Policy Title: Hospice Care Guidelines for Cancer and Non Cancer Diagnosis

Policy Number: B.01

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NCQA Standard: N/A
URAC Standard: N/A

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Special Instructions Alert:

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<th>State/Program</th>
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Definitions:

End of Life/Hospice Care

This healthcare program is designed to meet the needs of terminally ill individuals when the individual decides that curative treatment is no longer in their best interest. These individuals choose palliative care, which is not a cure, but ensures comfort, dignity, and quality of life. Hospice is intended to address the needs of the individual with a terminal illness while also considering family needs. Michigan 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.

Policy: Eligibility for End of Life/Hospice Care has both objective and subjective criteria. It is difficult if not impossible to accurately predict timing for death, especially within the non-cancer diagnostic group. Meridian Health Plan (MHP) offers Hospice care for those patients identified as meeting all of MHP’s criteria including:

1. Expected death within a 6 month time frame;
2. Appropriate Certification of Illness (CTI) signed by the treating physician or medical director of the hospice (no electronic signature) and patient acceptance forms signed and faxed to MHP no later than fifteen calendar days from initiation of hospice care for each election period (initial 90 day period, a subsequent 90

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1 Original Medicare covers hospice services and any Part A and Part B services related to the terminal condition. See the special instructions section for information relating to Medicare coverage.
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day period, or an unlimited number of subsequent 60 day periods). MHP can accept verbal consent with signage by the person receiving the certification within three days of initiation of the hospice care.

Procedure:

Cancer or Non-Cancer Diagnosis

1. Hospice Care must be prior-authorized by MHP and verification of member ID undertaken.
2. Hospice Care will be considered for MHP members meeting all of the following criteria:
   a. Patient, and when applicable, family acceptance of Hospice.
   b. Certification by Medical Director or treating Physician that no additional life prolonging medications or chemotherapeutic agents will be continued.
   c. All written/verbal certification or documented verbal certification within fifteen calendar days from the effective date of each election period
   d. Hospice care must include:
      i. A brief narrative summary;
      ii. Face-to-face encounter: Upon request for recertification MHP will review the member’s claim history for evidence of a home or office visit between the member and hospice provider. The home or office visit must be conducted by a hospice physician, hospice physician assistant, or a hospice nurse practitioner prior to the 180th day of recertification of the patient’s terminal illness;
         1. Documentation of a face-to-face encounter (must include date of the visit) explaining why the clinical findings support a life expectancy of six months or less prior to the 180th day of recertification (third 90 day election period) and for every 60 days thereafter to assure that eligibility criteria for Hospice Care continues to be met.
         2. Hospice Physician Assistant and/or the hospice Nurse Practitioner is allowed to perform and attest (in writing with the date of the visit included) to the face-to-face encounter but the certification and recertification of terminal illness must be done by the hospice physician.
      iii. The statement that the individual’s medical prognosis is a life expectancy of 6 months or less if the terminal illness runs its normal course;
      iv. Specific clinical findings and other documentation supporting a life expectancy of six months or less; and
      v. A plan of care must be established including the member’s goals of care.
   vi. Hospice care for children under 21 years of age will cover concurrent curative treatment. Thus, this allows the beneficiary or the beneficiary’s representative to elect the hospice benefit when the terminal diagnosis is certified by a physician and the hospice medical director without forgoing curative treatment of the terminal condition.

Levels of Care: A change to a higher level of care would require pre-authorization by MHP.

1. Home
   a. Member is able to be maintained in home and has support of family/significant other.
   b. Continuous home care may be provided by the hospice during a period of crisis. A period of crisis is a period in which a member requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms.

2. Skilled Nursing Facility
   a. Skilled care may be needed by a patient whose home support has broken down if this breakdown makes it no longer feasible to furnish needed care in the home setting.
   b. MHP will pay the hospice the daily amount allowed for room and board while the member is receiving hospice care, and the hospice pays the facility.

3. In-patient
a. General in-patient care for pain control and symptom management that cannot feasibly be
provided in other settings. Requires regular clinical review.
b. Respite care for the relief of the patient’s caregivers up to 5 days.

**Revocation:** An individual or representative may revoke the election of hospice care at any time in writing. To
revoke election of hospice care, the individual must file a document with the hospice that includes a signed
statement that the individual revokes the election for hospice care. A verbal revocation of benefits is not
acceptable. An individual may not designate an effective date earlier than the date that the revocation is made. The
hospice provider must fax the revocation to MHP within 24 hours of receipt.

Hospice may not be authorized and/or continued for a client when one or more of the following is true:
- The medical documentation no longer supports the above criteria (e.g., change in condition,
- Change in the plan of care, etc.).
- The family chooses to discontinue hospice.
- The medical services being rendered by the hospice provider are available through another benefit.

**Hospice Discharge**
1. The hospice benefit is available only to individuals who are terminally ill; therefore, a hospice may
discharge a member if it discovers that the member is not terminally ill.
2. Discharge may also be necessary when the member moves out of the service area of the hospice.
3. Once a hospice chooses to admit an MHP member, it may not automatically or routinely discharge the
beneficiary at its discretion, even if the care promises to be costly or inconvenient. The election of the
hospice benefit is the beneficiary’s choice rather than the hospice’s choice, and the hospice cannot
revoke the beneficiary’s election. Neither should the hospice request nor demand that the member
revoke his/her election.
4. Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the
recertification of the terminal illness requirement. This results in the beneficiary no longer being
eligible for the hospice benefit. At this point, the hospice must complete a Hospice Membership Notice
(DCH-1074) form with the last date of the benefit period as the effective disenrollment date.

**Special Instructions:**

**Medicaid/Michigan: Out of State Hospice Providers:** Out-of-state, borderland hospice providers cannot provide
services to an MHP Medicaid beneficiary in Michigan unless:
- The agency is licensed and Medicare certified as a hospice in Michigan, or
- The state in which they are licensed and certified has a reciprocal licensing agreement with the state
  of Michigan.

If the above conditions are met and the hospice provides services across state lines, its personnel must be licensed
to practice in Michigan. Medicaid will not cover services for a beneficiary who enters a hospice-owned residence
outside of Michigan. When a Michigan Medicaid beneficiary voluntarily enters a hospice-owned residence in
another state to receive routine hospice care, they are no longer considered a Michigan resident and, therefore, not
eligible for hospice benefits under Michigan Medicaid.

**Medicare/All:** Original Medicare, not Meridian Advantage Plan (MAP) will pay for hospice services and any Part
A and Part B services related to the terminal condition. The hospice provider will bill Original Medicare for the
services that Original Medicare pays for.

Covered services include:
1. Drugs for symptom control and pain relief
2. Short term respite care
3. Home care
Criteria: If the member needs non-hospice care (care that is not related to a member’s terminal condition), then:

1. Original Medicare will cover the member’s care. This means the member will be responsible for any cost-sharing amounts under Original Medicare, except for emergency or urgently needed care. After the member makes the payment, they can inquire about having MAP reimburse them for the difference between the cost sharing in our plan and the cost sharing under Original Medicare, if applicable.

If the member needs non-hospice care (care that is not related to the member’s terminal illness), the member should contact MAP to arrange any needed services. MAP will cover hospice consultation services (one time only) for a terminally ill member who hasn’t elected the hospice benefit.

**CPT/HCPCS Codes:**

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Approved by: __________________________________ Date: 10/20/2015

Reviewed and approved by Medical Policy and Procedures Committee: Date: 08/20/2015

Reviewed and approved by Medical Policy Operations Committee: Date: 08/28/2015

Reviewed and approved by Physician Advisory Committee: Date: 09/25/2015

Reviewed and approved by Corporate Compliance Committee: Date: 10/20/2015

References:


**State Letters/ Bulletins:**

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<tr>
<td>Medicare Managed Care Manual:</td>
<td>Ch 9- Coverage of Hospice Services under Hospital Insurance; Rev. 141, 03/2011</td>
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<td>Medicaid CFR:</td>
<td>42 CFR § 418.202</td>
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<td>State Administrative Codes:</td>
<td>II-G3</td>
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**GENERAL GUIDELINES (WHEN DISEASE SPECIFIC GUIDELINES BELOW DO NOT APPLY)**

The patient should meet all of the following criteria: The patient’s condition is life limiting and the patient and/or family are aware. The patient and/or family have elected treatment goals directed toward relief of symptoms rather than cure of disease. Individuals or Guardian must voluntarily choose Hospice which precludes usage of Medicaid services for terminal illness and related conditions. The patient has either:

- Documented clinical progression, increasing Emergency care or hospitalizations, recent functional decline (from baseline) or Karnofsky Performance Status less than 50% or dependence in 3 of 6 ADL’s
- Recent impaired nutritional status related to the underlying disease (e.g. unintentional weight loss of > 10% over the preceding 6 months.)
**LIVER DISEASE**  End-Stage Liver Disease must have 1, 2 & 3 and at least 1 of  #4:

1. Prolonged prothrombin time > 5 sec. over control or INR > 1.5
2. Low serum albumin< 2.5 gm/dl
3. Child-Turcotte-Pugh Scale, Class C
4. Clinical indicators of ESLD
   a. Refractory Ascites
   b. Spontaneous bacterial peritonitis
   c. Hepatorenal syndrome (BUN >100, Oliguria <400ml/day)
   d. Recurrent Variceal Bleeding despite therapy
   e. Hepatic Encephalopathy either refractory or non-compliant pt

ICD 10 Codes that support medical necessity:  Liver Cancer, Alcoholic Cirrhosis of liver , Chronic Hepatitis, Cirrhosis of liver w/o mention of alcohol, Biliary Cirrhosis, Hepatic coma, Hepatorenal Syndrome

**RENAL DISEASE**

Acute Renal Failure (A,B, &C must be present)

a. Patient is not seeking dialysis or renal transplant
b. Creatinine clearance <10 cc/min (<15 cc/min for diabetes)
c. Serum creatinine > 8.0 mg/dl  6.0 mg/dl for diabetes

Comorbid Conditions predictors of early mortality in hospitalized patients with ARF:
1. Mechanical Ventilation
2. Malignancy (Other Organ System)
3. Chronic lung disease
4. Advanced liver disease

Sepsis, Immunosuppression/AIDS, Albumin < 3.5 mg/dl, Cachexia, Advanced cardiac disease, Mechanical ventilation, Malignancy, Platelet Count< 25,000

Disseminated intravascular coagulation, Gastrointestinal bleeding

2. Chronic Renal Failure

A. Patient is not seeking dialysis or renal transplant
B. Creatinine clearance < 10 cc/min (< 15 cc/min for diabetes)
C. Serum creatinine > 8.0 mg/dl (6.0 mg/dl for diabetes)

Supportive Documentation  Signs and symptoms of renal failure:
1. Uremia
2. Oliguria (<400 cc/day)
3. Intractable Hyperkalemia (7.0) not responsive to treatment
4. Uremic pericarditis
5. Hepatorenal Syndrome
6. Intractable Fluid overload, not responsive to treatment

ICD-10 Codes that support medical necessity:  Acute renal Failure, Chronic Renal failure, Renal failure, Unspecified

**HIV Correlates of early mortality:**
1. CD + count <25
2. Persistent Viral Load> 100,000
3. Co-morbidity factors
4. The following HIV related opportunistic diseases are all associated with prognosis ≤ 6 months:
   a.) CNS Lymphoma (2.5 months)
   b.) Progressive multifocal leukoencephalopathy (4 months)
   c.) Cryptosporidiosis (5 months)
   d.) Wasting (loss of 33% lean body mass) <6 months
   e.) MAC bacteremia, untreated (<6 months)
   f.) Visceral Kaposi’s sarcoma, unresponsive to therapy (50% @ 6 months)
   g.) Renal failure, refuses or fails dialysis (<6 months)
   h.) Advanced AIDS dementia complex (6 months):)
   i.) Toxoplasmosis (6 months)
   j.) Poorly responsive systemic lymphoma
HEART DISEASE Both 1 & 2 must be present for consideration.

1. NYHA Class IV
2. Patient is already optimally treated w/ diuretics and vasodilators (ACE Inhibitors) or Nitrates plus Hydralazine

Supportive Documentation

1. O₂ Sat. <88%
2. Ejection Fraction of 20% or less
3. SV or Ventricular Arrhythmias, resistant to treatment
4. Hx. Of Cardiac Arrest
5. Hx. Of Syncope, unexplained
6. Cardiogenic Brain Embolism
7. Concomitant HIV
8. If patient can’t tolerate ACE Inhibitors, MD must document why

Codes that support medical necessity: Chronic Ischemic Heart Disease

STROKE AND COMA Both 1 & 2 must be present for consideration

1. FAST Score (must be at least level 7)
   (7a) Speaks, 6 intelligent words or less
   (7b) All intelligible vocabulary lost
   (7c) Non-Ambulation
   (7d) Can’t sit without assistance
   (7e) Loss of ability to smile
   (7f) Unable to hold up head independently
2. Inability to maintain hydration and caloric intake with one of the following:
   - Weight loss >10% during previous 6 months
   - Weight loss > 7.5% in previous 3 months
   - Serum albumin < 2.5 gm/dl
   - Aspiration Pneumonia
   - Inadequate caloric/fluid intake

Codes that support medical necessity: Subarachnoid hemorrhage, Intracerebral hemorrhage, Nervous system complication: iatrogenic cerebrovascular infarction or hemorrhage.

PULMONARY DISEASE Both 1 & 2 must be present for consideration.

1. Severe chronic lung disease documented by A and B
   A. Disabling Dyspnea at rest or with minimal exertion, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity.
   *If available, documentation of forced expiratory volume in one second (FEV1) after bronchodilator, less than 30% predicted.*
   B. Progression of end-stage pulmonary disease, as evidenced by either:
      i. increasing visits to the emergency department or prior hospitalizations for pulmonary infections/respiratory failure
      ii. If available, documentation of serial decrease in FEV1 on serial testing > 40 ml per year.
2. Hypoxemic at rest on room air, as evidenced by:
   - pO₂ ≤ 55 mm Hg
   - O₂ Saturation ≤ 88%
3. Hypercapnia (pCO₂ > 50 mm Hg)

Supportive Documentation

1. Cor pulmonale and right heart failure (RHF), Secondary to advanced Pulmonary Disease.
2. Progressive weight loss > than 10% over preceding 6 months
3. Resting tachycardia > 100/mm

Codes that support medical necessity: Senile dementia with delirium, Alzheimer’s disease, Pick’s disease, Senile degeneration of the brain

ALZHEIMER’S DISEASE & DEMENTIA: Both 1 & 2 must be present for consideration.

1. FAST Score (must be at least level 7)
   (7a) Speaks, 6 intelligent words or less
   (7b) All intelligible vocabulary lost
   (7c) Non-Ambulation
   (7d) Can’t sit without assistance
   (7e) Loss of ability to smile
   (7f) Unable to hold up head independently
2. Comorbid or secondary conditions such as:
   - COPD
   - CHF
   - Fever recurrent after antibiotic
   - Aspiration or Recurrent aspiration pneumonia, Sepsis/Septicemia, Upper UTI (e.g. pyelonephritis)
   - Progressive weight loss > 10% in past 6 months
   - Serum albumin < 2.5 gm/dl
   - Age > 70
   - Decubitus ulcers (multiple stage 3-4)

Codes that support medical necessity: Senile dementia with delirium, Alzheimer’s disease, Pick’s disease, Senile degeneration of the brain

AMYOTROPHIC LATERAL SCLEROSIS (ALS)
The only factor that is critical in end-stage ALS is respiratory function. The overall rate of decline in each patient is fairly constant. The following have expected survival of approximately 6 months:

1. Both rapid progression of ALS and critically impaired ventilatory capacity
2. Both rapid progression of ALS and critical nutritional impairment with a decision not to receive artificial feedings
3. Both rapid progressions of ALS and life-threatening complications such as aspiration pneumonia, urinary tract infections, sepsis, decubitus ulcers.

Rapid progression of ALS is the development of their disability within the past 12 months.

Critical impaired ventilatory capacity: The patient should have developed severe breathing disability within the past 12 months.

Nutritional impairment documented by:
1. Continued weight loss
2. Dehydration or hypovolemia

CANCER DIAGNOSES

Disease with metastases at presentation

Progression from an earlier stage of disease to metastatic disease with either continued decline in spite of therapy or patient refuses further therapy