Hospice Care (for Tennessee Only)

Guideline Number: CS147TN.H
Effective Date: March 1, 2022

Instructions for Use

Table of Contents Page

Related Policy

- Home Health Care (for Tennessee Only)

Application

This Coverage Determination Guideline applies to Medicaid only plans in the state of Tennessee.

Coverage Rationale

Indications for Coverage

Hospice Care is an integrated treatment approach for individuals who seek pain and symptom management for their Terminal Illness rather than curative treatment.

- Palliative Care focuses on treatment of and relief from the symptoms life-threatening medical conditions while also addressing the social, emotional, and spiritual needs of patients and their families; and
- Hospice Services are Palliative Care services intended for medically fragile, terminally ill individuals who have a life expectancy of 6 months or less.

Recipients Over Age 21 Receiving Hospice and Concurrent Care

Once an individual elects the hospice benefit, that individual has chosen to end Curative Treatment for their terminal illness. UnitedHealthcare Community Plan (UHCCP) will not pay for curative services, including drugs, relating to the treatment of the individual's terminal illness unless the individual is a child under the age of 21.

UHCCP will continue to pay for other services for illnesses not related to the terminal illness. Members must select a participating UHCCP Hospice.

Recipients Under Age 21 Receiving Hospice and Concurrent Care

Recipients under the age of 21 years are not required to forego Curative Treatment as a result of their hospice election, and may continue to receive medically necessary covered services.

Benefit Periods

Tennessee follows the Medicare election periods and allows the member to elect Hospice for two 90-day periods and unlimited 60-day periods.

Covered Hospice Services

Covered services include core hospice services such as physician services, nursing care, medical social services, and counseling services as well as special coverage services such as continued home care, respite care, bereavement counseling and general inpatient care. All hospice providers and personnel must meet applicable state and federal licensing/certification requirements.

Clinical Review

Hospice providers are expected to maintain a Hospice Certification of Terminal Illness (CTI) form and appropriate documentation of the treatment plan, available upon request.

Providers may be required to submit an updated CTI form with a physician narrative documenting continued qualifications for hospice services.

Discontinuing Hospice Care

Hospice benefits end when the any of the following conditions are met:

- Individual is no longer considered terminally ill; or
- Individual chooses to revoke hospice services through a written, signed statement with the hospice provider; or
- Individual is discharged from hospice due to refusal of services and/or does not adhere to the plan of care.

If the individual is discharged from Hospice Care, any days remaining in the benefit period will be lost. If an individual chooses to restart Hospice services, the individual would still be eligible for benefits as long as they continue to be a covered member under the plan and meet the above criteria. Refer to Clinical Review for required documentation.

Note: Individuals in the terminal stage of their illness who originally qualify for the hospice benefit but stabilize or improve while receiving Hospice Care yet have a reasonable expectation of continued decline for a life expectancy of less than six months, remain eligible for Hospice Care.

Definitions

Check the definitions within the member benefit plan document that supersede the definitions below.

Curative Care: Medical treatment and therapies provided with the intent to cure an underlying disease or to prolong or sustain life. Curative treatment does not necessarily include home health services, durable medical equipment, personal care services, extended home health or contracting with another provider for the performance of these services.

Hospice Care: An integrated program of Palliative Care for patients facing the last six months of life.

Palliative Care: Medical treatment and supportive care provided with the intent to ameliorate pain and other physical, psychological, social, and spiritual distress.

Terminal Illness: Terminally ill is defined as a medical prognosis of limited expected survival should the underlying illness run its natural course.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
T2042	Hospice routine home care; per diem
T2043	Hospice continuous home care; per hour
T2044	Hospice inpatient respite care; per diem
T2045	Hospice general inpatient care; per diem

Revenue Code	Description
0115	Hospice private
0125	Hospice 2 bed
0135	Hospice 3-4 bed
0145	Hospice private (deluxe)
0155	Hospice ward
0235	Hospice, incremental nursing unit
0650	Hospice general
0651	Hospice/RTN home
0652	Hospice/CTNS home
0655	Hospice IP Respite Care
0656	Hospice IP non-respite
0657	Hospice/physician
0658	Hospice room and board nursing facility
0659	Hospice other

References

Centers for Medicare & Medicaid Services Local Coverage Determination (LCD): Hospice Determining Terminal Status (L34538) at https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34538&ContrId=236&ver=3&ContrVer=2&CntrctrSelected=236*2&Cntrctr=236&name=CGS+Administrators%2c+LLC+(15004%2c+HHH+MAC)&DocType=Active%7cFuture&s=All&bc=AggAAAQAAAAAAA%3d%3d&. Accessed April 22, 2021.

Centers for Medicare & Medicaid Services Title 18, Section 1861 (dd) of the Social Security Act; Section 2302 of the Patient Protection and Affordable Care Act of 2010 at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html. Accessed April 22, 2021.

Medicare Benefit Policy Manual (Pub.100-2), Chapter 9 - Coverage of Hospice Services under Hospital Insurance at http://www.cms.hhs.gov/manuals/Downloads/bp102c09.pdf. Accessed April 22, 2021.

Medicare Claims Processing Manual (Pub. 100-4), Chapter 11 - Processing Hospice Claims at http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf. Accessed April 22, 2021.

Medicare Managed Care Manual (Pub. 100-16), Chapter 4 – Benefits and Beneficiary Protections, Section 10.2 Basic Rule at http://www.cms.gov/manuals/downloads/mc86c04.pdf. Accessed. April 22, 2021

TennCare, Division of Health Care Finance & Administration, Policy & Guidelines, TennCare Policy Manual, BEN 07-001 (Rev.7), Hospice at: https://www.tn.gov/content/dam/tn/tenncare/documents2/ben07001.pdf. Accessed April 22, 2021.

Guideline History/Revision Information

Date	Summary of Changes

03/01/2022	**Coverage Rationale**
	Indications for Coverage
	• Revised language to indicate Hospice Care is an integrated treatment approach for individuals who seek pain and symptom management for their Terminal Illness rather than curative treatment.
	  ○ Palliative Care focuses on treatment of and relief from the symptoms life-threatening medical conditions while also addressing the social, emotional, and spiritual needs of patients and their families; and
	  ○ Hospice Services are Palliative Care services intended for medically fragile, terminally ill individuals who have a life expectancy of 6 months or less
	Covered Hospice Services
	• Revised language to indicate covered services include core hospice services such as physician services, nursing care, medical social services, and counseling services as well as special coverage services such as continued home care, respite care, bereavement counseling and general inpatient care; all hospice providers and personnel must meet applicable state and federal licensing/certification requirements
	Discontinuing Hospice Care
	• Revised language to indicate:
	  ○ Hospice benefits end when the any of the following conditions are met:
	  ▪ Individual is no longer considered terminally ill; or
	  ▪ Individual chooses to revoke hospice services through a written, signed statement with the hospice provider; or
	  ▪ Individual is discharged from hospice due to refusal of services and/or does not adhere to the plan of care
	  ○ If the individual is discharged from Hospice Care, any days remaining in the benefit period will be lost
	  ▪ If an individual chooses to restart Hospice services, the individual would still be eligible for benefits as long as they continue to be a covered member under the plan and meet the above criteria
	  ▪ Refer to the *Clinical Review* section of the policy for required documentation
	  ○ Individuals in the terminal stage of their illness who originally qualify for the hospice benefit but stabilize or improve while receiving Hospice Care yet have a reasonable expectation of continued decline for a life expectancy of less than six months, remain eligible for Hospice Care
	Definitions
	• Added a definition of “Palliative Care”
	• Updated definition of:
	  ○ Curative Care (previously Curative Treatment)
	  ○ Hospice Care
	  ○ Terminal Illness
	Supporting Information
	• Removed *CMS* section
	• Archived previous policy version CS147TN.G

Instructions for Use

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this guideline, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its

Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Coverage Determination Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.