United Healthcare Community Plan

Hospice Care (for Tennessee Only)

Guideline Number: CS147TN.G
Effective Date: August 1, 2020

Instructions for Use

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Related Community Plan Policy
- Home Health Care (for Tennessee Only)

Medicare Advantage Coverage Summary
- Hospice Services

Application

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

Coverage Rationale

Hospice Care is an alternative treatment approach that is based on recognition that impending death requires a change from Curative Treatment to comfort care for the terminally ill individual and support for the family. Before using this guideline, please check the federal, state or contractual requirements for benefit coverage.

- Terminally ill is defined as a medical prognosis of limited expected survival, of six months or less at the time of referral to a hospice, of an individual who is experiencing an illness for which hospice care is appropriate.

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 his 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.

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Covered Hospice Services

Covered services provided through hospice include core hospice services such as physician services, nursing care, medical social services, and counseling services in addition to special coverage services such as continued home care, respite care, bereavement counseling and general inpatient care. All 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 are required to submit an updated CTI form with a physician narrative documenting qualifications for hospice for the initial 90-day period, a subsequent 90-day period, and at 60-day periods, thereafter.

If an individual improves or stabilizes sufficiently over time while in hospice such that he/she no longer has a prognosis of six months or less from the most recent recertification evaluation or definitive interim evaluation, that individual should be considered for discharge from the hospice benefit. Such individuals can be re-enrolled for a new benefit period when a decline in their clinical status is such that their life expectancy is again six months or less. 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 Treatment: Medical treatment and therapies provided with the intent to improve symptoms and cure. Its focus is on curing an underlying disease and the providing medical treatments to prolong or sustain life. Examples of Curative Treatments are antibiotics, chemotherapy, radiation, or a cast for a broken limb. Curative Treatment does not 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 that provides comfort and support services for the terminally ill. Hospice Care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving Hospice Care.

Terminal Illness: Terminally ill is defined as a medical prognosis of limited expected survival, of six months or less at the time of referral to a hospice, of an individual who is experiencing an illness for which hospice care is appropriate.

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

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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

Centers for Medicare and Medicaid Services (CMS)

Medicare does not have a National Coverage Determination (NCD) specifically for hospice services. Local Coverage Determinations (LCDs) exist; see the LCDs for Hospice Alzheimer's Disease & Related Disorders, Hospice Cardiopulmonary Conditions, Hospice - Neurological Conditions, Hospice - HIV Disease, Hospice - Liver Disease, Hospice - Renal Care and Hospice The Adult Failure To Thrive Syndrome. Also see the Medicare Benefit Policy Manual, Chapter 9 - Coverage of Hospice Services under Hospital Insurance. (Accessed April 1, 2020)

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 13, 2020.

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 13, 2020.

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 13, 2020.

Medicare Claims Processing Manual (Pub. 100-4), Chapter 11 - Processing Hospice Claims at http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf. Accessed April 13, 2020.

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 13, 2020.

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 13, 2020.

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Guideline History/Revision Information

Date	Summary of Changes
05/01/2021	**Template Update** • Reformatted policy; transferred content to new template • Replaced reference to "MCG™ Care Guidelines" with "InterQual® criteria" in *Instructions for Use*
08/01/2020	• Routine review; no change to coverage guidelines • Archived previous policy version CS147TN.F

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.

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