Clinical Policy: Hospice Services

Reference Number: IL.CP.MP.551 Coding Implications

Last Review Date: 05/2021 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Definitions:

Routine Hospice Level of Care	Routine Hospice LOC can be carried out in the home, nursing facility, LTAC, or in a Ventilator Dependent Care Unit (VDCU).
Inpatient Hospice	Inpatient hospice care refers to end of life care at a facility such as a skilled nursing facility or a hospital when symptoms cannot be safely managed in a home or other residential setting.
Karnofsky Performance Scale	The Karnofsky Performance Scale Index allows patients to be classified as to their functional impairment. This can be used to compare effectiveness of different therapies and to assess the prognosis in individual patients. The lower the Karnofsky score, the worse the survival for most serious illnesses.
Palliative Performance Scale	The Palliative Performance Scale (PPS) is a valid, reliable functional assessment tool developed by Victoria Hospice that is based on the Karnofsky Performance Scale (KPS). This tool provides a framework for measuring progressive decline in palliative patients.

Policy

Hospice is intended to address the needs of the individual with a terminal illness while also considering family needs. Medicaid covers hospice care for a terminally ill beneficiary whose life expectancy is six months or less (if the illness runs its normal course), as determined by a licensed physician and the Hospice Medical Director

Criteria for Coverage:
Any request to transfer to a higher level of care for hospice services requires a prior authorization. A copy of the CTI must be submitted with the claim in order to be paid.

Recertification for Routine Home Hospice:
Members may receive two 180 days of routine hospice services. Subsequent requests will require pre-service and Medical Director Review.
1. Utilization Management Care Coordinators can approve the first two requests for 180 days of routine hospice services. Any requests submitted after the initial two requests (180 days per request) must be reviewed every 60 days by a Medical Director.

Contents of a CTI:
Each hospice recertification must be accompanied by a brief narrative describing the clinical findings supporting the beneficiary's life expectancy of six months or less. Each narrative must reflect the clinical circumstances and should not contain checkboxes or non-specific standard language. Each written certification must include:

1. A statement that the beneficiary's life expectancy is six months or less if the terminal illness runs its normal course.
2. Specific clinical findings and other documentation as needed to support the life expectancy of six months or less. All must be present:
a. Clinical findings must document the functional decline from the previous certification period in the form of a physician narrative and Face to Face Assessment conducted by an NP, PA, or MD/DO.
b. Functional Assessment Scale must be included in documentation. Scores above 50% on either KPS or PPS scale as indicated per provided documentation or per review of clinical documentation are reviewed by a Medical Director.

General Inpatient Level of Care:
Inpatient level of care can be approved for the first 5 days by the nurse reviewer. An additional 5 days (CSR) can be approved by the nurse reviewer. All subsequent reviews must be submitted to the Medical Director for review.
Requests for inpatient hospice should include all of the following:
1. Evidence of onset of uncontrolled symptoms or uncontrolled pain
2. Evidence that interventions while on routine home level of care have been unsuccessful at controlling symptoms or pain

Criteria for concurrent days for inpatient hospice services (criteria 1 OR 2, AND 3 must be present):
1. Documentation of pain control should include ONE of the following:
a. Frequent evaluation of a physician or nurse.
b. Frequent medication adjustments.

c. IV medications that cannot be administered under a routine home level of care.
d. Aggressive pain management that cannot be done under a routine home level of care.
e. Complicated technical delivery of medication.
OR;
2. Documentation of symptom control should include ONE of the following:
a. Rapid deterioration requiring intensive nursing intervention.
b. Uncontrolled nausea or vomiting.
c. Pathological fractures when metastatic lesions are present.
d. Open wounds requiring frequent skilled nursing care.
e. Uncontrolled respiratory distress.
f. New onset or worsening of delirium.
AND
3. Plan of care addressing the change in level of care and goals for member returning to routine level of care must be included. Goals should include returning member to routine home level of care once member pain or symptoms are stabilized.

Meridian Health Plan will allow a 5 day grace period to allow the hospice agency to submit the required forms and documentation.

Karnofsky Performance Scale (KPS):

Activity Level	Score	Detailed Activity Level
Able to carry on normal activity and to work; no special care needed.	100	Normal no complaints; no evidence of disease.
	90	Able to carry on normal activity; minor signs or symptoms of disease.
	80	Normal activity with effort; some signs or symptoms of disease.
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.	70	Cares for self; unable to carry on normal activity or to do active work.
	60	Requires occasional assistance, but is able to care for most of his personal needs.
	50	Requires considerable assistance and frequent medical care.
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.	40	Disabled; requires special care and assistance.
	30	Severely disabled; hospital admission is indicated although death not imminent.
	20	Very sick; hospital admission necessary; active supportive treatment necessary.
	10	Moribund; fatal processes progressing rapidly.

Palliative Performance Scale (PPS):

PPS Level	Ambulation	Activity & Evidence of Disease	Self -care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable normal job/work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance needed	Normal or reduced	Full or confusion
50%	Mainly sit/lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or confusion
40%	Mainly in bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or drowsy +/- confusion
30%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Normal or reduced	Full or drowsy +/- confusion
PPS Level	**Ambulation**	**Activity & Evidence of Disease**	**Self -care**	**Intake**	**Conscious Level**
20%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Minimal to sips	Full or drowsy +/- confusion
10%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Mouth care only	Full or drowsy +/- confusion
0%	Death				

Line of Business Applicability:
This policy applies to Illinois Medicaid.

For Medicaid/Medicaid Expansion Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the codes being submitted and considered for review being included on the Illinois Medicaid Fee Schedule (located at: http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx). If

there is a discrepancy between this policy and the Illinois Medicaid Provider Manual (located at: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx) the applicable Medicaid Provider Manual will govern.

References:

1. CGS. "General Inpatient Care". Accessed 05/24/21 at: **https://www.cgsmedicare.com/hhh/coverage/coverage_guidelines/general_inpatient_care.html**
2. Illinois DHFS. Handbook for Practitioners rendering Medical Services. Chapter K-200, Sec K-211-234. (Issued November 16, 2016). Accessed 5/24/21 at: **https://www.illinois.gov/hfs/SiteCollectionDocuments/hospicehandbook.pdf**
3. American Cancer Society. Hospice care. Copyright 2015 © American Cancer Society, Inc. Accessed 5/24/21 at: http://www.cancer.org/treatment/findingandpayingfortreatment/choosingyourtreatmentteam/ hospicecare/index?sitearea=ETO

State Letters/ Bulletins:					
CMS National/Local Coverage Determination (NCD/LCD):					
Medicare Managed Care Manual:					
Medicaid CFR:					
State Administrative Codes:					
Contract Requirements:					
Related Policies:					

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage,

policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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