PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

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Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Hospice Services</td><td colspan="3">☒External Policy
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Last Review Date: 11/13/2024</td></tr>
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 11/13/2024</td></tr>
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I. RELATED POLICIES:

A. MCUP3041 - Treatment Authorization Request (TAR) Review Process
B. MCUP3039 - Direct Members
C. MCUP3137 - Palliative Care: Intensive Program (Adult)
D. MCUP3140 - Palliative Care: Pediatric Program for Members Under the Age of 21

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

Terminal Illness: A condition caused by injury, disease, or illness from which, to a reasonable degree of certainty, there can be no restoration of health, and which, absent artificial life-prolonging procedures, will inevitably lead to natural death.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The purpose of the guideline is to delineate the requirements for authorization of hospice services and the reimbursement mechanisms for this service.

VI. POLICY / PROCEDURE:

A. Criteria for Admission to a Hospice Program
    1. A patient will be admitted to the hospice program when the following conditions are met:
        a. The patient has a limited life expectancy of 6 months or less, if the terminal illness follows its normal course. The patient's physician or the hospice medical director must certify that the Member has a terminal illness by providing specific clinical findings or other documentation to support a life expectancy of 6 months or less.
        b. Cure of the disease process is no longer the goal of treatment. (For specific pediatric hospice guidelines, please see VI.B.3. below.)
        c. The primary goal for the patient is to focus on comfort, pain control, and emotional, spiritual, and psychological support.
        d. It is appropriate to direct treatment to improve the quality of the remaining days for the patient

and family.

e. It is agreed by doctor and patient and/or family that advanced technology is used solely for the purpose of sparing the patient discomfort or limitations they would otherwise suffer.

f. The patient, family, and physician are all willing to participate in the program with the understanding that withdrawal is possible at any time.

2. Election of hospice care occurs when the Member (or guardian) voluntarily completes and signs the Hospice Election Form and selects a hospice provider. Signing this form indicates the Member's understanding that hospice care is intended to alleviate pain and suffering, rather than to cure the disease, and that certain benefits are waived by election of this service.

a. A member who lives in an area remote from Medi-Cal Hospice providers may be cared for under the intensive palliative care benefit at a higher reimbursement rate as described in policy MCUP3137 Palliative Care: Intensive Program (Adult).

B. Hospice Benefit

1. Members who elect hospice become case managed Direct Members. When the Partnership HealthPlan of California (Partnership) Claims Department receives the first claim for hospice related services from the hospice provider, the claim will be routed to the Health Services/Utilization Management Team. The Utilization Management (UM) Designee will contact the hospice provider to obtain a copy of the hospice election form signed by the Member or legal representative. The status change effective date is the date the hospice election form was signed by the Member or legal representative.

2. All services related to the terminal illness must then be provided or authorized by the hospice provider. Services not related to the terminal illness are the responsibility of Partnership. The Member can continue to obtain services that are unrelated to the terminal illness from any Medi-Cal provider subject to Partnership's Treatment Authorization Request (TAR) processes. (Refer to policy MCUP3041 Treatment Authorization Request (TAR) Review Process for a list of services that require a TAR.)

3. A Member under 21 years of age may be eligible for hospice services concurrently with curative care under the Patient Protection and Affordable Care Act (ACA) Section 2302, as detailed in CMS Letter #10-018.

4. The following services are billable by the hospice agency, however only one service may be billed for each day:

a. Routine Home Care (code Q5001) is provided in the Member's home but it is not continuous home care. Payment is made on an all-inclusive per diem basis without regard to the volume or intensity of routine home care provided on any given day.

b. Continuous Home Care (code Q5009) consists of continuous, predominately skilled nursing care provided on an hourly basis, for a minimum of eight hours only during a brief crisis period. Any Member of the hospice team may provide these services, including home health aide and homemaker services. The hospice provider is responsible for determining the medical necessity for this type of care and will bill the hourly continuous home care rate for each hour of the service.

c. Respite Care (code Q5006) occurs when the Member receives care in an approved Long Term Care (LTC) facility on a short-term basis to provide relief for family Members or others caring for the individual. The hospice provider is responsible for determining the medical necessity for this type of care. Each episode is limited to no more than 5 days. The hospice provider will pay the LTC per diem rate as agreed upon in the LTC/hospice contract.

d. Inpatient Care (code Q5005) related to the terminal illness for pain control or acute/symptom management that cannot be managed in other settings. Acute inpatient hospital services are subject to approval by the hospice provider. The hospice provider pays the acute, subacute or LTC facility and then bills Partnership for inpatient care related to the terminal illness code

(Q5005). The hospice provider pays the hospital or subacute facility per diem at the rate agreed upon in the hospital/hospice contract. While the Member is in the inpatient facility, the Hospice is responsible for payment to the LTC facility for a bed hold day for up to 7 days (if included in the Hospice/LTC contract) and will bill Code 658 to Partnership for a Member who resides in a Skilled Nursing Facility (SNF) or an Intermediate Care Facility (ICF). If responsibility for payment of bed hold days is not included in the Hospice/LTC facility contract, the LTC facility will not be able to obtain payment for the bed hold.

e. If the Member chooses to revoke his/her hospice enrollment and the Member remains in a LTC facility, it is the responsibility of the facility to obtain a new TAR from Partnership for these services.
f. Physician services for the Member are coordinated between the attending physician, the hospice team, and the hospice medical director as indicated. The attending physician bills Partnership using the regular Medi-Cal codes. The hospice physician fees are included in the hospice per diem rate. If specialist consultation is necessary to evaluate a complication related to the terminal condition, the specialist physician bills the hospice and the hospice should bill Partnership using code Q5010.

5. The following services are part of the hospice benefit and separate payment is not made. The hospice provider is responsible for having contracts with the appropriate providers and for paying the rate agreed upon in the contract for the service. Payment for these services comes out of the hospice per diem. The hospice provider must authorize all of the services related to care of the terminal illness.
   a. Nursing services
   b. Medical social services
   c. Hospice physician services
   d. Counseling services
   e. Home health aide and attendant care services
   f. Medical supplies and durable medical equipment
   g. Physical, occupational, and speech therapy
   h. Medications and infusion therapy (based on the Hospice Formulary)
   i. Nutritionist services
   j. Respite care at a SNF
   k. In-patient care at hospital or subacute facility
   l. Medical transportation

C. Treatment Authorization Request
1. A Partnership TAR is <u>not</u> required for the following services;
   a. Routine home care
   b. Continuous home care
   c. Respite Care
   d. Hospice Care room and board provided in a SNF or Intermediate Care Facility (ICF)
2. If a Member currently resides in an Independent Care Facility-Developmentally Disabled (ICF-DD) facility or is admitted to an ICF-DD facility, Partnership continues to be financially responsible for the ICF-DD per diem payment.
3. Non-emergency inpatient care related to the terminal illness requires preauthorization by Partnership. The Hospice provider must submit a TAR using inpatient code (Q5005) and attach a copy of the Hospice Inpatient Information Form.
4. Emergency admission related to the terminal illness is reviewed for medical necessity by the UM nurse and if appropriate, a length of stay assigned. Partnership must be notified within 24 hours of any emergency admission related to the terminal illness. The hospice provider must submit a TAR using inpatient code (Q5005) and attach a copy of the Hospice Inpatient Information Form.

5. The hospice provider is financially responsible for emergency room services related to complications of the terminal illness if the Hospice provider authorized the service.
6. Partnership continues to authorize and be financially responsible for outpatient, inpatient and emergency medical services not related to the terminal illness.
7. For Members with Medicare/Medi-Cal coverage, Medicare is the first payer for the hospice daily care. Medi-Cal (Partnership) is financially responsible for medications not related to the hospice diagnosis[1] and the room and board per diem if the Member resides in a LTC facility (bed code 658 for SNF or ICF). The claim must include a copy of the Medicare Explanation of Medical Benefits (EOMB) that shows that Medicare payment was made for hospice services during the period covered.
8. For Members with other coverage, Medi-Cal is the secondary payer and the hospice must submit a copy of the Explanation of Benefits (EOB) from the other insurer when billing Medi-Cal.

D. Hospice Periods of Care
1. Hospice is a covered Medi-Cal benefit with the following periods of care:
   a. Two 90-day periods, beginning on the date of hospice election
   b. Followed by unlimited 60-day periods
2. A period of care starts the day the patient receives hospice care and ends when the 90-day or 60-day period ends.

E. Patient Certification and Recertification Required
1. After a Member has met criteria for admission to a hospice program (section VI.A. above), the hospice provider must maintain an initial certification for the first 90-day period that the patient is terminally ill.
2. At the start of each subsequent period of care, the hospice provider must maintain a recertification that the patient is terminally ill.
3. No more than 30 calendar days prior to the start of the third benefit period, and no more than 30 calendar days prior to every subsequent benefit period thereafter, a hospice physician or nurse practitioner (NP) is required to have a face-to-face encounter with every hospice patient to determine the continued eligibility of that patient. When an NP performs the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician for use in determining whether the patient continues to have a life expectancy of six months or less.

F. Revocation of Hospice Care Services
1. An individual's voluntary election may be revoked or modified at any time during an election period. To revoke the election of hospice care, the individual or individual's representative must file a signed statement with the hospice agency revoking the individual election for the remainder of the election period. The effective date may not be retroactive. At any time after revocation, an individual may execute a new election for any remaining election period. An individual or representative may change the designation of a hospice provider once each election period; this is not a revocation of the hospice benefit.

VII. REFERENCES:

A. Medi-Cal Guidelines - Hospice Care *(hospic)*
B. Title 22, California Code of Regulations (CCR) / Hospice Care 51349

[1] Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy (prescription) benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 *Revised*, "Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx," and all medications (Rx and OTC) which are dispensed from pharmacies and covered under Medi-Cal Rx must be billed to the State Medi-Cal/DHCS-contracted pharmacy administrator instead of Partnership. Refer to the Partnership website page for pharmacy authorization criteria: http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx

C. Title 22, CCR ICF Sections 51118, 51120 and 51510; SNF 51121, 51123, 51124, 51215, 51511
D. Title 42 Code of Federal Regulations (CFR) Sections 418.28 and 418.30
E. Social Security Act 1812(d)(1)
F. Section 2302 of the Patient Protection and Affordable Care Act (ACA)
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020 Palliative Care (12/07/2018)
H. Centers for Medicare and Medicaid Services (CMS) Letter 10-018 Hospice Care for Children in Medicaid and CHIP (09/09/2010)

VIII. DISTRIBUTION:
A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 06/21/00; 11/28/01; 01/15/03; 02/01/03 vs. code changes; 09/15/04; 09/21/05; 08/20/08; 04/21/10; 03/20/13 – effective 04/01/13; 03/18/15; 03/16/16; 03/15/17; 06/21/17; *09/12/18; 08/14/19; 08/12/20; 01/13/21; 11/10/21; 11/09/22; 11/08/23; 11/13/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.