Hospice Services

Policy Number: MCS045.01
Approval Date: May 18, 2021

Instructions for Use

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Related Policies
None

Coverage Guidelines

Hospice is covered by Original Medicare under Part A for members who elect to receive hospice care.

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.

- As of the first of the month after the member elects hospice, the capitation from CMS to UnitedHealthcare is reduced to an administrative management fee per member per month. CMS places the member in an administrative suspension status.
- Care provided as it relates to the terminal diagnosis, by the hospice provider is paid directly by Medicare. (Refer to the below for care unrelated to the terminal diagnosis)
- When billing CMS, providers should follow CMS guidelines, using the appropriate modifiers.
- Members can revoke hospice elections at any time to resume curative care. If so revoked, UnitedHealthcare will resume coverage for the member according to his/her benefit plan, the first of the following month. UnitedHealthcare will then begin receiving normal capitation payments from CMS. Prior to the first of the month and after revocation of the hospice benefit, member reverts to original Medicare coverage.

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

- Education for the member regarding availability of hospice care
- Referral to a Medicare hospice provider
- Pre-Hospice consultation/evaluation by either the medical director or employee of a hospice provider for members who has not yet elected hospice benefit (effective January 1, 2005).

Covered care and services for conditions that are unrelated to the member's terminal illness.

- Basic Benefits
  A UnitedHealthcare Medicare Advantage member who has elected hospice and requires medical treatment for a non-hospice condition can do one of the following:
  - Use plan providers and services. In such a case, the member only pays plan allowed cost-sharing, and the plan provider would directly bill Medicare for Parts A and B services. Plan providers must bill Medicare for the member's basic benefits, using fee-for-service (FFS) mechanisms for those services. When billing Medicare, plan providers should follow-Medicare guidelines, using the appropriate modifiers.
  - Use non-plan/non-network providers and be treated under FFS. In such a case, if the service is not emergent/urgent care, the member would pay the total FFS allowed cost-sharing.

- Supplemental Benefits
  UnitedHealthcare is responsible for covering the member's supplemental benefits (e.g., eyeglasses, prescription drugs), if any, as long as it is authorized by the treating physician, the member uses a plan provider and remains enrolled with the UnitedHealthcare Medicare Advantage plan.

For Medicare detailed coverage guidelines for hospice services, refer to the Medicare Benefit Policy Manual, Chapter 9 – Coverage of Hospice Services under Hospital Insurance. (Accessed April 26, 2021)

Refer to the Medicare Claims Processing Manual, Chapter 11-Processing Hospice Claims and the Medicare Managed Care Manual, Chapter 4, §10.2-Basic Rule and §10.4-Hospice Coverage. (Accessed April 26, 2021)

Definitions

Hospice Benefit Period: Two (2) initial 90-day periods followed by an unlimited number of 60-day periods. Each benefit period requires the physician to certify that the member is terminally ill and has a life expectancy of 6 months or less. An election to receive hospice care will continue through each consecutive period if the member remains in hospice and does not revoke the election. Medicare Benefit Policy Manual, Chapter 9 – Coverage of Hospice Services under Hospital Insurance. (Accessed April 26, 2021)

Hospice Care: Items and services related to the terminal illness for which a member entered the hospice. An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is 6 months or less if the illness runs its normal course. Medicare Benefit Policy Manual, Chapter 9 – Coverage of Hospice Services under Hospital Insurance. (Accessed April 26, 2021)

Policy History/Revision Information

Date	Summary of Changes
05/18/2021	• Routine review; no change to coverage guidelines • Archived previous policy version MCS045.01

Instructions for Use

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member's Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member's EOC/SB, the member's EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).