Clinical Policy: Hospice Services

Reference Number: WNC.CP.272 Coding Implications
Last Review Date: 11/24 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

The North Carolina Medicaid hospice benefit is a comprehensive set of services, identified and coordinated by a hospice interdisciplinary group (IDG). The IDG delivers medical, nursing, social, psychological, emotional and spiritual services to enable physical and emotional comfort and support using a holistic approach to maintain the best quality of life for a terminally ill member, their family and caregivers. The priority of hospice services is to meet the needs and goals of the hospice member, family and caregivers with daily activities and to help the terminally ill member with minimal disruption to normal activities, in the environment that best meets the care and comfort needs of the member and unit of care.

The hospice IDG achieves this by organizing and managing a comprehensive care plan focused on coordinating care, services and resources to the member, caregivers, and family necessary for the palliation and management of the terminal illness and related conditions.

Only Medicare-certified and North Carolina licensed hospice agencies are eligible to participate as Medicaid hospice providers through the NC Division of Health Service Regulation (www.ncdhhs.gov). Each site providing hospice services must be separately licensed. The North Carolina Medical Care Commission has rulemaking authority for hospice. The statutes that apply to hospice agencies are General Statute 131E-200 through 207 and the licensure rules are under Title 10A of the North Carolina Administrative Code (10A NCAC 13K); (G.S. 131E, Article 9, 175-190) and administrative rules (10A NCAC Subchapter 14C).

A Hospice provider must have a contract with a nursing home or hospital if services are provided within those facilities.

Policy/Criteria[1]

I. WellCare of North Carolina® **shall cover** the following Hospice Services when medically necessary and the criteria and requirements are met according to federal hospice regulations, acceptable standards of practice, and criteria below.

A. Hospice services are only covered for individuals determined to be terminally ill. The hospice provider admits a member only on the recommendation of the medical

director in consultation with, or with input from, the Member's attending physician (if any). The hospice medical director shall consider at least the following information to determine that the Member is certified terminally ill:

1. Diagnosis of the terminal condition;
2. Health conditions, related or unrelated to the terminal condition; and
3. Current clinically relevant information supporting all diagnoses.

II. Certification: The hospice provider shall obtain written certification of terminal illness for each benefit period.

A. Exceptions:

1. If the written certification cannot be obtained within two calendar days, after a period begins, then an oral certification must be obtained within two calendar days and the written certification before submitting a claim for payment.
2. Certifications may be completed no more than 15 calendar days prior to the effective date of election.
3. Re-certifications may be completed no more than 15 calendar days prior to the start of the subsequent benefit period.

B. A hospice physician or hospice nurse practitioner shall have a face-to-face encounter with:

1. The Member, that must occur prior to, but no more than 30 calendar days prior to, the 3rd benefit period recertification, and every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care (see below for specific information regarding benefit periods).

C. Content of certification:

1. The physician or nurse practitioner who performs the face-to-face encounter shall attest in writing that he or she had a face-to-face encounter with the Member, reporting the date of that visit. The attestation of the nurse practitioner or the non-certifying hospice physician shall state that the clinical findings of that visit were provided to the certifying physician for use in determining continued eligibility for hospice care. All certifications and recertifications must be signed and dated by the physician(s) and must contain the benefit period dates to which the certification or recertification applies.

D. Sources of certification:

1. For the initial 90-day period, the hospice shall obtain a written certification statement from:
   a. The medical director of the hospice or the physician member of the hospice interdisciplinary group (IDG); and
   b. The individual's attending physician if the individual has an attending physician.
2. For subsequent periods, only certification by the medical director of the hospice or the physician member of the hospice interdisciplinary group is required.

III. Hospice Benefit:

A. The hospice benefit for NC Medicaid includes the following services:

1. Nursing services;
2. Medical social services;
3. Physicians' services;
4. Counseling services (bereavement, dietary, and spiritual) services;
5. Short-term inpatient care;
6. Interdisciplinary group, care planning, and coordination of services;
7. Medical appliances and supplies, including drugs and biologicals;
8. Hospice aide and homemaker services;
9. Physical therapy, occupational therapy and speech-language pathology services;
10. Volunteer services and any other service that is specified in the Member's plan of care as reasonable and necessary for the palliation and management of the patient's terminal illness and related conditions and for which payment may otherwise be made under Medicaid.

B. In addition to the above covered services, WellCare of North Carolina shall cover ambulance transport services when provided in relation to the palliation or management of the Member's terminal illness which occur after the effective date of election.

C. If a Medicaid hospice Member becomes a resident of a skilled nursing facility (SNF), nursing facility (NF) or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), WellCare of North Carolina shall cover room and board charge if that service would otherwise be a covered service under Medicaid Managed Care. If a member who is already residing in a SNF requires hospice services, the same authorization requirements apply.

IV. WellCare of North Carolina shall **not** cover:

A. Additional respite care services over and above the per diem amount contracted for hospice services.

B. Attending and consulting physician services are not considered a hospice service and are covered as they would be for a member who is not receiving hospice services.

V. Requirements for and Limitations on Coverage:

A. First and Second Benefit Periods The first (1st) benefit period and second benefit period (2nd) are both 90 calendar days. This begins the initial admission to Hospice service based on the original election date for the Member.

1. Beginning with the first (1st) benefit period, hospice providers must obtain written certification of terminal illness for each benefit period throughout the duration of hospice care to be maintained in the provider file and submitted to WellCare with the prior authorization request.

B. Third and Subsequent Benefit Periods The third (3rd) benefit period and each subsequent benefit period are 60 calendar days. The Hospice provider(s) shall include the following documents with the authorization request:

1. Hospice Recertification of Terminal Illness;
2. Physician Plan of Treatment - Order for care and services;
3. Face-To-Face Encounter by the certifying physician;
4. Supporting clinical documentation (i.e., medical history, nurses' IDG notes, etc.), and assessment tools used to measure Member status or decline. Hospice Assessment tool including, but not limited to, Functional Assessment Scales FAST); Palliative Performance Scales; New York Heart Association Functional Classification Tool (NYHA), and other applicable clinical documentation demonstrating ongoing appropriateness for hospice care.

Note: *If the above required documentation is not received, the recertification prior approval request will be denied.*

Note: *The hospice physician, hospice nurse practitioner or physician assistant may act as the Member's attending physician per Member choice.*

Background [1]

I. "Hospice" is a coordinated program of home care with provision for inpatient care for terminally ill patients and their families. This care is provided by a medically directed interdisciplinary team, directly or through an agreement under the direction of an identifiable hospice administration. A hospice program of care provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement.

II. For the purposes of hospice benefits, terminal illness means that the member has a medical prognosis such that his or her life expectancy is 6 months or less if the illness runs its normal course.

III. Additional information regarding requirements for admission, ongoing and discharge documentation required by NC Medicaid may be found in the NC Medicaid Clinical Coverage Policy 3D, Hospice, found at https://medicaid.ncdhhs.gov/community-based-services-clinical-coverage-policies

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are

from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Additional billing guidance may be found in the NC Medicaid Clinical Coverage Policy 3D, Hospice, found at **https://medicaid.ncdhhs.gov/community-based-services-clinical-coverage-policies**

HCPCS ®* Codes	Description
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15-minute increment up to 4 hours per day.
G0300	Direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting, each 15-minute increment up to 4 hours per day.
G0155	Services of a clinical social worker (SW) in Home Health or Hospice Settings, each 15-minute increment up to 4 hours per day.

Revenue Codes	Description	Units of Service
0651	**Routine Home Care** is the basic level of care that is provided to support the Member. It may be provided in a primary private residence, a hospice residential care facility, or an adult care home. It may also be provided in a nursing facility if the facility has a contractual arrangement with the hospice provider. It is billed by the day and is the provider's basic per diem rate. This service code is limited to once per day per Member, same or different provider. Routine Home Care is not allowed on the same day as Continuous Home or Inpatient Respite Care. The provider should provide and bill the appropriate level of service.	1 day
0652	**Continuous Home Care** is provided during a medical crisis and is billed by the hour. This level of service is provided when the hospice IDG determines that continuous care, primarily nursing care, is needed. The care is given to achieve palliation or management of acute medical symptoms. It can be provided in the private residence, hospice residential care facility, long term care facility, adult care home, or nursing facility. The care needed shall be: • continuous care for at least 8 hours of the calendar day (the hours may be split); AND • nursing services by an RN or LPN for at least half of the hours of care in a day.	1 hour

Revenue Codes	Description	Units of Service
	Homemaker and hospice aide services may be used to supplement the nursing care. Continuous Home Care is limited to a maximum of 24 units a day. Continuous Home Care is not allowed on the same day as Routine Home Care, Inpatient Respite Care or General Inpatient Care. The provider shall provide and bill the appropriate level of service.	
0655	**Inpatient Respite Care** is short-term care to relieve family members or other unpaid caregivers providing care for the Member in the private residence. It is provided in a hospice inpatient facility or in a hospital or nursing facility under a contractual arrangement. Hospitals or nursing facilities shall meet the special hospice standards for staffing and Member areas. This service can be provided only on an occasional basis for up to five consecutive days at a time. If the Member remains in the facility longer than five days, the extra days are billed at the routine home care rate. The date of discharge is usually billed at the routine home care rate. The inpatient respite rate may be billed if the discharge is due to the Member's death. Inpatient Respite Care counts toward the annual limit on inpatient care. This service code is limited to once per day per Member, same or different provider. Inpatient Respite Care is not allowed on the same day as Routine Home Care, Continuous Home Care or General Inpatient Care. The provider should provide and bill the appropriate level of service.	1 day
0656	**General Inpatient Care** is payment made to the hospice for a Member in an acute care hospital, inpatient facility or skilled nursing facility. The service is billed by the day as follows: • The number of days that a Member receives general inpatient care is billed, beginning with the date of admission. • The date of discharge is billed at the appropriate rate. If discharge is delayed while a Member awaits nursing facility placement, the general inpatient rate can be billed for up to three days. Bill any subsequent days as if the Member is in a nursing facility; that is, the routine home care rate plus the appropriate long-term-care rate to cover room and board. If a Member is discharged as deceased, bill the general inpatient rate for the date of discharge. If the Member is hospitalized for a condition not related to the terminal illness, the hospital bills Medicaid for the Member's	1 day

Revenue Codes	Description	Units of Service
	inpatient care. Additionally, the hospice bills the routine home care rate during the inpatient stay. General Inpatient Care counts toward the annual limit on inpatient care. This service code is limited to once per day per Member, same or different provider. General Inpatient Care is not allowed on the same day Continuous Home Care, Inpatient Respite Care or General Inpatient Care: The provider should provide and bill the appropriate level of service.	
0235	**Incremental Nursing Charge Rate-Hospice Service Intensity Add-On** (SIA) The SIA payment is in addition to the per diem for Routine Home Care (RHC) rate when all the following criteria are met: • The day is an RHC level of care day; • The day occurs during the last 7 (seven) days of the Member's life; • The Member is discharged as expired; and • Direct patient care is furnished by a registered nurse (RN) or social worker (SW) that day The SIA payment is based on the Continuous Home Care (CHC) hourly payment rate multiplied by the amount of direct care provided by an RN or social worker during the last 7 days of life in increments of 15 minutes, up to 4 hours per day. New G-codes will be used to identify the SIA provider (RN or Social Worker) in conjunction with Revenue Code 0235. When end-of-life continuous home care is rendered by the appropriate level of medical staff (RN- G0299 or SW-G0155) with code RC0235 the claim will process for authorized provider services. ***Note:*** *If G-code is incorrect or missing, the claim will be denied with a message that indicates the staff level of care is not authorized to provide care. SIA payment will only apply to visits that occur prior to death. Visit reported with the PM modifier will not receive an SIA payment. Per CMS policy, if the social worker provided comfort and grief counseling to the Member's family, the social worker time would be reported with the PM modifier.* ***Modifier:*** *Adding Post-mortem Visits (PM) modifier. Hospice shall report visits and length of visits (rounded to the nearest 15- minute increments), that occur on the date of death, after the patient has expired for nurses, aides, social workers, and therapists who are employed by the hospice. This requirement is applicable for all levels*	15-minute increments up to 4 hours total per day

Revenue Codes	Description	Units of Service
	of care (with the exception of GIP provided in a hospice inpatient facility).	
0658	**Hospice Nursing Facility Room and Board (Intermediate Level of Care)** Refer to "Hospice Nursing Facility Room and Board," below. Revenue code 0658 is used to bill this service if the Member has been approved for nursing facility care at the intermediate level	1 day
0659	**Hospice Nursing Facility Room and Board (Skilled Level of Care)** Refer to "Hospice Nursing Facility Room and Board," below. Revenue code 0659 is used to bill this service if the Member has been approved for nursing facility care at the skilled level or the approval was granted after May 31, 2004	1 day

Discharge Codes	Description
40	Expired at Home
41	Expired at Medical Facility
42	Expired Place Unknown

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	09/22	11/22
Deleted Section III verbiage "A beneficiary with Medicaid for pregnant Women (MPW) is eligible for hospice services only if the terminal illness is pregnancy related."	11/22	11/22
NCHC verbiage removed from NC Guidance Verbiage.	03/23	03/23
Annual Review. ICD-10-PCS table removed.	11/23	11/23
Annual Review. Deleted "Medicaid and health choice" verbiage throughout policy. Changed 'beneficiary' to 'member' throughout policy. Changed 'billing units' to 'units of service.'	11/24	11/24

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 3D Hospice Services Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published March 15, 2024. Accessed September 6, 2024.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);

b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.

2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer

to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to

applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.