SMSO Policy Manual
HOSPICE

Executive Sponsor:	Chief Medical Officer
Issuing Department:	Clinical Management
Gate Keeper:	Director, HSM Clinical Management

COMPLIANCE STATEMENT:

Enforcement:	All members of the workforce are responsible for compliance with this policy. Failure to abide by the requirements of this policy may result in corrective action, up to and including termination. Workforce members are responsible for reporting any observed violations of this policy.
Review Schedule:	This policy will be reviewed and updated as necessary and no less than every two years.
Monitoring and Auditing:	The Issuing/Collaborating Department(s) is responsible for monitoring compliance with this policy.
Documentation:	Documentation related to this policy must be maintained for a minimum of 10 years.

Applies to:

- ☒ SummaCare
- ☐ Summa Management Service Organization (SMSO)
- ☒ Apex
- ☒ Summa Insurance Company

Line of Business:

- ☒ Commercial Groups
- ☐ Medicare Supplemental
- ☒ Off-Exchange
- ☒ Medicare
- ☒ On-Exchange
- ☒ Self-Funded

1.0 Purpose:

1.1 To provide a consistent process for the administration of the Hospice benefit.

2.0 Policy:

2.1 Health Services Management will oversee all Hospice elections to ensure that appropriate services are obtained.

2.2 **For Medicare Advantage (MA) members, coverage decisions follow Medicare rules and regulations pertaining to MA plans, as well as federal and state regulations, and the member's evidence of coverage (EOC) document. When appropriate, relevant current clinical guidelines, SummaCare's internal policies/procedures and drug formularies may be utilized in the absence of Medicare guidance.**

2.3 **For non-Medicare members, coverage decisions follow appropriate federal and state requirements and the member's evidence of coverage (EOC) document. Additionally, SummaCare's internal policies/procedures, and drug formularies are followed when appropriate**

3.0 Procedure:

3.1 Settings

3.1.1 Although Hospice care may be delivered in any location, there are important characteristics that distinguish it from other types of care.

3.1.1.1 Hospice care is delivered intermittently and is a separate service from home care, custodial care in a skilled nursing facility (SNF) or intermediate care facility (ICF).

3.1.1.2 Hospice benefits normally cover inpatient status only when the reason is pain and symptom management. This situation normally occurs in a hospital or a facility licensed for hospice care only.

3.1.1.3 Many benefit descriptions use the term "approved hospice facility". This term means a facility that is properly licensed in the state in which it operates and is engaged mainly in providing palliative care to terminally ill patients within the network pertinent to the member's insurance plan.

3.2 Medical Indications for Authorization

3.2.1 A Physician has advised the patient and caregiver of a:

3.2.1.1 Terminal state;

3.2.1.2 Life expectancy of no longer than six months;

3.2.1.3 Termination of curative treatment.

3.3 SummaCare Medicare Members

3.3.1 Covered Services

3.3.1.1 Inpatient care for pain and symptom management at an approved hospice facility. (This term means a facility that is properly licensed in the state in which it operates and is engaged mainly in providing palliative care to terminally ill patients within the network pertinent to the member's insurance plan.)

3.3.1.2 Inpatient short term respite care for relief of the patient's caregivers in a Medicare participating hospital or hospice inpatient facility, or a Medicare or Medicaid participating nursing facility.

3.3.1.3 All standard covered home health care services provided by a Hospice Care Agency, such as:

3.3.1.3.1 Part-time or intermittent nursing care by a registered graduate nurse (R.N.) or licensed practical nurse (L.P.N.) for up to 8 hours in any one day.

3.3.1.3.2 Medical social services, under the direction of a physician, which include:

3.3.1.3.2.1 Assessment of the family member's social, emotional and medical needs, and the home and family situation.

3.3.1.3.2.2 Identification of the community resources, which are available to the family member.

3.3.1.3.2.3 Assisting the family member to obtain those resources needed to meet the family member's assessed needs.

3.3.1.3.3 Counseling services including dietary and bereavement.

3.3.1.3.4 Consultation or care management services by a physician.

3.3.1.3.5 Physical therapy, occupational therapy and speech-language pathology services.

3.3.1.3.6 Part-time or intermittent home health aide and homemaker services, for up to 8 hours in any one day, which consist mainly of caring for the family member. Medical supplies, drugs and medicines prescribed by a physician.

3.3.1.4 Physician services for a consultation and care management.

3.3.1.5

3.3.1.6 Continuous home care services provided by a Hospice Care Agency can be furnished only during brief periods of crisis (care needed to achieve palliation or management of acute medical symptoms) and only as necessary to maintain the terminally ill patient at home, and include:

3.3.1.6.1 Continuous care by nursing, hospice aide, and/or homecare care during a 24-hour day, which begins and ends at midnight for a minimum of 8 hours/day.

3.3.1.6.2 In addition to the 8 hour minimum, services provided must be predominantly nursing care, provided by an RN, LPN, or an LVN. More than half the hours must be provided by nursing; homemaker and hospice aide services may be provided to supplement the nursing care.

3.3.1.6.3 When fewer than 8 hours of care are required, the services are covered as routine home care rather than continuous home care.

3.4 Non-Covered services include:

3.4.1 Funeral arrangements;

3.4.2 Pastoral counseling;

3.4.3 Financial or legal counseling;

3.4.4 Any services or supplies not solely related to the care of the member, including but not limited to sitter or companion services for the member who is ill or other members of the family, transportation, house cleaning and maintenance of the house; and

3.4.5 Physician services for non-hospice procedures. (Note: these should bill with modifier 6W).

3.5 Limitations

3.5.1 Benefit periods:

3.5.1.1 Initial 90 days

3.5.1.2 Subsequent 90 days

3.5.1.3 Unlimited 60 day periods

3.5.2 The patient or designated representative may revoke the election of hospice care at any time, or may change the designation of the hospice agency once in each of the above time periods.

3.6 Commercial Fully Insured and Marketplace Members

3.6.1 Covered Services:

3.6.1.1 All covered home health services per Evidence of Coverage (or Certificate of Insurance), including:

3.6.1.1.1 Skilled nursing services which may be authorized for up to eight hours in any twenty four hour period;

3.6.1.1.2 In-home medical social services, under the direction of a provider;

3.6.1.1.3 In-home consultation or case management services by a provider;

3.6.1.1.4 In-home physical therapy, occupational therapy and speech-language pathology services;

3.6.1.1.5 Home health aide (part-time or intermittent, up to eight hours in any one day, which consists mainly of caring for the family member);

3.6.1.1.6 Services and supplies furnished by the hospice facility during an admission, including part-time nursing care by or under the supervision of a registered nurse;

3.6.1.1.7 Room and board while in a hospice facility;

3.6.1.1.8 In-home dietary counseling;

3.6.1.1.9 Medical supplies, drugs and medicines, prescribed by a provider

3.6.1.1.10 Durable medical equipment;

3.6.1.1.11 Bereavement counseling for covered family members up to two visits.

3.6.2 Non-Covered services include:

3.6.2.1 Homemaker services;

3.6.2.2 Volunteer services;

3.6.2.3 Spiritual counseling services;

3.6.2.4 Food or home-delivered meals;

3.6.2.5 Custodial care, rest care or care for someone’s convenience;

3.6.2.6 Intermediate care facility (ICF) care; and

3.6.2.7 Chemotherapy or radiation therapy, if other than palliative treatment.

3.7 SummaCare Self-Insured Members

3.7.1 Services may require prior authorization dependent on the specific self-insured plan.

3.7.2 Refer to specific plan Summary Plan Description (SPD) documents for prior authorization requirements and covered services.

3.8 The Plan's HSM Hospice Procedure

3.8.1 Medicare:

3.8.1.1 A Medicare Advantage (MA) enrollee who elects hospice care, but chooses not to disenroll from the plan, will have services covered as follows:

3.8.1.1.1 For Part A and Part B services unrelated to the terminal diagnosis, the MA plan is the secondary payer; the MA plan pays the difference in cost-sharing between original Medicare and the MA plan, if the member has followed plan rules in obtaining the services.

3.8.1.1.2 If the member does not follow plan rules when obtaining non-hospice related services, the member is responsible for original Medicare cost-sharing.

3.8.1.1.3 The MA plan remains responsible for supplemental (non-Parts A & B) benefits offered under the plan.

3.8.1.2 When a member signs a Hospice Election Statement (provided by Medicare Hospice Providers), the member must select and use a Medicare certified hospice provider(s) for care related to the terminal illness.

3.8.1.2.1 As of the first of the month after the member elects hospice, the capitation from CMS to the plan is reduced to an administrative management fee per member per month. CMS places the member in an administrative suspension status.

3.8.1.2.2 Care provided on or after the date of the hospice election, by the hospice provider as it relates to the terminal diagnosis is paid directly by Medicare.

3.8.1.2.3 When billing Medicare, providers should follow CMS guidelines, using the appropriate modifiers.

3.8.1.3 Members can revoke hospice elections at any time to resume curative care. If so revoked, the plan will resume coverage for the member according to his/her benefit plan, the first of the following month. The plan will then begin receiving normal capitation payments from CMS. Upon discharge or revocation, fee-for-service Medicare continues to cover the beneficiary

through the end of the month when the beneficiary revokes or is discharged from hospice alive.

3.8.1.4 The plan is only responsible for the following in relation to members seeking or receiving hospice care and services:

3.8.1.4.1 Education for the member regarding availability of hospice care

3.8.1.4.2 Referral to a Medicare hospice provider

3.8.1.4.3 Pre-Hospice consultation/evaluation by either the medical director or employee of a hospice provider for members who have not yet elected hospice benefit

3.8.1.4.4 Covered care and services for conditions that are unrelated to the member's terminal illness, as follows:

3.8.1.4.4.1 Plan providers must bill Medicare Carriers and Intermediaries for the member's basic benefits, using fee-for-service mechanisms for those services (applicable copayments also apply). When billing Medicare, providers should follow CMS guidelines, using the appropriate modifiers.

3.8.1.4.4.2 To ensure the plan's members are receiving their full plan benefit for non-hospice related services, basic benefits (i.e., benefits covered under Part A and Part B) will be coordinated with Medicare, not to exceed what the plan would have paid if they had been the only payer. Appropriate co-pays and coinsurance will apply.

3.8.1.4.4.3 The plan is responsible for covering the member's non-Part A and B (additional benefits (e.g., routine vision services, routine hearing exam)), if any, as long as the member uses a plan provider and remains enrolled with the plan.

3.8.1.4.4.3.1 Weekly reports will be used to identify claims for members electing hospice care. Accident and non-Part A and B services will be paid by the plan. All other claims will be reviewed by Health Services Management (HSM) to determine if the services are hospice related. If hospice related, the claim will be denied to bill traditional Medicare. If not hospice related, the claim will be paid by the plan.

3.8.2 Fully Insured Commercial:

3.8.2.1 Hospice services for fully insured commercial members do not require prior authorization.

3.8.2.2 The Plan retains payment responsibility for all covered Hospice services.

3.8.2.3 The Benefit Determination Unit may receive notification/election form indicating a member has elected the Hospice benefit.

3.8.2.4 If the level of care is "inpatient", no authorization is entered for the inpatient stay because the Hospice agency will bill the inpatient stay to us via the appropriate inpatient hospice code.

3.8.3 Self-Insured Commercial:

3.8.3.1 See Summary Plan Descriptions (SPDs) for prior authorization requirements for individual self-insured groups.

3.8.3.2 Self-insured groups retains payment responsibility for all covered Hospice services.

3.9 The Plan's Hospice Call Inquiry Procedure

3.9.1 The Plan may receive calls from Providers, Members, or Facilities, inquiring about benefit coverage in various locations. When these calls are received, care must be taken to determine all needed facts in order to provide an accurate answer.

3.9.1.1 Ask where the Hospice service will be performed. Note: "Home" may be in a person's own home or apartment, or in an ICF or long-term care (LTC) facility.

3.9.1.2 Ask what status will the patient be – resident, custodial, inpatient for pain and symptom management) Note: this is different from type of facility to be used.

3.9.1.3 Verify that the request is for intermittent hospice service.

3.9.1.4 Review the coverage above for Medicare or Commercial members. Review the Evidence of Coverage (EOC) document for members of Self-Insured plans.

3.10 Jacquie Potelicki, Director, HSM Clinical Management, has the authority and responsibility for the activities in this policy or procedure.

3.11 The Issuing Dept. is responsible for monitoring/enforcing the compliance with this policy.

3.11.1 Compliance will conduct periodic reviews to monitor and audit compliance with this policy.

4.0 References:

4.1 Source of the policy (regulatory citation, accreditation standard, internal standard)

4.1.1 Medicare Benefit Policy Manual Chapter 9

4.1.2 Code of Federal Regulations (CFR): 418.20

4.2 Are there any references to other documents, regulations, or intranet locations?

4.2.1 None

4.3 Are there other policies that work in conjunction with this policy?

4.3.1 None

4.4 Replaces (if applicable):

4.4.1 None

5.0 Definitions:

5.1 **Hospice Care:** is an approach to caring for terminally ill individuals that stresses palliative care (relief of pain and uncomfortable symptoms), as opposed to curative care. In addition to meeting the patient's medical needs, hospice care addresses the physical, psychosocial, and spiritual needs of the patient, as well as the psychosocial needs of the patient's family/caregiver. The emphasis of the hospice program is on keeping the patient at home with family and friends as long as possible.

6.0 Key Words or Aliases (Optional):

6.1 Hospice

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