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Subject: Hospice Care

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

NOTE: Coverage for hospice care is subject to the member's benefit terms, limitations and maximums. Refer to contract language regarding hospice care.

DESCRIPTION:

Hospice care is a comprehensive set of services, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill member and/or family members, as delineated in a specific patient plan of care.

Hospice care includes services rendered by a hospice agency in a member's home (e.g., residential, assisted living, retirement), a skilled nursing facility, intermediate care facility, a hospital, or other inpatient setting (e.g., residential hospice facility).

Hospice services are considered to be services specifically for the management of a terminal illness. Per the Florida Statutes, one is considered to be terminally ill if his/her medical prognosis is limited to one (1) year or less.

Certification of a terminal illness for hospice shall be based on the clinical judgment of the member's attending physician and hospice medical director regarding the normal course of the member's illness. The member (or his authorized representative) must elect hospice care.

Hospice care is defined by the services and care provided, in addition to the setting in which the services are delivered. The following levels of hospice care (routine, continuous, inpatient) may be provided:

Routine home care Fewer than eight hours of nursing care; may include skilled observation and monitoring, skilled care to control pain and other symptoms. Other routine home care, but not limited to therapy (e.g., respiratory, physical, occupational, speech), medical social worker services, nutritional counseling, pastoral counseling, and bereavement counseling.

Continuous home care (CHC) The hospice must provide a minimum of eight hours of care during a 24-hour day, which begins and ends at midnight. CHC is provided during a period of crisis; a period of crisis is a period in which a patient requires continuous care which is primarily nursing care (registered nurse (RN) or licensed practical nurse (LPN)) to achieve palliation or management of acute medical symptoms. Homemaker or home health aide services may be provided to supplement the nursing care. The fact that a patient is in the active dying process does not in itself justify CHC, apart from any need to address critically distressing symptoms in the patient.

Inpatient care Short-term inpatient care provided in a hospice inpatient facility when pain control, acute or chronic symptoms cannot be managed in the home, or the member's condition has worsened and become medically unstable. The fact that a member is in the active dying process does not in itself justify inpatient care, apart from any need to address critically distressing symptoms in the member.

Respite care Short-term inpatient care provided to the member in a hospice facility to relieve the primary caregiver (e.g., family member, other persons) caring for the member. **NOTE:** Coverage for respite care services is covered according to member's contract benefits; refer to specific member contract language.

Discharge from Hospice Care

If the member is no longer considered terminally ill, the member may be discharged from hospice. Also, a hospice discharge may be appropriate if the patient: refuses hospice care services, is uncooperative with the hospice plan of care, moves out of the service area, or transfers from one hospice program to another hospice program. Prior to discharge, the hospice must obtain a written discharge order from the hospice medical director.

POSITION STATEMENT:

NOTE: Coverage for hospice care is subject to the member's benefit terms, limitations and maximums. Refer to specific contract language regarding hospice care.

Prior authorization or certification/notification may be required for hospice care, refer to member's benefit.

If coverage is available for hospice care, the following criteria for coverage apply.

Hospice care **meets the definition of medical necessity** when **ALL** of the following criteria are met:

The member is terminally ill and expected to live one (1) year or less (for determining terminal illness status, refer to **OTHER** section of this guideline); **AND**

- The member, caregiver, or appointed designee has formally consented to hospice care; **AND**
- The attending physician and the hospice medical director or physician designee have certified the medical necessity of the hospice care; **AND**
- The written certification must include **ALL** of the following:
    - The statement that the member's medical prognosis is such that their life expectancy is one (1) year or less;
    - Clinical findings (e.g., current history and physical, current lab test results) and medical documentation supporting a life expectancy of one (1) year or less; **AND**

- The signatures of the attending physician and hospice medical director or physician designee must be noted on the certification statement(s).

NOTE: Written certification statement(s) must be retained by the hospice and maintained in the member's medical record.

- The hospice medical director, hospice nurse, or attending physician must develop a written plan of care, which includes hospice care services; written plan of care must be approved by the hospice medical director; **AND**
- The written plan of care must be reviewed and renewed by the hospice medical director not less than every thirty (30) days; **AND**
- Weekly progress summaries (provided by the hospice agency or facility) are required for assessment of the continued need for hospice care; **AND**
- The member or authorized representative has formally consented to hospice care; care directed towards management of a terminal illness; **AND**
- The hospice care is provided by a certified and accredited hospice agency with care available 24 hours per day, seven days per week; **AND**
- Nursing services must be skilled and provided by a registered nurse (RN) or a licensed practical nurse (LPN). Nursing services provided by an LPN must be under the supervision of an RN following a written plan of care developed by the attending physician in collaboration with the member, caregiver, and hospice agency.

Levels of Hospice Care

Prior notification is required for any change in level of hospice care.

The following levels of hospice care **meet the definition of medical necessity** when **ALL** of the hospice care criteria are met:

- Routine home care
- Continuous home care (CHC)
- Inpatient care
- Respite care

Routine Home Care

Routine home care for hospice includes skilled and supportive care provided on an intermittent basis in the member's home, long-term care facility, or assisted living facility.

This level of care requires fewer than eight hours of nursing care per day and is based on the member's needs. Nursing care may include, but not limited to:

- Observation and monitoring
- Pain and symptom control (e.g., nausea, vomiting, diarrhea)
- Adjustment of treatment plan per physician orders.

Other routine home care for hospice includes, but is not limited to:

- Bereavement counseling
- Medical social worker services

- Nutritional counseling
- Occupational therapy
- Pastoral counseling
- Physical therapy
- Respiratory therapy
- Speech therapy
- Volunteer services.

Continuous Home Hospice Care (CHC)

Continuous home hospice care (CHC) is provided during a crisis in which the member requires continuous care which is primarily nursing care (RN or LPN). CHC is provided in the home and includes a minimum of 8 hours of direct patient care during a 24-hour day, which begins and ends at midnight. CHC need not be continuous (e.g., 4 hours may be provided in the morning and 4 hours may be provided in the evening), an aggregate of 8 hours of nursing care (RN or LPN) is required. Homemaker or home health aide services may be provided to supplement the nursing care.

The following are examples (not all inclusive) of CHC performed in the home when **ALL** of the hospice care criteria are met:

- Frequent medication adjustment to manage uncontrolled pain or symptoms (e.g., intractable nausea and vomiting)
- Medical management of new onset of seizures or status epilepticus
- Medical management of severe, distressing dyspnea
- Medical management of symptoms associated with rapid deterioration and imminent death.

Inpatient Hospice Care

Inpatient hospice care **meets the definition of medical necessity** when **ALL** of the hospice care criteria **AND** following criteria are met:

- The member has intractable (acute or chronic) symptoms (e.g., pain, nausea and vomiting, seizures, diarrhea, respiratory distress) that cannot be managed in the home and requires frequent adjustment by the hospice team or the member's condition has worsened and become medically unstable; **AND**
- Inpatient hospice care must be delivered at and by staff of a licensed hospice facility; **AND**
- Inpatient hospice care length of stay is based on medical necessity and is subject to individual review.

Respite Care

Coverage for respite care services is covered according to member's contract benefits; refer to specific member contract language.

Hospice Care Services

Hospice care services related to the terminal illness or condition are **considered integral** to the hospice care and are not separately reimbursable. Hospice care services related to the terminal illness or condition may include the following (not all inclusive):

- Chemotherapy, radiation therapy, and other modalities for palliative care
- Counseling services (e.g., bereavement, dietary)
- Drugs and biologicals related to the terminal illness (for pain relief (pain management), symptom management, parenteral hydration) related to the management of patient's terminal illness
- Enteral formula when used as the primary source of nutrition via a feeding tube (nasogastric, gastrostomy, jejunostomy)
- Home health aide services
- Homemaker services
- Medical equipment (durable medical equipment)
- Medical supplies (e.g., bandages, catheters) related to the management of the patient's terminal illness
- Medical social services
- Occupational therapy
- Oxygen, including oxygen supplies
- Physical therapy
- Physician services that are administrative in nature (e.g., establishment, review, and updating plan of care, supervising care and services). **NOTE:** Physician services are provided by or through the hospice. The physician must be a member of the hospice interdisciplinary team.
- Short-term inpatient care
- Skilled nursing services (intermittent)
- Speech and language pathology services.

NOTE: Medical equipment is provided by the hospice for use in the member's home while the member is under hospice care. Medical supplies include supplies that are part of the written plan of care.

Medical Conditions

The following are examples (not all inclusive) of medical conditions that may be considered for hospice care when **ALL** of the hospice care criteria are met:

- Acquired immune deficiency syndrome (AIDS)
- Alzheimer's disease
- Amyotrophic lateral sclerosis
- End-stage adult failure to thrive
- Metastatic or aggressive cancer, when curative therapy is not in the plan-of-care
- End-stage heart disease (e.g., congestive heart failure)
- End-stage liver disease (e.g., cirrhosis)
- Parkinson's disease

- End-stage pulmonary disease (e.g., chronic obstructive pulmonary disease (COPD))
- End-stage renal disease (e.g., acute or chronic renal failure) when dialysis is not in the plan of care
- End-stage stroke/cerebrovascular accident (CVA).

Non-Covered Services

The following hospice care services **do not meet the definition of medical necessity** (the following may not be all inclusive):

- Custodial care
- Hospice care services for members no longer considered terminally ill
- Hospice care services, medical equipment, medical supplies, procedures, treatment modalities, and therapy (e.g., chemotherapy, radiation therapy, transfusions (blood, platelets)) that are directed towards curing the member's terminal illness
- Medical equipment and medical supplies unrelated to the management of the member's terminal illness.

Discharge from Hospice Care

NOTE: Hospice providers must obtain a written discharge order from the hospice medical director prior to discharge of a member from hospice care.

A member may be discharged from hospice care for **ANY** of the following:

- The member is no longer considered terminally ill
- The member refuses continued hospice care services
- The member is uncooperative with the hospice plan of care
- The member moves away from an existing hospice service area
- The member relocates to another hospice service area for new enrollment due to a change in primary residence.

BILLING/CODING INFORMATION:

Coding requirements are based on national coding and billing guidelines, additional details may be found in the manual for physicians and providers.

REIMBURSEMENT INFORMATION:

Refer to member's benefit plan limitations and maximums for hospice care.

Reimbursement for levels of hospice care (routine home care, continuous home care (CHC), or inpatient care) is based on medical necessity, subject to medical review.

LOINC Codes:

The following information may be required documentation to support medical necessity: physician history and physical, physician progress notes, plan of treatment, laboratory studies, and reason for hospice care.

Documentation Table	LOINC Codes	LOINC Time Frame Modifier Code	LOINC Time Frame Modifier Codes Narrative
Physician history and physical	28626-0	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Attending physician progress note	18741-9	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim
Plan of treatment	18776-5	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim

PROGRAM EXCEPTIONS:

Blue Card Host: Refer to member's specific contract language regarding hospice care.

Federal Employee Program (FEP): Follow FEP guidelines.

Medicare Advantage products: The following was reviewed on the last guideline reviewed date: Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services. 30-Physician Services: Provider-Based Physician Services (hospice services) located at cms.gov.

State Account Organization (SAO): Follow SAO guidelines.

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if based on medical necessity. The process for requesting a protocol exemption can be found at Coverage Protocol Exemption Request.

DEFINITIONS:

Bereavement counseling: counseling services provided to the individual's family after the individual's death.

BMI (body mass index): a measure of body fat based on height and weight.

Cachexia: general ill health and malnutrition.

Custodial care: those services provided to a member primarily to assist in the activities of daily living or respite care, or services provided for the sole purpose of allowing a family member or caregiver to return to work.

Hospice care: a comprehensive set of services, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/ or family members, as delineated in a specified patient plan of care.

Hospice: a public agency or private organization or subdivision of either of these that is primarily engaged in providing hospice care.

Intractable: resistant to cure, relief, or control.

Palliative care: patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

Period of crisis: a period in which a patient requires continuous care, which is primarily nursing care to achieve palliation or management of acute medical symptoms.

Plan of care: a written assessment by the hospice of each member's and family's needs and preferences, and the services to be provided by the hospice to meet those needs.

Respite care **(as related to this guideline):** short-term inpatient care provided to the member in a hospice facility for respite to relieve the primary caregiver (e.g., family member, other persons) caring for the member.

Skilled services (as related to this guideline): services provided in accordance with physician orders that require the skills of professional personnel such as registered nurse or licensed practical nurse.

Terminally ill: member's medical prognosis is limited to one (1) year or less.

RELATED GUIDELINES:

Home Health Care, 01-99500-01

OTHER:

The member should be referred to case management, prior to initiation of hospice care. A case management plan of care should be developed with input from the attending physician, hospice medical director, hospice, and caregiver.

Clinical Care Programs Referral Form (For referring physicians or providers).
https://www.floridablue.com/sites/floridablue.com/files/docs/Clinical_Care_Referral_Form_0.pdf

Determining Terminal Illness Status

The following may be documented in the member's medical record as indication of decline in clinical status (not all inclusive):

Clinical Status of Terminal Illness

- Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics

- Decreasing serum albumin
- Dysphagia leading to recurrent aspiration or inadequate oral intake documented by decreasing food consumption
- Recurrent or intractable infections (e.g., pneumonia, sepsis, upper urinary tract)
- Weight loss as evidenced by a decreasing BMI, not due to reversible causes such as depression or use of diuretics.

Symptoms of Terminal Illness

- Anorexia
- Cachexia
- Cough (intractable)
- Diarrhea (intractable)
- Dyspnea
- Nausea and vomiting, unresponsive to medical treatment
- Pain requiring increasing doses of analgesics
- Shortness of breath.

Signs of Terminal Illness

- Ascites
- Change in level of consciousness
- Decline in systolic blood pressure below 90 or progressive hypotension
- Edema
- Pleural/pericardial effusion
- Venous, arterial or lymphatic obstruction
- Weakness.

Functional Status Tools

The **Palliative Performance Scale (PPS)** measures functional and physical status. The PPS level is determined by reading left to right to find a best horizontal fit. Begin at the left column reading downwards until current ambulation is determined, then read across to next and downwards until each column (activity level and evidence of disease, self-care, intake, level of consciousness) is determined.

Palliative Performance Scale (PPS)\

%	Ambulation	Activity Level and Evidence of Disease	Self-Care	Intake	Level of Consciousness
100	Full	Normal activity No evidence of disease	Full	Normal	Full
90	Full	Normal activity	Full	Normal	Full

		Some evidence of disease			
80	Full	Normal activity with effort Some evidence of disease	Full	Normal or reduced	Full
70	Reduced	Unable do to do normal job/work Some evidence of disease	Full	Normal or reduced	Full
60	Reduced	Unable to do hobbies or housework Significant disease	Occasional Assistance Necessary	Normal or reduced	Full or confusion
50	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance needed	Normal or reduced	Full or confusion
40	Mainly in Bed	Unable to do any work Extensive disease	Mainly assistance	Normal or reduced	Full or drowsy or confusion
30	Totally Bed Bound	Unable to do any work Extensive disease	Total Care	Reduced	Full or drowsy or confusion
20	Totally Bed Bound	Unable to do any work Extensive disease	Total Care	Minimal sips	Full or drowsy or confusion
10	Totally Bed Bound	Unable to do any work Extensive disease	Total Care	Mouth care only	Drowsy or coma
0	Death	-	-	-	-

Adapted from: Anderson F, Downing GM, Hill J et al. Palliative Performance Scale (PPS): A New Tool. Journal of Palliative Care 1996; 12(1): 5-11

The **Karnofsky Performance Scale (KPS)** allows patients to be classified as to their functional impairment. The scale relates to physical ability and covers 11 stages, ranging from normal health to death, with each stage scored as a percentage. A score between 0 and 100 is assigned by a healthcare professional after observing a patient perform a task and/or activity of daily living. A score of 100% means that the patient has normal physical abilities with no signs of disease, decreasing percentage means that the patient has less ability to perform activities of daily living. The Karnofsky Performance Scale can be used to compare effectiveness of different therapies and to assess patient's prognosis.

Karnofsky Performance Scale (KPS)

General Category	%	Criteria
Able to carry on normal activity and 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.
Terminal state	10	Moribund
	0	Dead

Adapted from: Crooks V, Waller S, Smith T et al. The Use of the Karnofsky Performance Scale in Determining Outcomes and Risk in Geriatric Outpatients. The Journals of Gerontology 1991 Jul; 46(4): M139-M144

The **Functional Assessment Staging (FAST)** evaluates changes in functional performance and activities of daily living. The FAST is scored primarily on the basis of information obtained from a knowledgeable informant and/or caregiver. The FAST stages are enumerated as follows: 1, 2, 3, 4, 5, 6(a), 6(b), 6(c), 6(d), 6(e), 7(a), 7(b), 7(c), 7(d), 7(e) and 7(f). The FAST Stage is the highest consecutive level of disability. Note: Functional staging score = Highest ordinal value.

Functional Assessment Staging (FAST)

Stage	Area of Assessment/Skill Level
1	• No difficulties, either subjectively or objectively
2	• Complains of forgetting location of objects; subjective work difficulties
3	• Decreased job functioning evident to co-workers; difficulty in traveling to new locations
4	• Decreased ability to perform complex tasks (e.g., planning dinner for guests, handling personal finances (forgetting to pay bills), difficulty marketing)

5	• Requires assistance in choosing proper clothing to wear for the day, season or occasion (e.g., may wear the same clothing repeatedly)
6	• Decreased ability to dress, bathe, and toilet independently • Difficulty putting clothing on properly • Unable to bathe properly; may develop fear of bathing (e.g., difficulty adjusting bath water temperature) • Inability to handle mechanics of toileting (e.g., forgets to flush, doesn't wipe properly) • Urinary incontinence • Fecal incontinence
7	• Loss of speech, locomotion, and consciousness • Speech ability limited to the use of a single intelligible word in an average day or in the course of an interview • Speech ability is limited; vocabulary becomes limited to a single word (the individual may repeat the word over and over) • Non-ambulatory/ambulatory ability is loss (cannot walk without personal assistance) • Unable to sit up without assistance • Loss of ability to smile • Loss of ability to hold head up

Adapted from: Sclan, SG, Reisberg B. Functional Assessment Staging (FAST) in Alzheimer's disease: Reliability, Validity, and Ordinality. International Psychogeriatrics 1992; 4 Suppl 1: 55-69

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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy and Coverage Committee on 10/24/24.

GUIDELINE UPDATE INFORMATION:

10/01/10	New Medical Coverage Guideline.
11/15/10	Deleted criteria regarding curative treatment or therapy.
10/01/11	Revision; formatting changes.
10/15/11	Annual review; maintain position statements. Updated references.
12/15/11	Added functional assessment tools (Palliative Performance Scale (PPS), Karnofsky Performance Scale (KPS) and Functional Assessment Staging (FAST). Updated references.
01/15/13	Annual review; no change in position statement and updated references.
05/11/14	Revision: Program Exceptions section updated.
11/15/18	Review and revision; no change in position statement. Updated references.
11/15/20	Review; no change in position statement. Updated references.
11/15/22	Review; Added physician designee to criteria and respite care to levels of hospice care. Updated references.
05/23/23	Update to Program Exceptions section.
01/01/24	Position statements maintained.
11/15/24	Review; no change in position statement.