JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Medical Policy Manual** **Medical Policy**	*Policy Number*	CMS03.00
		Effective Date	11/01/2023
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	Subject **Hospice and Palliative Services**	*Supersedes Date*	08/01/2022
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This document applies to the following Participating Organizations:

EHP	Johns Hopkins Advantage MD	Johns Hopkins Health Plan of Virginia Inc. (JHHPVA)	Priority Partners
US Family Health Plan			

Keywords: Hospice, Palliative, Respite care

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I. ACTION

	New Policy	
X	Revising Policy Number	CMS03.00
	Superseding Policy Number	
	Retiring Policy Number	

II. POLICY DISCLAIMER

Johns Hopkins Health Plans (JHHP) provides a full spectrum of health care products and services for Advantage MD, Employer Health Programs, Johns Hopkins Health Plan of Virginia Inc., Priority Partners, and US Family Health Plan. Each line of business possesses its own unique contract, benefits, regulations, and regulators' clinical guidelines that supersede the information outlined in this policy.

III. POLICY

For Advantage MD refer to: Medicare Coverage Database

- Refer to Plan specific Evidence of Coverage Documents Advantage MD EOCs (*Hospice covered through Original Medicare)*
- Local Coverage Determination (LCD) L34538 Hospice Determining Terminal Status

For Employer Health Programs (EHP) refer to:

- Plan specific Summary Plan Descriptions (SPDs)

For Johns Hopkins Health Plan of Virginia LLC (JHHPVA) refer to: Medicare Coverage Database (Effective 1/1/2024)

- Refer to Plan specific Evidence of Coverage Documents *(Hospice covered through Original Medicare)*
- Local Coverage Determination (LCD) L34538 Hospice Determining Terminal Status

For Priority Partners (PPMCO) refer to: Code of Maryland Regulations

- 10.67.06.23 Benefits - Hospice Care Services
- Maryland Department of Health - Hospice Levels of Care Reimbursement Fiscal Year 2023

For US Family Health Plan refer to: Tricare Policy Manuals

- TRICARE Policy Manual 6010.63-M, April 1, 2021, Chapter 1, Section 1.2 Exclusions
- TRICARE Policy Manual 6010.63-M, April 1, 2021, Chapter 9, Section 10.1 Extended Care Health Option (ECHO), Institutional Care
- TRICARE Reimbursement Manual 6010.64-M, April 1, 2021, Chapter 11, Section 1 Hospice Reimbursement-General Overview
- TRICARE Reimbursement Manual 6010.64-M, April 1, 2021, Chapter 11, Section 2 Hospice Reimbursement-Coverage/ Benefits
- TRICARE Reimbursement Manual 6010.64-M, April 1, 2021, Chapter 11, Section 3 Hospital Reimbursement-Conditions For Coverage
- TRICARE Reimbursement Manual 6010.64-M, April 1, 2021, Chapter 11, Section 4 Hospice Reimbursement-Guidelines For Payment Of Designated Levels Of Care
- TRICARE Reimbursement Manual 6010.64-M, April 1, 2021, Chapter 11, Section 5 Hospice Reimbursement-Concurrent Hospice Services and Curative Care For Pediatric Beneficiaries

IV. POLICY CRITERIA

A. General Considerations - Adults: When benefits are provided under the member's contract, JHHP considers hospice and/ or palliative care medically necessary for adult members aged 21 and older who meet the following criteria:

1. Hospice Care:
   a. Member is certified to be within the last six months of life, if the disease runs its normal course, AND;
   b. Criteria outlined in Hospice Levels of Care in section C below are met.
2. Palliative Care:
   a. Member is diagnosed with a serious illness AND ANY of the following:
      i. Two or more visits for acute care (ED, urgent care or hospitalizations) within 6 months, OR;
      ii. Difficult pain or symptom management, OR;
      iii. Uncertainty regarding prognosis, OR;
      iv. DNR order or ethical conflicts, OR;
      v. Need for complex care coordination, OR;
      vi. Prolonged hospitalization of greater than 3 weeks

b. Palliative care rendered concurrently with disease-modifying therapy for adult members aged 21 and older is considered medically necessary.

B. General Considerations - Under 21: When benefits are provided under the member's contract, JHHP considers hospice and/or palliative care rendered concurrently with disease-modifying therapy medically necessary for members whose age is from birth through age 20 who meet the following criteria:

1. Hospice Care:
   a. Member is certified to be within the last six months of life, if the disease runs its normal course, AND;
   b. Criteria outlined in Hospice Levels of Care in section C below are met.
2. Palliative Care:
   a. Members with a serious illness AND ANY of the following:
      i. Two or more visits for acute care (ED, urgent care or hospitalizations) within 6 months, OR;
      ii. Difficult pain or symptom management, OR;
      iii. Uncertainty regarding prognosis, OR;
      iv. DNR order or ethical conflicts, OR;
      v. Need for complex care coordination, OR;
      vi. Prolonged hospitalization of greater than 3 weeks.

Note: Some adults over the age of 21 are still considered part of this population because they have conditions monitored by pediatric subspecialists or have developmental and/or physical challenges that are better served by pediatricians.

C. Hospice Levels of Care: When *benefits are provided under the member's contract*, JHHP considers Hospice Levels of Care medically necessary and/or reasonable to meet the member's clinical needs when the following criteria are met:

1. Routine Care:
   a. Member has had an initial hospice evaluation that includes an individualized assessment with member goals and a multidisciplinary plan of care, AND;
   b. Primary care provider (PCP) or attending practitioner, or a specialist determines such care is reasonable and medically necessary for a terminally ill member and certifies that life expectancy is 6 months or less, AND;
   c. Member elects hospice care, AND;
   d. Services are reasonable and necessary for the management and palliation of the terminal illness and related conditions, AND;
   e. For home-based services, when available, there is a caregiver in the member's residence who is willing and capable of assisting the member, AND;
   f. Plan of care periodically reviewed by the attending physician, the hospice medical director, and the interdisciplinary care team of the hospice program, AND;
   g. Services are provided by a Medicare Certified Hospice Provider.
2. Continuous Care:
   a. Only available during brief periods of symptom crisis and only as necessary to maintain the terminally ill member in the community, AND;
   b. Hospice Medical Director determines and documents in the plan of care that a nurse is required to stay with the member for:
      i. Frequent medication adjustment to control symptoms, AND;
      ii. Reassess the uncontrolled symptoms/ symptom management/rapid deterioration/imminent death, AND;
      iii. When at least a total of eight hours of primarily skilled care, which can be intermittent, is required in a 24-hour period.
   c. Appropriate documentation of the situation and the need for continuous care services consistent with the plan of care.

3. General Inpatient Care:
   a. Documented that the physician and hospice interdisciplinary team believe the member needs pain control or symptom management that cannot possibly be provided in other settings, AND;
   b. Member requires frequent skilled nursing care interventions for pain control and symptom management.
4. Inpatient Respite Care:
   a. Documentation that the physician and hospice interdisciplinary team confirms respite care is necessary for the member's caregiver, AND;
   b. Respite care for the member's caregiver may be provided up to five (5) consecutive days at a time.
   c. Limitations include but may not be all-inclusive:
      i. Coverage for respite care may not be provided for members who are receiving hospice in or who reside in a facility.
      ii. Respite may not be covered for more than five (5) consecutive days at a time at reasonable frequency as defined by the benefit.

V. DEFINITIONS

Disease-modifying Therapy: Any treatment that is provided with a goal to modify the underlying disease and to promote a curative or life-prolonging effect.

Hospice Care: An array of services furnished to terminally ill individuals with a prognosis of six months or less if the disease runs its normal course. These services include: nursing, medical, social services, physician services, counseling services to the terminally ill individual and the family members or others caring for the individual at home, short-term inpatient care, medical appliances and supplies, home health aide and homemaker services, physical therapy, occupational therapy and speech-language pathology services. There are 4 levels of hospice care: *routine hospice care* which occurs wherever the patient resides, *continuous hospice care* for crisis symptom management which provides skilled care where the patient resides, *general inpatient care* for acute symptom management that cannot be managed in a community setting, and *inpatient respite care* to provide temporary relief to caregivers (CMS, 2020).

Palliative Care: Palliative care is specialized medical care for people (adults and children) living with a serious illness. This type of care focuses on assessment and management of pain and other symptoms, support of caregiver needs, and coordination of care. The goal is to relieve the symptoms and stress of the illness for the patient, and to improve the quality of life for both the patient and the family (CAPC, 2021a).

Respite Care: Respite care is short-term care provided to the individual enrolled in hospice only when necessary to relieve the family members or other persons who normally care for that individual at home (CMS, 2021).

VI. BACKGROUND

Palliative care is a medical specialty that was initiated as a direct result of the hospice care model. While hospice care and palliative care both provide interdisciplinary and holistic care focusing on palliative symptom management and resources to improve quality of life, there are distinctions between the two models. Palliative care is appropriate at any age and any stage of a serious illness and can be provided concurrently with life-prolonging or curative therapies. In contrast, hospice care is a care delivery system for eligible patients with a terminal illness who are not seeking curative therapies and have a prognosis of 6 months or less if the illness follows its expected course (Meier, 2020).

Pediatric palliative care addresses serious medical conditions, including genetic disorders, cancer, prematurity, neurologic disorders, heart and lung conditions and others. It relieves the symptoms of these diseases, such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite and difficulty sleeping, anxiety and depression, improving the quality of life of the child and family. Pediatric palliative care is family-centered, assisting with communication and coordination of care and

options that are in line with values, traditions and culture. The palliative care team are specially-trained physicians, nurses, social workers and others who, together with the child's other doctors, work as an extra layer of support. Palliative care is appropriate at any age and at any stage of an illness, and it can be provided along with treatment meant to cure. It is based on need, not prognosis, so it is best to start palliative care as early as possible (CAPC, 2021). Since 2000, the American Academy of Pediatrics has not only supported the dual provision of curative care in conjunction with palliative hospice services for minors, but also the provision of an integrated model of palliative care for the duration of illness from the time of diagnosis, (American Academy of Pediatrics, 2000). Notably, under Section 2302 of the Patient Protection and Affordable Care Act of 2010, the prohibition on the concurrent provision of both curative and hospice services is removed for Medicaid-eligible children. Children eligible for Medicaid and Medicaid-expansion CHIP programs are thus able to receive both curative and hospice services concurrently.

The American Society of Clinical Oncology (ASCO) has a national clinical practice guideline that recommends the integration of palliative care into standard oncology care for all patients diagnosed with cancer. The guideline update in 2016 reflects changes in evidence since the previous guideline which was in 2012. Nine randomized controlled trials (RCTs), one quasiexperimental trial, and five secondary analyses from RCTs in the 2012 provisional clinical opinion (PCO) on providing palliative care services to patients with cancer and/or their caregivers, including family caregivers, were used to inform the updated guidelines (Smith, 2012; Ferrell, 2017).

Trials that serve as the foundation for much of the research described in the update include the Temel et al. study and the ENABLE (Educate, Nurture, Advise Before Life Ends) II study, both described in 2012 PCO. Summary of the Temel et al. phase III RCT in patients with newly diagnosed Non-Small Cell Lung Cancer NSCLC compared early palliative care with standard care in an outpatient setting. Patients in the intervention arm had high (Quality of Life) QOL, less aggressive end-of-life (EOL) care, lower rates of depression, and longer survival of 2.7 months. The ENABLE II study randomly assigned patients with advanced cancer to an advanced practice nursing palliative care intervention versus usual care and found higher QOL and lower depressed mood with the intervention. (Smith, 2012; Ferrell, 2017).

The ASCO guidelines conclude all “inpatients and outpatients with advanced cancer should receive dedicated palliative care services, early in the disease course, concurrent with active treatment. Referral of patients to interdisciplinary palliative care teams is optimal, and services may complement existing programs.” (Ferrell, 2017).

The Code of Maryland Regulations (COMAR 10.07.01.31) requires acute general and special hospitals-chronic care with 50 or more beds, to establish an active hospital-wide palliative care program, comprised of a multidisciplinary care team, that provides consultation services to patients suffering from pain and symptoms due to serious illness or conditions.

Palliative Care provided by a multidisciplinary team improves the quality of life for patients and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual. It uses a team approach to support patients and caregivers, which includes assisting with everyday needs and providing bereavement counseling. It offers a support system to help patients live as actively as possible until death. (WHO, 2023).

“Open access” is a label for a hospice program that allows patients to enroll in hospice services while currently receiving medical treatments not historically supported by a hospice vendor, such as artificial nutrition or intravenous antibiotics or radiation therapy etc., to promote hospice level services sooner in the course of an illness. (Wright, 2007). Specifically, with open-access enrollment policies, hospices enroll patients who are not yet eligible for hospice under the Medicare hospice benefit. Patients receive the medical comfort and social support traditionally available through hospice while at the same time retaining access to medical treatments to slow or halt their disease progression. (Aldridge-Carlson, 2013).

VII. CODING DISCLAIMER

Note: The following CPT/HCPCS codes are included below for informational purposes and may not be all inclusive. Inclusion or exclusion of a CPT/HCPCS code(s) below does not signify or imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member's specific benefit plan document 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 of payment. Other policies and coverage determination guidelines may apply.

Note:All inpatient admissions require preauthorization.

Adherence to the provision in this policy may be monitored and addressed through post payment data analysis and/or medical review audits
Advantage MD: Regulatory guidance supersedes JHHP Medical Policies. If there are no statutes, regulations, NCDs, LCDs, or LCAs, or other CMS guidelines, apply the Medical Policy criteria.
Employer Health Programs (EHP): Specific Summary Plan Descriptions (SPDs) supersedes JHHP Medical Policy. If there are no criteria in the SPD, apply the Medical Policy criteria.
Johns Hopkins Health Plan of Virginia Inc. (JHHPVA): Regulatory guidance supersedes JHHP Medical Policies. If there are no statutes, regulations, NCDs, LCDs, or LCAs, or other CMS guidelines, apply the Medical Policy criteria.
Priority Partners (PPMCO): Regulatory guidance supersedes JHHP Medical Policy. If there are no criteria in COMAR regulations, or other State guidelines, apply the Medical Policy criteria.
US Family Health Plan (USFHP): Regulatory guidance supersedes JHHP Medical Policy. If there are no TRICARE policies, or other regulatory guidelines, apply the Medical Policy criteria.

VIII. CODING INFORMATION

CPT® CODES ARE FOR INFORMATIONAL PURPOSES	
CPT®CODES	**DESCRIPTION**
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)
99377	Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

99378	Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

HCPCS CODES ARE FOR INFORMATIONAL PURPOSES	
HCPCS CODES	**DESCRIPTION**
G0151	Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0153	Services performed by a qualified speech-language pathologies in the home health or hospice setting, each 15 minutes
G0155	Services of clinical social worker in home health or hospice settings, each 15 minutes
G0156	Services of home health/hospice aide in home health or hospice setting, each 15 minutes
G0157	Services performed by a qualified physical therapy assistant in the home health or hospice setting, each 15 minutes
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes
G0182	Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes
G0337	Hospice evaluation and counseling services, preelection
G9473	Services performed by chaplain in the hospice setting, each 15 minutes
G9474	Services performed by dietary counselor in the hospice setting, each 15 minutes
G9475	Services performed by other counselor in the hospice setting, each 15 minutes
G9476	Services performed by volunteer in the hospice setting, each 15 minutes
G9477	Services performed by care coordinator in the hospice setting, each 15 minutes

G9478	Services performed by other qualified therapist in the hospice setting, each 15 minutes
G9479	Services performed by qualified pharmacist in the hospice setting, each 15 minutes
Q5001	Hospice or home health care provided in patient's home/residence
Q5002	Hospice or home health care provided in assisted living facility
Q5003	Hospice care provided in nursing long-term care facility (LTC) or nonskilled nursing facility (NF)
Q5004	Hospice care provided in skilled nursing facility (SNF)
Q5005	Hospice care provided in inpatient hospital
Q5006	Hospice care provided in inpatient hospice facility
Q5007	Hospice care provided in long-term care facility
Q5008	Hospice care provided in inpatient psychiatric facility
Q5009	Hospice or home health care provided in place not otherwise specified (NOS)
Q5010	Hospice home care provided in a hospice facility
S0255	Hospice referral visit (advising patient and family of care options) performed by nurse, social worker, or other designated staff
S0271	Physician management of patient home care, hospice monthly case rate (per 30 days)
S9126	Hospice care, in the home, per diem
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
T2046	Hospice long-term care, room and board only; per diem

IX. REFERENCE STATEMENT

Analyses of the scientific and clinical references cited below were conducted and utilized by the Johns Hopkins Health Plans (JHHP) Medical Policy Team during the development and implementation of this medical policy. The Medical Policy Team will continue to monitor and review any newly published clinical evidence and revise the policy and adjust the references below accordingly if deemed necessary.

X. REFERENCES

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XI. APPROVALS

Historical Effective Dates: 09/02/2016, 05/03/2021, 08/01/2022, 11/01/2023