

HOSPICE SERVICES

Policy

NHP 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
Each change in level of hospice care	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 covered for 14 days per calendar year. Inpatient respite care includes date of admission, but not date of discharge and is authorized per episode. Unused days are forfeited. Respite care is not reimbursed in addition to routine hospice home care.

NHP 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.

Exceptions to Policy Criteria

Despite the election of hospice care services for end-of-life care, 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. 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 refuses services or is uncooperative, moves out of the area, or transfers to another hospice program.

Member Cost-Sharing

The provider is responsible for verifying on a daily basis, 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.

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 unforeseen emergencies on 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 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 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:

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)

- 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
- The hospice is responsible for reimbursing the inpatient facility for the provision of general inpatient hospice care.

OTHER HOSPICE CARE (RESIDENTIAL *inpatient* HOSPICE)

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

Neighborhood Health Plan 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, 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.

Neighborhood Health Plan Does *Not* Reimburse Hospice Providers For

- 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).
- Services to solely aid in the performance of activities of daily living (ADLs).
- Nutritional supplements, vitamins, and non-prescription drugs.
- Medical supplies unrelated to the palliative care to be provided.
- Services for which any other benefit would apply.
- Inpatient care other than the services described above.

Procedure Codes

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
0652	Hospice Service-Continuous Home Care	Enter the number of hours in UB-04 Form Locator 46
0655	Hospice Service-Inpatient Respite Care	Enter the number of days in UB-04 Form Locator 46
0656	Hospice Service-Inpatient General Care (non-respite)	Enter the number of days in UB-04 Form Locator 46
0657	Hospice-Physician Services	Provide CPT/HCPCS Level II code detail
0658	Hospice- Room and Board-Nursing Facility	Enter the number of days, in addition to Rev Code 0651 or 0652.
0659	Hospice-Other	Enter the number of hours in UB-04 form Locator 46

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

Provider Payment Guidelines and Documentation

Bill for hospice services on an Institutional UB-04 (CMS-1450) Form using the appropriate revenue code(s), per your contractual agreement with NHP.

Submit HCPCS Level II codes (Q5001-Q5009) 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.

NHP reimburses physician services and radiation services outside the hospice contracted per diem for residential *inpatient* hospice to contracted providers.

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 NHP Authorization number in the UB-04 Form Locator 63.

Please refer to your contract with NHP for information regarding specific coding requirements.

References

Commonwealth of Massachusetts Transmittal Letter HOS-10, 08/01/98
 Mass. Division of HCFA, 114.3 CMR 43.00 Hospice Services

Publication History

Topic: Hospice	Effective Date: May 25, 2010
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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. Neighborhood Health Plan utilizes McKesson’s claims editing software, ClaimCheck, a clinically oriented, automated program that identifies the “appropriate set” of procedures eligible for provider reimbursement by analyzing the current and historical procedure codes billed on a single date of service and/or multiple dates of service, and also audits across dates of service to identify the unbundling of pre and post-operative care. Questions may be directed to Provider Network Management at prweb@nhp.org.