Hospice care services

Effective February 1, 2015, hospice services will be a covered benefit covered by Healthy Blue.

Healthy Blue recognizes the importance of the provision of quality health care to all members with or without terminal illnesses. Hospice care is identified as an excellent resource in providing not only quality health care but also support systems for the member and family.

Healthy Blue will work closely with hospice in arranging for the provision of health care services for terminally ill members (with a prognosis of six months or less to live) who choose to enroll in hospice care. This notice will serve to guide providers on the administration of the Healthy Blue hospice program including but not limited to determining appropriateness for hospice care, correct level of care assignment, reimbursement and prior authorization (PA) requirements.

Covered services

Hospice care is an interdisciplinary approach to the delivery of care with attention to the physical, sociological, spiritual, educational and emotional needs of the terminally ill patient and family. This treatment approach is based on the recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and support for the family. Its focus is on maintaining the terminally ill patient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible.

Hospice services include physician services; skilled nursing; medical social services; nutritional and bereavement counseling; pastoral care; hospice aide and homemaker services; and physical, occupational and speech therapy. Medical appliances and supplies, including drugs and biologicals as defined in Section 1861 (t) of the Social Security Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness, are covered. When appropriate, short-term inpatient care or inpatient respite care are covered.

Members under age 21 may continue to receive curative treatments for their terminal illness. However, the hospice provider is responsible for coordinating all curative treatments related to the terminal illness and related conditions. Curative is medical treatment and therapy provided with the intent to improve symptoms and cure. It 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. All treatments and therapies must be included in the plan of care.

Qualifications for hospice services

An election statement for hospice care must be filed by the member or by a person authorized by law to consent to medical treatment for the member. Verbal elections are prohibited. A member who elects hospice services must select a hospice provider who meets the Medicare and Medicaid conditions for participation for hospices and has a valid provider agreement with Healthy Blue. A member may change hospice providers once per election period.

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The hospice service benefits determined necessary for the palliation and management of the member's terminal illness and related conditions will be covered by Healthy Blue as long as the service is a Healthy Blue-covered service.

The hospice will be required to submit a written certification of illness as part of the PAn process. The written certification of illness is a physician narrative that must specify that the member's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. The narrative must be based on the physician's clinical judgment, include a brief explanation of the clinical findings that support the physician's decision and must be signed by the physician. This certification and narrative must be completed for each election period even if a single election continues in effect for two or more periods. The certification may be completed up to two weeks prior to the beginning of each election period. The hospice is responsible for establishing a written plan of care (POC) before services can be provided. The date of the POC should be the date it is established. List the care that is to be provided to a member that is reasonable and necessary for the palliation or management of the terminal illness as well as all related conditions, include all comorbidities even if they are not related to the terminal illness, and encompass plans on access to emergency care.

PA process

PA is required upon the initial request for hospice coverage. Providers may utilize the Healthy Blue PA form located on the provider website. The PA request must be submitted within 10 calendar days of the hospice election date. If the PA is approved, it will cover a date of service span of 90 days. If another 90-day election is required, the PA request must be submitted at least 10 days prior to the end of the current election period to ensure that requests are received and approved/denied before the preceding period ends. If this requirement is not met and the period ended, reimbursement will not be available for the days prior to the receipt and will be effective the date the Healthy Blue outpatient Utilization Management (UM) department receives the proper documentation if approved. It is the responsibility of the provider to verify eligibility on a monthly basis. Prior authorization only approves the existence of medical necessity, not member eligibility.

Required documentation

PA requests should be submitted by the provider within one business day to Healthy Blue by:

- Fax: **1-844-864-7868**
- Phone: **1-844-521-6942** (available 24/7)
- Online: **https://providers.healthybluela.com**

Documentation that is provided to support the request should paint a picture of the recipient's condition by illustrating the recipient's decline in detail (for example, documentation should show last month's status compared to this month's status) and should not merely summarize the recipient's condition for a month. Documentation should also show daily and weekly notes on why the recipient is considered to be terminal and not chronic. The documentation must explain why the recipient's diagnosis has created a terminal prognosis and show how the systems of the body are in a terminal condition.

The following provides a list of required documentation for each type of hospice request:

First benefit period (90 days):

- A completed Healthy Blue PA form
- Clinical/medical information
- Hospice provider plan of care:
    - Progress notes (hospital, home health, physician's office, etc.)
    - Physician orders for plan of care
- Documentation to support patient's hospice appropriateness:
    - Paint a picture of patient's condition.
    - Illustrate why patient is considered terminal and not chronic.
    - Explain why his/her diagnosis has created a terminal prognosis.
    - Show how the body systems are in a terminal condition.

Second (90 days) and subsequent (60 days) periods:

- Providers requesting PA for the second period and each subsequent period must send the following packet to the Healthy Blue outpatient UM department.
    - A completed Healthy Blue form
    - An updated plan of care
    - An updated physician's orders
    - Documentation to support patient's continued hospice appropriateness:
    - List of current medications (within the last 60 days)
    - Current laboratory/test results (within the last 60 days if available)
    - Description of hospice diagnosis
    - Description of changes in diagnoses
    - Progress notes for all services rendered (daily/weekly physician, nursing, social worker, aide, volunteer and chaplain)
    - The recipient's current weight, vital sign ranges, lab tests and any other documentation supporting the continuation of hospice services

The Healthy Blue outpatient UM department will review all prior authorization requests, and medical necessity decisions will be made within contractual time frames. Once a decision has been made, the provider will be notified of the outcome to approve or deny the request within one business day of the decision via fax notification. If the provider disagrees with our decision, the provider may request a peer-to-peer reconsideration or may file an appeal. Additional information on reconsideration requests and appeals can be located in the provider handbook or website.

Hospice levels of care

With the exception of payment for physician services, Healthy Blue reimbursement for hospice care is made at one of four predetermined per diem rates for each day in which a member is

under the care of the hospice regardless of the amount of services furnished on any given day. Payment rates are determined for the following five categories of hospice care:

Type of care	Revenue code	Units of service	Description
Routine home care	651	24 hours (1 day)	The routine home care rate is paid for each day the recipient is under the care of the hospice and not receiving one of the other categories of care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day. It is also paid when the recipient is receiving hospital care for a condition **unrelated** to the terminal condition
Continuous home care	652	1 hour	A minimum of eight hours of care must be provided during a 24-hour day, which begins and ends at midnight. This care need not be continuous; in other words, four hours could be provided in the morning and another four hours provided in the evening of that day. Homemaker and aide services may also be provided to supplement the nursing care. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate.
Inpatient respite care	655	1 day	The payment for respite care may be made for a maximum of five consecutive days in an election period at a time including the date of admission but not counting the date of discharge alive. Payment for the sixth and any subsequent days is to be made at the routine home care rate.
General inpatient care	656	1 day	For the date of admission to the contracted inpatient facility, the general inpatient rate is to be paid. For the day of discharge from the contracted inpatient unit, the appropriate routine home care rate is to be paid unless the recipient dies as an inpatient. Upon death, the general inpatient rate is to be paid for the discharge date for the recipient admitted to the contracted facility.

			The provider should **bill revenue code 656 for recipients admitted to a contracted facility. The hospice may not bill the general inpatient rate for days the recipient is in a noncontracted facility or in a facility for a reason unrelated to the terminal condition or an inpatient facility where the facility is considered the recipient's temporary or permanent residence/home. The hospice bills routine home care rate for these days.**
Physician services	657	1 day	This is for use when physician professional services are being provided to hospice recipients and the hospice is responsible for reimbursing the physician. The physician can be an employee of the hospice, a volunteer or a consultant.

Hospice care revocation
A member or his/her legal representative may revoke the election of hospice care at any time during an election period. At no time is the hospice provider to demand a revocation, and the member or legal representative must not be asked to sign a blank revocation statement. When a member revokes or is discharged alive during an election period, the member or legal representative must sign and date a statement acknowledging that he or she is aware of the revocation, state why the revocation is chosen and contain their contact information. The written statement must be in the handwriting of the member or legal representative, and it must be dated. It cannot designate an effective date earlier than the date the revocation is made. The revocation statement must be faxed to Healthy Blue at **1-844-864-7868** within three calendar days of the date of the revocation.

Hospice provider transfer
A *Notice of Transfer* is sent when the recipient is in the middle of an election period and wants to change hospice providers. A recipient may change hospices providers once each election period. The date of discharge from the current hospice provider must be only one day before the date of admission to the newly designated hospice provider.

Hospice care discharge
A member may only be discharged from hospice care in the following circumstances: a signed revocation; a change in terminal status; member relocation to an area the hospice does not cover; member enters a noncontracted nursing home or hospital and has Medicaid only; or the hospice provider determines that the member's (or other person[s] in the member's home) behavior is

disruptive, abusive or uncooperative to the extent that delivery of care to the member or the ability of the hospice staff to operate effectively is seriously impaired.

The hospice must obtain a discharge order from the hospice medical director and fax the discharge notification and orders to Healthy Blue within two calendar days of discharge.

Upon the death of a member, the hospice provider must fax the discharge notification to Healthy Blue within two calendar days.

What if I need assistance?

If you have questions about this communication or need assistance with any other item, contact your local Provider Relations representative or call Provider Services at **1-844-521-6942**.