



## Clinical Policy Title: Hospice and palliative care

Clinical Policy Number: 18.02.04

**Effective Date:** January 1, 2015  
**Initial Review Date:** August 20, 2014  
**Most Recent Review Date:** July 3, 2018  
**Next Review Date:** July 2019

Policy contains:

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

### Related policies:

None.

**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

AmeriHealth Caritas considers the use of hospice and palliative care to be 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 six 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 (NCPQPC, 2009; NHPCO, 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 (CMS) 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 developed countries, an estimated 70 percent of deaths are preceded by a disease or condition that 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 (NHPCO, 2017).

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 (NHPCO, 2018).

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

Indication	Specific predictors of decline/terminal status with documentation requirements
Clinical status	Recurrent or intractable infection, e.g., pneumonia, sepsis, or upper urinary tract infection Progressive inanition (cachexia of chronic disease), documented by: <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	Dyspnea with increasing respiration rate. Intractable cough. Nausea and/or vomiting unresponsive to treatment. Intractable diarrhea. Pain requiring consistently increased doses of major analgesics.
Signs	Decline in systolic blood pressure to below 90 or progressive postural hypotension. Ascites. Venous, arterial, or lymphatic obstruction due to local progression or metastatic disease (cancer). Pleural or pericardial effusion. Weakness. Change in level of consciousness.
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 (ABFM, 2017). 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).

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 (NCPQPC, 2009).

## Searches

AmeriHealth Caritas searched PubMed and the databases of:

- UK National Health Services Centre for Reviews and Dissemination.
- Agency for Healthcare Research and Quality's National Guideline Clearinghouse and other evidence-based practice centers.
- CMS.

We conducted searches on May 11, 2018. 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

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 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).

Reviewers such as Dy (2012) and Leclerc (2014) sifted through tens of thousands of citations to arrive at a relatively small number of low-quality and/or heterogeneous studies from which only limited conclusions (beyond the need for additional and higher-quality research) can be drawn.

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 ICU 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). Potential overuse of unneeded medications in the frail elderly is not well studied (Tjia, 2013).

Much improvement is needed in outcome measures for care of the terminally ill. A review of 200 articles and 165 outcome measures addressed in these articles determined that most are not well reviewed (Mularski, 2007). A more recent study 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 (Lockett, 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).

**Policy updates:**

A total of two guidelines/other and three peer-reviewed references were added to, and four peer-reviewed references were removed from this policy in May 2018.

**Summary of clinical evidence:**

Citation	Content, Methods, Recommendations
Lockett (2014)  Elements of effective models	<b>Key points:</b> <ul style="list-style-type: none"> <li>• Palliative home nursing increased the rate of death at home without compromising symptom relief, quality of life (QOL), or costs.</li> </ul>
Gomes (2013)  Home palliative care services	<b>Key points:</b> <ul style="list-style-type: none"> <li>• RCTs and CCTs, –2012.</li> <li>• Twenty-three studies (six high-quality RCTs): 37,561 subjects, mostly with advanced cancer but also heart failure, COPD, HIV/AIDS, and multiple sclerosis.</li> <li>• Clear and reliable evidence that home services increase the chance of dying at home and reduce symptom burden for cancer patients without impacts on caregiver grief.</li> <li>• More research is needed for other conditions.</li> </ul>
Dy (Agency for Healthcare Research and Quality 2012)  Improving quality of palliative care delivery	<b>Key points:</b> <ul style="list-style-type: none"> <li>• Addresses effectiveness of processes and outcomes within quality improvement models for pain communication and decision-making for continuity, coordination, and transitions of care; and for patient and family distress.</li> <li>• Studies (excluding retrospective or uncontrolled) enrolling patients with advanced diseases, such as cancer or intensive care unit (ICU) patients at high risk of dying (unlikely to be cured, recover, or stabilize); 2000 – 2011.</li> <li>• Twenty-three studies (one RCT) focused on continuity, coordination, and/or transitions of care: evidence low for improvements to patient QOL, symptoms, or health care utilization; moderate for improvements in patient and family satisfaction.</li> <li>• Nursing homes: care pathways had inconsistent results.</li> <li>• Quality improvement: patient-centered interventions (patient, family, and caregiver</li> </ul>

Citation	Content, Methods, Recommendations
	<p>education and promotion of self-management) improved satisfaction and QOL or health care utilization in some studies.</p> <p>Evidence is strongest for pain interventions and targets of communication, decision-making, and continuity for some outcomes. Only a few well-designed and –conducted studies are available for improving patient outcomes in palliative care.</p> <ul style="list-style-type: none"> <li>• Available research is too heterogeneous and results inconsistent for firm conclusions.</li> </ul>
<p>Shepperd (2012)</p> <p>Home-based end-of-life care</p>	<p><b>Key points:</b></p> <ul style="list-style-type: none"> <li>• RCTs, interrupted time-series, controlled before-and-after,</li> <li>• Outcomes considered: rates of dying in hospital and effects on symptoms, quality of life, health service costs, and caregivers versus hospital or hospice inpatient.</li> <li>• Four trials; patient mean age 63 – 74; blinding not possible in all trials, increasing risk of bias.</li> <li>• Three studies assessing effects on place of death: home care increased likelihood of death at home.</li> <li>• Patient outcomes: no significant effects on functional status, psychological well-being, or cognitive status.</li> <li>• Patient satisfaction at one month follow-up better, but no difference at six months; may have been attributable to interval deaths and reduced sample size.</li> <li>• No Significant differences in admission to hospital or hospital length of stay.</li> <li>• Use of other health services inconsistently reported.</li> <li>• Caregivers of home patients more stratified at one month but no difference at six months.</li> </ul>

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**CMS National Coverage Determinations (NCDs):**

There is no NCD 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 May 10, 2018.

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**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
N/A		

ICD-10 Code	Description	Comment
Z51.5	Palliative care	

<b>HCPCS Level II Code</b>	<b>Description</b>	<b>Comment</b>
<b>Q5001</b>	Hospice or home health care provided in patient's home/residence	
<b>Q5002</b>	Hospice care provided in assisted living	
<b>Q5003</b>	Hospice care provided in nursing long-term care facility(LTC) or nonskilled nursing facility (NF)	
<b>Q5004</b>	Hospice care provided in skilled nursing facility (SNF)	
<b>Q5005</b>	Hospice care provided in inpatient hospital	
<b>Q5006</b>	Hospice care provided in inpatient hospice facility	
<b>Q5007</b>	Hospice care provided in long term care facility	
<b>Q5008</b>	Hospice care provided in inpatient psychiatric facility	
<b>Q5009</b>	Hospice or home health care provided in a place not otherwise specified	
<b>Q5010</b>	Hospice home care provided in a hospice facility	
<b>S9126</b>	Hospice care, in the home, per diem	Not covered by Medicare