

Effective: June 1, 2023

Prior Authorization Required

If **REQUIRED**, submit supporting clinical documentation pertinent to service request.

Yes No

Applies to:

Commercial Products

- Harvard Pilgrim Health Care Commercial products; Fax 800-232-0816
- Tufts Health Plan Commercial products; Fax 617-972-9409
CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Public Plans Products

- Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax 888-415-9055
- Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax 888-415-9055
- Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax 857-304-6404
- Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax 857-304-6304

*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

Senior Products

- Harvard Pilgrim Health Care Stride Medicare Advantage; Fax 617-673-0965
- Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); Fax 617-673-0965
- Tufts Medicare Preferred HMO, (a Medicare Advantage product); Fax 617-673-0965
- Tufts Medicare Preferred PPO, (a Medicare Advantage product); Fax 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Hospice care involves an interdisciplinary team-oriented approach to specialized medical, psychological, and spiritual care and support provided to individuals and their families facing a life-limiting illness or injury. This specialized care focuses on caring, not curing, and on managing pain and other symptoms of illness so patients can remain as comfortable as possible near the end of life. In most cases, care is provided in the person’s home, but can also be provided in free-standing hospice centers, hospitals, nursing homes, and other long-term care facilities. The hospice team usually includes doctors, nurses, home health aides, social workers, clergy or other counselors, and trained volunteers. The team may also include speech, physical and occupational therapists, if needed. Hospice care is very individualized; the hospice team will work with the patient on his or her goals for end-of-life care.

Palliative care is a specialized form of medical care focused on helping patients feel relief from the pain, symptoms, and emotional distress caused by a serious illness or its treatment. It may also be referred to as supportive care, symptom management, or comfort care. The goal of palliative care is to improve how a patient functions each day as well as improve his or her quality of life throughout the course of a serious illness, whether that illness is curable, chronic, or life-threatening. It can offer an extra layer of support and can be provided as the main goal of care or along with treatments meant to cure. Palliative care services can be appropriate at any age or at any time during a person’s illness, and can be provided in a variety of settings, including the member’s home.

Providers are responsible for:

1. Verifying member eligibility and informing the plan of their intent to provide services before services are initiated.
2. Developing an individualized plan of care, and for providing covered services that are medically necessary for the management and palliation of the member’s terminal illness; and

3. Notifying the plan of any significant change in the member's status (e.g., change in condition or level of care, revisions to treatment plan/goals, discharge from hospice services).

Clinical Guideline Coverage Criteria

Home-Based Care

The plan uses InterQual® Home Care criteria to determine medical necessity and to authorize home care services, including hospice and palliative home care, after the initial evaluation visit.

In addition to InterQual criteria, the plan may authorize coverage of intermittent palliative care services in the home when the following are met:

1. Provided under a plan of care established by and periodically reviewed by a physician.

AND

2. Medically necessary and reasonable based on the Member's condition and accepted standards; of clinical practice

AND

3. An integral part of treatment of the Member's medical condition and associated symptoms.

In addition to InterQual criteria, the plan may authorize medically necessary routine or ongoing hospice care when the following are met:

1. The primary care physician or attending practitioner determines such care is reasonable and medically necessary for a terminally ill member and certifies that life expectancy is 6 months or less;

AND

2. The Member elects or continues to elect hospice care;

AND

3. The plan of care must be established and periodically reviewed by the attending physician, the hospice medical director, and the interdisciplinary care group of the hospice program;

AND

4. The services are reasonable and necessary for the management and palliation of the Members terminal illness and conditions.

Note: The initial skilled nursing (SN) and/or physical therapy (PT) home care assessment/evaluation visit does not require prior authorization. Speech therapy, occupational therapy and/or social worker visit will require prior authorization for the initial evaluation when provided independently and not in conjunction with physical therapy or skilled nursing visits. Providers requesting authorization after the initial evaluation visit must submit a thoroughly completed Universal Health Plan/Home Health Authorization Form (UHHA) to the appropriate fax number listed above.

Note: For palliative care services, evidence of homebound status is not required.

In addition to the UHHA, the requesting provider must also provide documentation of a discussion between the Member and his or her provider during which palliative care was discussed and agreed to by the Member. (Discussions with home care agency staff do not fulfill this requirement.) Updated documentation of ongoing discussions regarding palliative care status will be required every 6 months.

Continuous Hospice Care

Continuous home hospice care consists primarily of nursing care on a continuous basis in the home. Home health aide (HHA) services may also be provided on a continuous basis at home. In addition to InterQual content, coverage of continuous home care may be provided on a limited basis when the Member is experiencing a period of crisis and the continuous care is necessary to maintain the Member at home. A Member is considered to be in a period of crisis if he or she requires continuous care, which is predominantly nursing care, in order to manage acute medical symptoms or to achieve palliation.

A minimum of 8 hours of nursing and HHA care is required in a 24-hour period, which begins and ends at midnight (care hours do not need to be continuous). More than 50% of the continuous hours must be nursing care provided by either an R.N. or L.P.N.

Note: When fewer than 8 hours of nursing and HHA care are required, the care is covered as routine hospice care in the home.

For additional information, please consult the applicable Provider Manual for [Tufts Health Plan Commercial](#) business, [Tufts Health Public Plans](#), or [Harvard Pilgrim Health Care](#). You can also find important reimbursement information in our Payment Policies, which are located on the [Harvard Pilgrim Health Care](#) and [Tufts Health Plan](#) provider websites.

Facility-Based Care

Short-term inpatient care may be provided in a extend-care facility, or inpatient unit, general inpatient hospital, or a nursing facility.

The Plan considers facility-based hospice and palliative care as reasonable and medically necessary when documentation confirms **ALL** the following:

1. The physician and/or interdisciplinary team determine such care is reasonable and medically necessary for the management and palliation of the illness and related conditions for a Member who requires either;
 - a. Palliative care (i.e., diagnosed with a serious, complex, and often terminal illness) **OR**
 - b. Hospice care and certifies the Member has a life expectancy of 6 months or less

AND

2. The Member requires pain control or symptoms management that cannot feasibly be provided in other settings (e.g., member requires frequent skilled nursing care intervention on all three shifts directed toward pain control and symptom management)

AND

3. The plan of care must be established with individualized member goals and periodically reviewed by the attending physician and the interdisciplinary team

AND

4. The care provided is consistent with the plan of care.

Note: For Respite Care – if it conforms to the written plan of care, may also be furnished to provide respite for the Member’s family or other persons caring for the individual in their home up to 5 consecutive days.

Limitations:

The plan considers hospice services as not medically necessary when criteria above are not met.

- Coverage for services and subsequent payment are based on the Member's benefit plan document. Refer to the Electronic Services section of our website for our self-service channel options. Benefit specifics should be verified prior to initiating services by logging on to our website or by contacting Provider Services.
- Respite care may be covered for no more than five consecutive days at a time.
- Coverage for respite care may not be provided for Members who are receiving hospice care in or who reside in a facility
- General inpatient care days are not covered in situations where the sole reason for the inpatient stay is that the Member’s caregiver support has broken down, without the guidelines for general inpatient care outlined above being met
- Residential or respite care must be for members who are terminally ill are receiving authorized hospice care from a certified hospice provider

Codes

The following code(s) require prior authorization:

Table 1: Revenue Codes

Revenue Code	Description
0652	Continuous Home Care
0655	Inpatient respite care
0656	General inpatient care
0658	Other Hospice I (Room & Board)

References:

1. National Hospice and Palliative Care Organization, caringinfo.org. Accessed November 19, 2022.

2. United States Department of Health and Human Services, National Cancer Institute at the National Institutes of Health. [cancer.gov/about-cancer/advanced-cancer/care-choices#HC](https://www.cancer.gov/about-cancer/advanced-cancer/care-choices#HC). Accessed November 28, 2022.
3. Centers for Medicare and Medicaid Services, Internet-Only Manuals, Publication 100-02, Medicare Benefit Policy Manual, Chapter 9, [cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf). Accessed November 28, 2022.
4. Hospice: Philosophy of care and appropriate utilization in the United States. UpToDate.com/subscriber [via subscription only]. Last accessed: March 29, 2021.
5. Kumar P, Wright A, Hatfield L, Temel J, Keating N. Family Perspectives on Hospice Care Experiences of Patients with Cancer. *Journal of Clinical Oncology*. 2017;35(4):432-439. doi:10.1200/jco.2016.68.9257.
6. National Hospice and Palliative Care Organization, <http://www.caringinfo.org>. Last accessed: November 28, 2022.
7. What is hospice care? Cancerorg. 2017. Available at: <https://www.cancer.org/treatment/finding-and-paying-for-treatment/choosing-your-treatment-team/hospice-care/what-is-hospice-care.html>. Last accessed: November 28, 2022.

Approval And Revision History

November 16, 2022: Reviewed by the Medical Policy Approval Committee (MPAC) for integration between Harvard Pilgrim Health Care and Tufts Health Plan for effective date June 1, 2023

Background, Product and Disclaimer Information

Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. For Tufts Health Together (Medicaid), coverage may be available beyond these guidelines for pediatric members under age 21 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits of the plan in accordance with 130 CMR 450.140 and 130 CMR 447.000, and with prior authorization.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.