APPLICATION STATEMENT

The application of the Clinical Coverage Guideline is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations and state-specific Medicaid mandates, if any.

DISCLAIMER

The Clinical Coverage Guideline (CCG) is intended to supplement certain standard WellCare benefit plans and aid in administering benefits. Federal and state law, contract language, etc. take precedence over the CCG (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). The terms of a member’s particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from this Coverage Position. For example, a member’s benefit plan may contain specific exclusions related to the topic addressed in this CCG. Additionally, CCGs relate exclusively to the administration of health benefit plans and are NOT recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member. The application of the CCG is subject to the benefit determinations set forth by the Centers for Medicare and Medicaid Services (CMS) National and Local Coverage Determinations, and any state-specific Medicaid mandates. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then “Tools” and “Clinical Guidelines”.

BACKGROUND

Hospice Services are defined as palliative medical care and services designed to meet the physical, social, psychological, emotional and spiritual needs of terminally ill recipients and their families. Hospice care is an approach that focuses on palliative care rather than curative care. An individual is considered to be terminally ill if he has a medical diagnosis with a life expectancy of six months or less if the disease runs its normal course.¹

According to Title 18, Section 1861 (dd) of the Social Security Act, the term “hospice care” means the following items and services provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan (for providing such care to such individual) established and periodically reviewed by the individual's attending physician and by the medical director (and by the interdisciplinary group described in paragraph (2)(B)) of the program.²
A. Nursing care provided by or under the supervision of a registered professional nurse,
B. Physical or occupational therapy, or speech-language pathology services,
C. Medical social services under the direction of a physician,
D. Services of a home health aide who has successfully completed a training program approved by the
   Secretary and -(ii) homemaker services,
E. Medical supplies (incl. drugs and biologicals) and the use of medical appliances, while under such a plan,
F. Physicians’ services,
G. Short-term inpatient care (incl. both respite care and procedures necessary for pain control and acute and
   chronic symptom management) in an inpatient facility meeting such conditions as the Secretary determines
   to be appropriate to provide such care, but such respite care may be provided only on an intermittent, non-
   routine, and occasional basis and may not be provided consecutively over longer than five days,
H. Counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment
to his death, and
I. Any other item or service which is specified in the plan and for which payment may otherwise be made
   under this title.

The care and services described in subparagraphs (A) and (D) may be provided on a 24-hour, continuous basis
only during periods of crisis (meeting criteria established by the Secretary) and only as necessary to maintain the
terminally ill individual at home.

Nebraska Specific Information

The following list provides a brief description of hospice services available to Nebraska Medicaid recipients. For a
full description of all services please refer to the Nebraska Medicaid Hospice benefit here.

A. Nursing Services – Regular visits to monitor conditions, provide care and maintain, weekly face to face visits,
education, initial assessment, individualized care plan and coordination of care.
B. Home Health Aide/Homemaker – Personal care services under the hospice care plan (ex – bathing, dressing,
   bladder and bowel care, personal grooming, etc.) Homemaker services to maintain a safe and sanitary
   environment (ex – meal prep, changing linens, light housekeeping and laundry, etc.)
C. Medical Social Services – Crisis intervention for client, caregiver or family, psychosocial assessment,
counseling for coping mechanisms, client advocacy, liaison for community resources, ect.
D. Medical Equipment and Supplies including Drugs and Biologicals – Medication, durable medical equipment,
   and personal care items
E. Other Counseling Services - Dietary, Spiritual and Bereavement counseling
F. Volunteer Services
G. Physician Services
H. Physical, Occupational or Speech Therapy - For symptom control and to enable the client to maintain activities
   of daily living and basic functional skills.
I. Medical Interventions related to the terminal illness that have been evaluated by the attending physician,
hospice medical director, hospice team, client/caregiver, and family, based on the client’s quality of life and the
   services are in congruence with the palliative care goals of the client/caregiver, family, and hospice. Planned
   interventions shall be included in the hospice plan of care.

POSITION STATEMENT

Applicable To:
☑ Medicaid – Florida, Nebraska and New Jersey
☑ Medicare – Florida and New Jersey

FLORIDA 1,2

Exclusions

The following hospice care services are not covered as each is specifically excluded from coverage or is considered
not medically necessary as hospice care (this list may not be all inclusive):
• Services for individuals no longer considered terminally ill;
• Services, supplies or procedures that are directed towards curing the terminal condition;
• Services to primarily aid in the performance of activities of daily living;
• 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.

Coverage

Hospice Services are a covered benefit when the member meets the following criteria:

1. Is terminally ill; AND
2. Meets specific program and eligibility requirements; AND
3. Is eligible for and voluntarily elects to receive hospice care for the terminal illness; AND
4. Can be certified by a physician as terminally ill with a life expectancy of six months or less if the disease runs its normal course (see Certification Documentation below); AND
5. Sign and date a statement electing hospice care. (Note: WellCare will require a hard copy of the Hospice Election Form); AND
6. Hospice Services are available 24 hours/day, 7 days per week by an accredited/certified hospice agency.

Medicaid reimburses for services that are determined medically necessary, do not duplicate another provider’s service, and meet the following conditions:

• Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
• Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
• Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
• Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
• Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider.

Levels of Hospice Care

The following levels of care are covered when the medical necessity criteria above are met:

• 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 respite care that is short term (e.g., ≤ 5 days) and provided as part of the overall treatment plan, to relieve the primary caregiver at home and only if coverage for respite care is available under the plan.
• Inpatient hospice care when the intensity or scope of care needed is not practical 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.

When the above coverage criteria are met, the following hospice care services may be covered as part of the hospice treatment plan:

• 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

**Certification Documentation**

Documentation to support the terminal prognosis must accompany the initial certification of terminal illness. This documentation must be on file in the recipient’s hospice record and must include, where applicable, the following:

- Terminal diagnosis w/ life expectancy of ≤ 6 months if the terminal illness progresses at its normal course;
- Serial physician assessments, laboratory, radiological, or other studies;
- Clinical progression of the terminal disease;
- Recent impaired nutritional status related to the terminal process;
- Recent decline in functional status; and
- Specific documentation that indicates that the recipient has entered an end-stage of a chronic disease.

**Election Periods**

The recipient may elect to receive hospice care during one or more of the following election periods:

- An initial 90-day period;
- A subsequent 90-day period; and
- Subsequent 60-day periods.

There is no limit on the number of 60-day periods, as long as the recipient meets the requirements to receive hospice benefits.

**NOTE**: See Hospice Revocation later in this chapter for information about elections subsequent to revocation of hospice.

**Initial Election Period**

The first 90 days of hospice care is considered the initial hospice election period.

For the initial period, the hospice must obtain written certification statements from a hospice physician and the recipient’s attending physician, if the recipient has an attending physician, no later than two calendar days after the period begins. An exception is if the hospice is unable to obtain written certification, the hospice must obtain verbal certification within two days following initiation of hospice care, with a written certification obtained before billing for hospice care.

If these requirements are not met, Medicaid will not reimburse for the days prior to the certification. Instead, reimbursement will begin with the date verbal certification is obtained.

**Subsequent Election Periods**

For the subsequent election periods, written certification from the hospice medical director or physician member of the interdisciplinary group is required.

If written certification is not obtained before the new election period begins, the hospice must obtain a verbal certification statement no later than two calendar days after the first day of each period from the hospice medical director or physician member of the hospice’s interdisciplinary group.

A written certification must be on file in the recipient’s record prior to billing hospice services.

Supporting medical documentation must be maintained by the hospice in the recipient’s medical record.

**Hospice Election for Nursing Facility Residents**

A hospice recipient residing in a nursing facility may receive hospice care under Medicaid in:
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- A Medicaid certified bed; or
- A decertified bed in a unit that a licensed hospice leases from the nursing facility.

To elect and receive Medicaid hospice in a Medicaid certified bed, the following requirements must be met prior to the Medicaid hospice anticipated start date or placement:

- The hospice must contract with the nursing facility;
- The facility must be Medicaid certified;
- The recipient must occupy a Medicaid certified bed; and
- The nursing facility must concur with the hospice plan of care.

NEBRASKA

Exclusion
1. Members residing in a non-hospice bed in skilled nursing facility (SNF)

Coverage
The Medicaid Hospice Benefit is a covered service when the following criteria are met:

1. The client is currently eligible for Medicaid; AND,
2. The client is diagnosed as terminally ill by the hospice medical director and the attending physician with a medical prognosis that his/her life expectancy is six months or less if the illness runs its normal course; AND,
3. The client is one of the following:
   A. An adult and has chosen to receive palliative/comfort care to manage symptoms of terminal illness and has chosen not to receive curative treatment or disease management; OR,
   B. The client is a child and has elected to receive palliative/comfort care to manage symptoms of terminal illness. *NOTE* - Such election by a child shall not constitute a waiver of any rights of the child to be provided with, or receive Medicaid payment for, concurrent services related to the treatment of the child’s condition for which a diagnosis of terminal illness has been made;
   AND,
4. Member is receiving one or more of the following covered services (select all that apply):
   J. Nursing Services
   K. Home Health Aide/Homemaker
   L. Medical Social Services
   M. Medical Equipment and Supplies including Drugs and Biologicals
   N. Other Counseling Services (ex - Dietary, Spiritual, Bereavement)
   O. Volunteer Services
   P. Physician Services
   Q. Physical, Occupational or Speech Therapy
   R. Medical Interventions

NEW JERSEY

Coverage
In January 2016, the State of New Jersey issued guidance on hospice coverage. The final Medicare hospice rule, published on August 6, 2015 (CMS-1629-F), changes the payment methodology for Routine Home Care to implement two rates that will result in a higher base payment for the first 60 days of hospice care and a reduced base payment rate for days thereafter. It also establishes an add-on payment for services provided by a RN or social worker during the last seven days of a beneficiary's life. Both the dual Routine Home Care rates and the Service Intensity Add-On payment rate will be in effect on January 1, 2016.
Fee-for-service claims for Routine Home Care (T2042) that are provided during the first 60 days of hospice care must be submitted to the fiscal agent using the procedure code modifier ‘22’ in the first modifier position after the HCPCS procedure code (T2042 22). Claims that are not submitted with the ‘22’ modifier will not receive the enhanced rate regardless of the number of days the person has been receiving hospice care. Claims that are received with the ‘22’ modifier where a determination that more than 60 hospice days have been paid will pay at the lower rate and receive the new error code 1439 ‘Routine Home Care hospice with mod 22 priced at lower rate’. Unless there is a significant break in hospice care, the systemic calculation will take all hospice days into consideration when determining if the higher payment rate is appropriate.

Fee-for-service claims for the Service Intensity Add-On payment must be submitted to the fiscal agent using the procedure code ‘T2043’ and modifier ‘22’ in the first modifier position after the HCPCS procedure code (T2043 22). This service is limited to 4 units and is only payable if the following requirements are met. The code ‘T2043 22’ should be billed by hospice providers during the last 7 days of the beneficiary’s life when a registered nurse or social worker provided services. The total number of hours used by the RN or social worker to fulfill the services must be reported in whole numbers in the ‘days or units’ position of the claim form and cannot exceed 4. The units should not be rounded up and the time reported should only include the actual visit time. Time spent preparing for the visit or completing paperwork after the visit should not be included when reporting the units/hours for the Service Intensity Add-On payment (T2043 22).

Because claims submitted to the fiscal agent are processed on a ‘first come – first serve’ basis, the Division is aware that, in some cases, the logic used to count the first 60 days of hospice care will not identify the appropriate claims. The Division strongly recommends that hospice providers submit all hospice claims to the fiscal agent on a monthly basis. Denied claims should be corrected and re-submitted as soon as possible. To ensure that the hospice days are correctly identified, the Division will instruct the fiscal agent to recycle all historical hospice claim records, verifying the days of hospice care per beneficiary. Questions regarding this Newsletter should be directed to the State fiscal agent, Molina Medicaid Solutions. Their Provider Services telephone number is 1-800-776-6334.

**CODING**

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services do not, in itself, make such care, goods, or services medically necessary or a covered service. WellCare will comply with provisions of the Florida Medicaid Hospice Services Coverage and Limitation Handbook. When a recipient elects hospice, the recipient waives the rights to Medicaid payment, for the duration of the election, for any services related to the treatment of the terminal illness or associated conditions. All services related to the terminal illness or associated conditions are covered by the hospice either directly or under arrangement. This includes the arrangement for room and board payments for a Medicaid hospice recipient residing in a nursing facility. The recipient may continue to receive other Medicaid services in the usual manner for conditions totally unrelated to the terminal illness. These services are billed directly to Medicaid.

**FLORIDA**

**CPT® Codes**

99377 Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient’s care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

99378 - 30 minutes or more

**Covered ICD-10-CM Diagnosis Code**

Z51.5 Encounter for palliative care

**Covered HCPCS Codes**

G0337 Hospice evaluation and counseling services, pre-election

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
S0271 Physician management of patient home care, hospice monthly case rate (per 30 days)
S9126 Hospice care, in the home, per diem

NEBRASKA
G0299 TD (modifier) For hospice services provided by a registered nurse Modifier is not required
G0155 For hospice services provided by a social worker
T2042 For days 61 forward
T2042 (U1) modifier For days 1-60 days of hospice care
T2043 Continuous Home Care (per hour)
T2044 Inpatient Respite Care
T2045 General Inpatient Care

NEW JERSEY
Covered HCPCS Codes
T2042 Routine Home Care Rate
T2043 Continuous Home Care Rate
T2044 Inpatient Respite Rate
T2045 General Inpatient Rate
T2046 Room and Board Rate
Y6337 Therapeutic Leave Days
Y6338 Bed Reservation Days
Y6339 Hospice Respite Co-Payment
Y6343 Drug and Biological Co-Payment

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

REFERENCES

MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date Action
3/1/2018 Approved by MPC. No changes.
10/5/2017 Approved by MPC. Added Nebraska criteria to CCG.
4/6/2017 Approved by MPC. No changes.
4/7/2016 Approved by MPC. Expanded coverage for New Jersey.
2/4/2016 Approved by MPC. Inclusion of CMS reference on Hospice.
1/8/2015 Approved by MPC. New; for Florida only.