entered into a written contract.

Covered Services

Prior authorization by FCHP is required for hospice services provided to commercial plan members including FCHP Select Care, FCHP Direct Care, Fallon Preferred Care, Major Medical, Commonwealth Care, Companion Care, and MassHealth members. Note: Hospice benefit only applies to FCHP MassHealth Standard/CommonHealth and Family Assistance members. FCHP MassHealth Basic and Essential members do not have hospice benefits through either FCHP or MassHealth.

To request authorization for hospice services for commercial plan members, the hospice agency must submit (1) a completed Universal Health Plan Authorization form and (2) a copy of the signed Hospice Election Statement to FCHP’s Care Management Department (fax number: 508-368-9507).

- Only one level of care will be authorized for each day a plan member receives hospice care.¹ There are four levels of hospice care:
 - Routine home care
 - Continuous home care
 - Respite care
 - Short-term general inpatient care
 - Each change in level of care requires separate authorization.
 - Room and board requires separate authorization.
 - Separate authorization is required for services related to the terminal illness that are included in the plan of care but not covered by the hospice agency as specified in the contract between the hospice agency and FCHP.
 - Separate authorization is required for curative services related to a terminal illness provided to a MassHealth member under age 21.
1. FCHP covers hospice care for commercial plan members, subject to the terms and conditions of the plan member’s Evidence of Coverage. Note: In accordance with the Patient Protection and Affordable Care Act (PPACA) Section 2302: Concurrent Care for Children, effective April 1, 2011, MassHealth

¹ The authorization will specify the level of care and dates of service authorized. A new Universal Health Plan Authorization Form must be submitted for each change in level of care or to continue hospice services beyond the dates of service authorized. It is not FCHP’s intention to be restrictive in the provision of hospice care. Case managers are responsible for documenting the level of care authorized and the applicable dates of services to facilitate claims payment.

members under age 21 may elect hospice without foregoing curative treatment related to a terminal illness.²

- To elect hospice, a plan member must sign a hospice election statement. By signing the hospice election statement the plan member is acknowledging that he/she understands the palliative rather than curative nature of hospice care as it relates to his/her terminal illness. Each hospice designs its own election statement.
 - A plan member who elects hospice must designate an attending physician who will maintain primary responsibility for his or her care. The attending physician may be the plan member's PCP or another plan provider (including the hospice medical director).
 - Certification of terminal illness with a limited life expectancy: The hospice agency must obtain certification of terminal illness signed by the attending physician and the hospice medical director. Certification must include the statement that the plan member's life expectancy is six months or less and the specific clinical findings and or other documentation that support a life expectancy of six months or less.
 - There is no limit to the length of time a plan member can receive hospice care.
 - A plan member can revoke a hospice election at any time. Revocation of a hospice election must be in writing.
2. Plan of Care: The hospice team together with the attending physician will develop a plan of care for the plan member who has elected hospice prior to the provision of hospice services.
- The plan of care will identify a primary care giver who is responsible for the plan member's care and support on a 24-hour basis.³
 - The plan of care will document the needs of the plan member and the scope of services required to address these needs.
 - The plan of care will reflect the changing needs of the plan member and should be reviewed and revised as necessary but at least twice monthly.
3. For each day that a plan member receives hospice care one of the following levels of care will be authorized:
- **Routine home care** – Routine home care is covered for each day that a plan member has elected hospice and one of the other levels of care is not authorized. The day of discharge from routine hospice is not covered unless it is the date of death. Routine home care is provided in the plan member's home. A plan member's home may be a long-term care facility or residential

² Hospices are not responsible for providing or paying for curative treatment. If a service is appropriate under the hospice benefit, it remains the responsibility of the hospice to provide it and pay for it. FCHP will determine the medical necessity of curative treatment related to a terminal illness for a child also receiving hospice services on a case-by-case basis. FCHP will collaborate with the ordering physician and the hospice plan of care in determining whether a medically necessary service is curative or palliative. The hospice plan of care must identify any curative treatment the child receives. What's curative for one child could be palliative for another.

³ A primary care giver is not necessary if the plan member lives alone and is safe at present. The hospice agency may accept a patient who is safe at home and alone as long as they are agreeable to an alternate plan when they are no longer safe at home alone. The alternate plan may be placement in a long-term care facility, residential hospice, etc.

hospice, if this is where he or she lives.⁴ Pursuant to Massachusetts Department of Public Health Regulation 105 CMR 141.204, the hospice agency will provide all of the following services to the extent that they are related to the terminal illness and included in the plan of care for the plan member:

- Physician’s administrative and supervisory services
- Nursing care provided by or under the direction and supervision of a registered nurse
- Social work services provided under the direction and supervision of a licensed social worker
- Volunteer services
- Counseling services, including bereavement counseling, spiritual counseling and psychosocial/supportive counseling, provided by professional staff or volunteer staff under the supervision of a qualified counselor
- Homemaker services
- Home health aide services
- Therapeutic services including dietary therapy, physical therapy, occupational therapy, speech therapy, hearing therapy and respiratory therapy
- Medical supplies
- Durable medical equipment
- Drugs and biologicals, including prescription drugs, related to the terminal illness (for pain relief, symptom control or hydration), regardless of the method of administration⁵
- **Continuous home care** – Continuous home care is covered during a period of crisis and only as necessary to maintain the plan member at home. A period of crisis is a period during which the plan member requires care that is primarily nursing care to achieve palliation or manage symptoms. Continuous home care is not intended to be used as respite care. The hospice must provide a minimum of eight hours of primarily nursing care⁶ in a 24-hour period which begins and ends at midnight. The nursing care need not be continuous. (When fewer than 8 hours of nursing care are needed, the care is covered as routine home care rather than continuous home care.) Continuous home care includes all of the services provided under routine home care.
- **Respite care** – Respite care is covered to temporarily relieve the primary caregiver (the individual designated by the hospice patient and documented in the plan of care) from unforeseen emergencies or the daily demands of caring for the patient. The hospice agency will provide respite care in either:
 - The plan member’s home (in-home respite), or

⁴ A plan member could be in a skilled nursing facility (SNF) under the SNF benefit for a condition unrelated to the terminal illness and simultaneously be receiving hospice care for the terminal illness.

⁵ Administration of drugs and biologicals related to the terminal illness is nursing care, regardless of the method of administration.

⁶ Primarily nursing care is defined as direct patient care provided by a registered nurse (RN) or licensed practical nurse (LPN) working under the supervision of an RN for at least half of the period of care. Homemaker or home health aide services may supplement nursing care for the remainder of the period of care.

- In a hospital, long-term care facility or residential hospice, under contract with or owned and operated by the hospice agency (inpatient respite). Two separate episodes of respite care are covered per calendar year. The two episodes cannot be concurrent. Up to seven consecutive days, including the date of admission but not the date of discharge, may be authorized per episode. Unauthorized/unused days will be forfeited. Respite care includes all of the services provided under routine home care.
 - **Short-term inpatient care** – Short-term general inpatient care is covered for the control of pain and management of acute and severe symptoms that cannot be managed in a home setting. The hospice agency will provide short-term inpatient care in a hospital, long-term care facility or residential hospice under contract with or owned and operated by the hospice agency. For the day of discharge from short-term general inpatient care, the appropriate level of home care will be authorized. Short-term general inpatient care includes all of the services provided under routine home care
4. FCHP covers services related to the terminal illness that are included in the plan of care but not covered by the hospice agency as specified in the contract between the hospice agency and FCHP
 5. FCHP covers room and board for commercial plan members and NaviCare members when:
 - a. A primary care giver is unavailable or unable (i.e., the plan member does not have a designated primary care giver) to provide needed care, and
 - b. The hospice agency has a bed available.⁷

Each hospice agency establishes its own admission criteria which includes criteria for patients who do not have a primary care giver. When permitted by the hospice agency, an alternative plan of care may be developed in the absence of a primary caregiver, which ensures that the plan member's needs are met 24 hours a day. In some cases, there are financial resources available to hire someone to come into the home. When remaining at home is no longer an option for a plan member without a primary caregiver, the hospice must make other arrangements which may include admission to a facility, i.e., a hospital, long-term care facility or residential hospice, under contract with or owned and operated by the hospice agency.

Room and board is only covered in conjunction with routine home care or continuous home care.

Room and board is not covered to temporarily relieve the primary care giver from unforeseen emergencies or the daily demands of caring for the patient. This is respite care.

Room and board is not covered for Commonwealth Care members.

⁷ A primary care giver is not necessary if the plan member lives alone and is safe at present. The hospice agency will accept a patient who is safe at home and alone as long as they are agreeable to an alternate plan when they are no longer safe at home alone. The alternate plan may be placement in a long-term care facility, residential hospice, etc.

Plan members with FCHP as secondary insurance (i.e., FCHP Select Care or Direct Care or Fallon Preferred Care) and Original Medicare as primary insurance are eligible for coverage for hospice room and board.

Coding

For each day that a commercial plan member receives authorized hospice care, the hospice agency will be paid a daily rate dependent upon the level of care authorized for that day. The hospice agency may arrange for the provision of hospice services on a contract basis. When the hospice agency arranges for the provision of a hospice service on a contract basis, the hospice agency is responsible for reimbursing the contracted facility and/or provider. All claims for services related to the terminal illness must be submitted with the primary diagnosis code (ICD-9-CM) that describes the terminal illness of the hospice patient.

Codes	Number	Description
Revenue	0651	Routine home care
	0652	Continuous home care
	0655	Inpatient respite
	0656	General inpatient care
	0658	Room and board
	0659	In-home respite

Medicare Advantage (Fallon Senior Plan and NaviCare members *with Medicare Part A*)

Medicare Advantage members (Fallon Senior Plan and NaviCare members *with Medicare Part A*) may receive hospice care from any Medicare-certified hospice. FCHP will be notified by the hospice agency when a Medicare Advantage member elects hospice.⁸ Preauthorization is not required.

When a Medicare Advantage member (i.e., Fallon Senior Plan and NaviCare members *with Medicare Part A*) enrolls in a Medicare-certified hospice, the hospice agency will provide or arrange for the provision of all Medicare-covered (Part A and Part B) services related to the terminal illness, including prescription drugs that are covered under Original Medicare.

Fallon Senior Plan providers will provide Medicare-covered (Part A and Part B) services unrelated to the terminal illness to Fallon Senior Plan members. Fallon Senior Plan providers will submit claims for Medicare-covered (Part A and Part B) services unrelated to the terminal illness to Medicare. Providers may reference FCHP's Hospice Payment Policy at www.fchp.org for additional information.

Fallon Senior Plan providers will provide supplemental services (i.e., services that are not Medicare-covered Part A and Part B services), such as routine eye care and dental care to Fallon Senior Plan members. Fallon Senior Plan providers will submit claims for covered services to FCHP.

⁸ The hospice agency will fax a copy of the signed Hospice Election Statement to FCHP's Outpatient Care Services Department (Fax: 508-368-9507). The hospice diagnosis and primary diagnosis code must either be written on the Hospice Election Statement or provided on the confidential fax cover sheet.

NaviCare providers will provide Medicare-covered (Part A and Part B) services and MassHealth Standard-covered services unrelated to the terminal illness to NaviCare members *with Medicare Part A*. NaviCare providers will submit claims for Medicare-covered (Part A and Part B) services unrelated to the terminal illness to Medicare. NaviCare providers will submit claims for non-Medicare-covered MassHealth Standard covered services unrelated to the terminal illness to FCHP.

NaviCare providers will provide supplemental services to NaviCare members *Medicare part A*. NaviCare providers will submit claims for NaviCare covered services to FCHP.

Fallon Senior Plan members with the Part D prescription drug benefit and NaviCare members *with Medicare Part A* who enroll in hospice will continue to have coverage for Part D prescription drugs through FCHP.

Fallon Senior Plan members may revoke a hospice election at any time in writing.

The Medicare program has written a booklet about hospice benefits for Medicare members. It is called "Medicare Hospice Benefits" and is available at: <http://www.medicare.gov/Publications/Pubs/pdf/02154.pdf>.

Products to Which This Policy Applies

- ⊕ FCHP Direct & Select Care
- ⊕ Fallon Preferred Care (PPO)
- ⊕ Major Medical
- ⊕ MassHealth (with the exception of MassHealth Basic and Essential members who do not have coverage for hospice care either through FCHP or MassHealth.)
- ⊕ Commonwealth Care
- ⊕ Companion Care
- ⊕ Fallon Senior Plan
- ⊕ NaviCare
- ∅ Summit Elder Care® PACE (With the exception of emergency care, all services for Summit ElderCare® PACE participants must be authorized and arranged by the Summit ElderCare (SE) Interdisciplinary Team (IDT) overseeing the care for that participant. The applicable IDT can be determined by the HCO code on the participant ID card. A Summit ElderCare clinician is always on call and can be reached by dialing any of the site telephone numbers.)

References

1. General Laws of Massachusetts, Part I, Title XXII, Chapter 176G, Section 4L Coverage for hospice services.
2. General Laws of Massachusetts, Part I, Title XXII, Chapter 175, Section 47S Accident and sickness insurance benefits for licensed hospice services.
3. General Laws of Massachusetts, Part I, Title XXII, Chapter 111, Section 57D Hospice Programs.
4. Code of Massachusetts Regulations, Title 105, Chapter 141.000: Licensure of Hospice Programs (105 CMR 141.000), 2003.

5. Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections. <http://www.cms.hhs.gov/manuals/downloads/mc86c04.pdf>.
6. Medicare Benefit Policy Manual, Chapter 9 – Coverage of Hospice Services Under Hospital Insurance. <http://www.cms.hhs.gov/manuals/Downloads/bp102c09.pdf>.
7. Medicare Claims Processing Manual, Chapter 11 – Processing Hospice Claims. <http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf>.

Committee Review Dates:

Benefit Committee: 3/1995

Benefit Oversight Committee: 11/01/06, 07/08/2009, 05/11/2011

IMPORTANT NOTE

Not all services are covered for all products or employer groups. This medical policy expresses FCHP's determination of whether certain services or supplies are medically necessary, experimental or investigational or cosmetic. FCHP has reached these conclusions based upon the regulatory status of the technology and a review of clinical studies published in peer-reviewed medical literature. Even though this policy may indicate that a particular service or supply is considered covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. Members and their providers need to consult the Evidence of Coverage to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and the plan of benefits, the provisions of the benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this medical policy.