

# **MEDICAL ASSOCIATES HEALTH PLANS AND HEALTH CHOICES HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL**

**POLICY TITLE:** HOSPICE CARE GUIDELINES

**POLICY PURPOSE:** Provide continuity and coordination of care when a member elects hospice for a terminal condition.

## **PROCEDURE:**

### **Commercial Hospice Benefits**

Coverage for Hospice Services will be paid according to the limitations of the member's contract and subject to any applicable co-pays and deductibles. Review individual subscriber agreement for the plan coverage and reimbursement.

### **Health Choices Benefits**

Review individual subscriber agreement for the plan coverage/reimbursement and authorization requirement. If an authorization is required, it is spanned for 1-3 months depending on prognosis.

**Medicare Hospice Benefits:** Please refer to the Medicare Benefit Policy Manual, Chapter 9 – Coverage of Hospice Services under Hospital Insurance.

Hospice services are to provide comfort and support to a member and family during a terminal illness. Facts about hospice:

- Hospice provides comfort and support services to people who are terminally ill.
- Hospice care is provided by a specially trained team that cares for the “Whole person,” including his or her physical, emotional, social and spiritual needs.
- Hospice provides support to family members caring for a terminally ill person.
- Hospice is generally given in the home.
- Hospice services may include drugs, physical care, counseling, equipment, and supplies for the terminal and related conditions.
- Hospice isn't only for cancer patients.
- Hospice doesn't shorten or prolong life.
- Hospice focuses on comfort, not on curing an illness.

Hospice care is given in periods of care. Members can receive care for two 90-day periods followed by an unlimited number of 60-day periods. At the start of each period, the hospice medical director or other hospice physician must recertify that the member is terminally ill.

Hospice services are paid for a terminally ill person while in a Hospice care program when:

- a. A participating physician has certified that the member is terminally ill.
- b. The participating physician has recommended and the MAHP Medical Director has approved the Hospice care program.
- c. The terminally ill person is a member.
- d. The services are charged for by the Hospice care program.
- e. The services are provided within six months of the terminally ill Member's entry or re-entry (after a remission period) in the Hospice care program.

When an authorization is required, authorizations are spanned for a period of 6 months.

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There are four levels of hospice care:

1. Home hospice care: Routine intermittent skilled services are covered in the member's home for the member and his/her family.
2. Hospice care in a nursing home or residential facility, including hospice facilities: Routine intermittent skilled hospice services are covered. Room and board is not a covered benefit.
3. Inpatient care: Short-term inpatient care is covered when necessary for managing symptoms or to perform procedures for pain control that cannot be performed or provided in other settings.
4. Respite care: Inpatient respite care is short-term care (i.e., five days or less per benefit period) that may be provided when necessary to relieve the family member(s) or other caregivers that are caring for the member at home. See individual contract/plan document language for coverage criteria and limitations.

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