POLICY AND PROCEDURE MANUAL

Policy Title: Hospice	**Policy Number: B.01**
Primary Department: Medical Management **Affiliated Department(s): N/A**	**NCQA Standard: N/A** **URAC Standard: N/A**
Last Revision Date: 06/2019 **Revision Dates: 06/2018; 06/2019** **Effective Date: 06/2018**	**Next Review Date: 07/1/2020** **Review Dates: 06/27/2018; 6/26/2019**
Applicable Lines of Business: ☐MeridianCare ☒MeridianHealth ☐MeridianComplete ☒MeridianChoice	
Applicable States: ☐All ☒MI ☒IL ☐OH ☐_____ ☐_____	
Applicable Programs: ☒All ☐Other _____	
Policy is to be published: Internally Only ☐ Internally & Externally ☒	

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.

Procedure:
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 mets 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):

100%	Normal, no complaints, no signs of disease
90%	Capable of normal activity, few symptoms or signs of disease
80%	Normal activity with some difficulty, some symptoms or signs
70%	Caring for self, not capable of normal activity or work
60%	Requiring some help, can take care of most personal requirements
**50%	Requires help often, requires frequent medical care
**40%	Disabled, requires special care and help
**30%	Severely disabled, hospital admission indicated but no risk of death
**20%	Very ill, urgently requiring admission, requires supportive measures or treatment
**10%	Moribund, rapidly progressive fatal disease processes
**0%	Death

Palliative Performance Scale (PPS):

100%	Full ambulation. Normal no complaints. No evidence of disease. Full self-care. Normal intake. Full level of conscious
90%	Full ambulation. Able to carry on normal activity; minor signs or symptoms of disease. Able to carry on normal activity and to work; no special care needed. Full self- care. Normal intake. Full level of level of conscious.
80%	Full ambulation. Normal activity with effort; some signs or symptoms of disease. Full self-care. Normal or reduced intake. Full level of conscious
70%	Reduced ambulation. Cares for self; unable to carry on normal activity or to do active work. Full self-care. Normal or reduced intake. Full level of conscious
60%	Reduced ambulation. Unable to do hobby or some house work, significant disease. Occasional assistance with self-care. Normal or reduced intake. Full level of conscious or some confusion
**50%	Mainly sits or lies during the day hours. Unable to do any work, shows extensive disease. Considerable assistance required for self-care. Normal or reduced intake. Full level of conscious or some confusion
**40%	Mainly in bed. Unable to do any work and extensive disease. Mainly assistance needed for self-care. Normal or reduce intake. Full level of conscious, drowsy, or confusion
**30%	Totally bedbound. Unable to do any work, extensive disease. Total care. Reduce intake. Full level of conscious, drowsy, or confusion
**20%	Totally bedbound. Unable to do any work. Extensive disease. Total care. Minimal sips or bites. Full level of conscious, drowsy, or confusion
**10%	Totally bedbound; fatal processes progressing rapidly. Unable to care for self; mouth care only, drowsy or coma
**0%	Death

State specific special instructions:

None: ☒
MI:
IL:
OH:

Line of Business Applicability:
This policy applies to Michigan Medicaid, Illinois Medicaid, and Individual plans.

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 either the Michigan Medicaid Fee Schedule (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html), or 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 either the Michigan Medicaid Provider Manual (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html), or the Illinois Medicaid Provider Manual (located at: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx) the applicable Medicaid Provider Manual will govern.

For **Individual** members, consult the individual insurance policy. If there is a discrepancy between this policy and the individual insurance policy document, the guidelines in the individual insurance policy will govern.

References:

1. **CGS. "General Inpatient Care". Accessed 04/21/2019.**
2. **Michigan Department of Health and Human Services. Medicaid Provider Manual. Hospice-Sec.3-Sec.6. Version Date: April 1, 2019.**
3. **Illinois DHFS. Handbook for Practitioners rendering Medical Services. Chapter K-200, Sec K-211-234. (Issued November 16, 2016).**

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