



## Clinical Policy Title: Hospice and palliative care

Clinical Policy Number: CCP.1133

**Effective Date:** January 1, 2015  
**Initial Review Date:** August 20, 2014  
**Most Recent Review Date:** September 10, 2019  
**Next Review Date:** December 2020

Policy contains:

- Hospice
- Palliative care
- Survival prediction
- Terminal disease.

**ABOUT THIS POLICY:** AmeriHealth Caritas has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas' clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered by AmeriHealth Caritas when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas' clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas' clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas will update its clinical policies as necessary. AmeriHealth Caritas' clinical policies are not guarantees of payment.

### Coverage policy

Hospice and palliative care is clinically proven and, therefore, medically necessary when the following criteria are met:

- Physician certification for hospice care that life expectancy is six months or less if the terminal illness runs its clinically anticipated course. The certification must document the decline in clinical status, which should be irreversible and characterized by predictors listed in page three of this policy.
- Physician certification for palliative services is for relief of suffering for unlimited time periods.
- When palliative care services are provided concurrent with hospice services, palliation is considered integral to hospice care benefits.
- Hospice care must be delivered by multidisciplinary teams, nurses, and/or community workers in dedicated hospice sites, hospitals, nursing homes, or a patient's home ( National Consensus Project for Quality Palliative Care, 2009; National Hospice and Palliative Care Organization, 2017).

### **Limitations:**

- Survival prediction in terminal patients is not infallible nor all predictors completely defined;

some patients may not meet all Centers for Medicare & Medicaid Services guidelines, but still have a life expectancy of six months or less.

- Patients may stabilize or improve in hospice and be considered for discharge.
- Re-enrollment may be considered in a new benefit period if the same patient again declines to a life expectancy of six months or less with the same documentation requirements.

**Alternative covered services:**

None.

**Background**

In the U.S., about 15 percent of adults live with a chronic health condition, many of which limit their activities later in life (Lorenz, 2004). This fact, plus the growing number of elderly in the population, makes it feasible to plan for death in the foreseeable future. Cancer generally is cited as the paradigm, but is not the only example of illness with a recognizable and predictable terminal phase. Chronic diseases such as heart or liver failure, chronic obstructive pulmonary disease, and some forms of dementia also have such terminal phases, making end-of-life care an important part of many medical specialties and one in which relief of illness-related suffering rather than prolonging of life is the guiding principle.

The National Hospice and Palliative Care Organization has issued a definition of hospice. Central to the definition are the existence of documentation that the patient has a terminal illness; hospice and palliative care are based on the patient's right to die pain-free and with dignity; care is delivered by a multidisciplinary team; and a family member will be the primary caregiver (National Hospice and Palliative Care Organization, 2019a).

In 2016, 1.43 million U.S. Medicare beneficiaries received hospice care. Nearly half (48 percent, or 1.04 million) of Medicare decedents were enrolled in hospice at time of death. The median days of care was 24. Most (64 percent) of Medicare recipients of hospice are over 80 years of age. Cancer (27.2 percent) and cardiac/circulatory disease (18.7 percent) were the most common primary diagnoses of Medicare hospice patients (National Hospice and Palliative Care Organization, 2019b).

Assessment of terminal status is complex, with no single standardized instrument available and relevant to all diagnoses. Assessment should cover all four domains affected by illness: physical, psychological, social, and spiritual. Specific questions will generally follow the traditional history and physical, with an emphasis on symptoms aimed at discerning sources of suffering.

The following lists predictors for each of the indications often associated with appropriate referral to hospice service, namely, clinical status, symptoms, signs, and labs:

**Clinical indicators typically associated with appropriate referral to hospice care**

<b>Indication</b>	<b>Specific predictors of decline/terminal status with documentation requirements</b>
Clinical status	<p>Recurrent or intractable infection, e.g., pneumonia, sepsis, or upper urinary tract infection</p> <p>Progressive inanition (cachexia of chronic disease), documented by:</p> <ul style="list-style-type: none"> <li>• Weight loss that is not caused by reversible causes such as depression or diuretic use.</li> <li>• Decreasing serum albumin or cholesterol.</li> <li>• Decreasing anthropomorphic measurements (mid-arm circumference or abdominal girth).</li> <li>• Dysphagia with recurrent aspiration and/or inadequate oral intake evidenced by decreasing food portion consumption.</li> </ul>
Symptoms	<p>Dyspnea with increasing respiration rate.</p> <p>Intractable cough.</p> <p>Nausea and/or vomiting unresponsive to treatment.</p> <p>Intractable diarrhea.</p> <p>Pain requiring consistently increased doses of major analgesics.</p>
Signs	<p>Decline in systolic blood pressure to below 90 or progressive postural hypotension.</p> <p>Ascites.</p> <p>Venous, arterial, or lymphatic obstruction due to local progression or metastatic disease (cancer).</p> <p>Pleural or pericardial effusion.</p> <p>Weakness.</p> <p>Change in level of consciousness.</p>
Laboratory (where available; testing not required for eligibility)	Increasing PCO <sub>2</sub> or decreasing PO <sub>2</sub> /SaO <sub>2</sub> .
Other tests, such as lactate clearance, are under investigation (Zhang, 2014).	

Since 2008, the American Board of Medical Specialties has offered certification in hospice or palliative medicine. Central to this approach is a multidisciplinary team encompassing pain and symptom management, along with spiritual and psychological care for the patient and support for the family during bereavement and terminal illness. Care settings can be flexible, but all four quality domains are consistent and addressed in comprehensive assessment and needs screens, as well as in care planning (American Board of Family Medicine, 2019). Various types of education and training for physicians providing palliative care are available, but consensus on what types are most effective remains elusive (Downar, 2018).

### **Searches**

We searched PubMed and the databases of:

- UK National Health Services Centre for Reviews and Dissemination.

- Agency for Healthcare Research and Quality.
- Centers for Medicare & Medicaid Services.
- The Cochrane library.

We conducted searches on July 2, 2019. Search terms were: “hospice,” and “palliative care.”

We included:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
- **Guidelines based on systematic reviews.**
- **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

## **Findings**

In 2009, the National Consensus Project for Quality Palliative Care developed guidelines for quality care. The guidelines are extensive, but they include the basic components of hospice and palliative care, e.g., that a terminal illness with life expectancy less than six months is documented, and that care is delivered by multidisciplinary teams, with family integrated into care (National Consensus Project for Quality Palliative Care, 2013). A systematic review of 139 studies was issued by the Project to support practice guidelines. Areas of study include interdisciplinary team care, care coordination, physical aspects, psychological aspects, social aspects, spiritual/religious/existential aspects, cultural aspects, care of the patient nearing the end of life, and ethical/legal aspects (Ahluwalia, 2018).

In 2015, the Centers for Medicare & Medicaid Services issued a Local Coverage Determination that listed indications for covering hospice care, including decline in clinical status guidelines, non-disease specific baseline guidelines, and co-morbidities. Each included specific criteria for inclusion. The policy also listed limitations for inclusion in hospice care (Centers for Medicare & Medicaid Services L34538, 2015).

Since the usual survival outcomes used in critical analysis of interventions are less relevant in a palliative care setting, many reviews focus on interventions for physical symptom management in diagnosis-specific groups of patients. Reviewers taking a broader approach use patient or family satisfaction, also by definition problematic for end-of-life care, as core among quality indicators. The literature is extensive and diffuse, with little agreement on such fundamentals as outcome measures, a single universally applicable and validated prediction model for six-month survival, or even consistent definition of terminal status.

A systematic review of 36 studies concluded that hospice agencies employ discrete strategies to improve performance. For example, innovation and volunteer usage were linked with better outcomes. Hospice organizational factors, market environment, and patient characteristics were related to hospice strategic conduct and performance. Performance studies tend to examine the relationship between hospice structure and strategic conduct/process, rather than strategy performance (He, 2019).

A systematic review of 34 studies assessed what families and caregivers valued most in hospice care. Notable variations of what people valued and why were prominent, specifically in relation to a lack of social support for caregivers disparate access to essential services, the underrepresentation of patients with a non-cancer diagnosis, and the dissatisfaction with the range of services provided (Hughes, 2019).

A systematic review of palliative care in Scotland over a 10-year period included 308 studies, with the number of articles growing over time (similar to a cited article from Ireland). Most commonly addressed research topics were services and settings, experiences/needs, and physical symptoms. One-fifth of papers addressed topics other than cancer. Authors concluded the large amount of existing research means intervention studies need to be prioritized (Finucane, 2018).

A meta-analysis included 23 studies, 16 of which were randomized, of persons on hospice ( $n = 37,561$  patients and 4,042 family caregivers), most with advanced cancer. Hospice significantly increased the odds of these patients dying at home ( $P = .003$ ). Small but statistically significant beneficial effects of home palliative care services compared to usual care on reducing symptom burden for patients were observed. Evidence on cost-effectiveness is inconclusive (Gomes, 2013).

One systematic review of seven trials compared 1158 terminally ill patients, some of whom received palliative care and others receiving treatment targeted at underlying disease. Those with palliative care had a longer overall survival than those undergoing treatment that approached significance; in addition, a significantly greater rate of adverse events occurred in those undergoing treatment (Reljic, 2017).

A systematic review of 13 studies found that terminally ill patients were more likely to be discharged or die with more end-of-life care if they received more care from primary care practitioners than those who had less primary care (Kim, 2016). A systematic review of 40 studies of pediatric end-of-life care identified higher use with older age, cancer diagnosis, family support, inter-organizational care coordination, geography, concurrent care, hospice eligibility, and funding/payment (Boyden, 2018).

The most commonly-cited burden cited by family caregivers in end-of-life care is pain management. A systematic review of 14 studies documented that the greatest concerns include inadequate knowledge and assessment skills in pain management, misunderstanding of pain medications, and poor communication with the care team (Chi, 2017).

Another systematic review and meta-analysis of 10 studies ( $n = 2454$ ) of adults with an incurable illness, 72 percent of whom had cancer, found a small positive effect from specialist care through screening and resulting early provision of unmet patient needs (Gaertner, 2017).

A review of 369 terminally ill patients showed a home-based palliative care program reduced utilization over 18 months, including total hospitalizations/days, total/variable costs, and 30-day readmissions, but not emergency department visits (Lukas, 2013). A review of 37 articles on palliative care treatment in intensive care showed most efforts reduced hospital and Intensive Care Unit length of stay without affecting patient satisfaction (Asiakson, 2014). A Cochrane review of three trials (n = 735) showed palliative care interventions in nursing home patients reduced hospital admissions/days and raised the number of “do not resuscitate” orders (Hall, 2011).

Much improvement is needed in outcome measures for care of the terminally ill. A systematic review of 31 articles of patient reported outcome measures guide practitioners on which ones to focus on and when best to measure (Antunes, 2014). Models of care also vary, with the most consistently reported one being case management, according to a study of 23 systematic reviews and nine randomized controlled trials (Luckett, 2013). Advanced care planning has also been shown to decrease life-sustaining treatment and improve compliance with patient wishes (Brinkman-Stoppelenburg, 2014).

A Cochrane review of integrated end-of-life care pathways included 16 general medicine hospital wards and 232 providers of care to cancer patients. Only 34 percent of patients were cared for in accordance of the planned care pathway, leaving great opportunity for improvement (Chan, 2016).

Some reviews address palliative care other than direct provision of medical care. One review of 20 studies documented that a quality improvement approach improves communications, and thus outcomes and appropriate utilization, in the care of terminally-ill patients (Fawole, 2012). Another review of 13 measures found that psychological, social, and spiritual distress are often overlooked in quality measures for palliative care (Kamal, 2014). Another review of nine studies concluded the most frequently unmet need was effective communications between health professionals and patients (Ventura, 2014).

A systematic review of six trials indicated that better-focused efforts to identify patients who are candidates for palliative care increased referral rates for hospice (Kirolos, 2014).

A systematic review of 20 studies revealed that end-of-life discussions are associated with lower health-care costs in the last 30 days of life (median \$1048 versus U\$23,482;  $P < .001$ ); lower likelihood of acute care at the end of life; lower likelihood of intensive care at the end of life; lower odds of emergency department use and shorter length of hospital stay; greater use of hospice; and greater likelihood of death outside the hospital (Starr, 2019).

#### **Policy updates:**

The policy number was changed from CP#18.02.04 to CCP.1133 in July 2019.

A total of one guideline/other and three peer-reviewed references were added to, and four

guidelines/other and four peer-reviewed references were removed from this policy in July 2019.

## **References**

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### **Peer-reviewed references:**

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### **Centers for Medicare & Medicaid Services National Coverage Determinations:**

There is no National Coverage Determination because of the hospice policy in the Medicare Benefit Policy Manual. This chapter was last updated May 8, 2015, Revision 209. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf>. Accessed July 2, 2019.

### **Local Coverage Determinations:**

L34538 Hospice: Determining Terminal Status.

A52830 Hospice: Determining Terminal Status - Supplemental Instructions Article.

**Commonly submitted codes**

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

CPT Code	Description	Comment
99339	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) 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 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	
99340	Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) 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 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	
99374	Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision	
99375	Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision	
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 relate	
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 relate	
99379	Supervision of a nursing facility 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	

CPT Code	Description	Comment
	patient status, review	
99380	Supervision of a nursing facility 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	

ICD-10 Code	Description	Comment
Z51.5	Palliative care	

HCPCS Level II Code	Description	Comment
G0337	Hospice evaluation and counseling services, preelection	
G9054	Oncology; primary focus of visit; supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end-of-life care planning, management of palliative therapies (for use in a medicare-approved demonstration project)	
G9473-G9479	Hospice services	
G9758	Patient in hospice at any time during the measurement period	
G9857	Patient admitted to hospice	
G9858	Patient enrolled in hospice	
M1017	Patient admitted to palliative care services	
M1059	Patient was in hospice or receiving palliative care at any time during the performance period	
Q5001-Q5010	Hospice/Home Care Temporary Q Code	
T2042-T2046	Hospice Services State Medicaid Agencies	
S9126	Hospice care, in the home, per diem	Not covered by Medicare

## Appendix

No additional information was identified for this section during the writing of this policy.