Medical Necessity Guidelines:

Hospice Services for Tufts Health Together, Tufts Health RITogether, and Tufts Health One Care

Effective: December 1, 2024

Prior Authorization Required If REQUIRED, submit supporting clinical documentation pertinent to service request to the FAX numbers below	Yes ☒ No ☐
Notification Required IF REQUIRED, concurrent review may apply	Yes ☐ No ☒

Applies to:

Commercial Products

☐ Harvard Pilgrim Health Care Commercial products; 800-232-0816
☐ Tufts Health Plan Commercial products; 617-972-9409
CareLink℠ – 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); 888-415-9055
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; 888-415-9055
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan; 857-304-6404
☒ Tufts Health One Care Plan—A dual-eligible product; 857-304-6304

Senior Products

☐ Harvard Pilgrim Health Care Stride Medicare Advantage; 866-874-0857
☐ Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product); 617-673-0965
☐ Tufts Medicare Preferred HMO, (a Medicare Advantage product); 617-673-0965
☐ Tufts Medicare Preferred PPO, (a Medicare Advantage product); 617-673-0965

Note: While you may not be the provider responsible for obtaining prior authorization or notifying Point32Health, as a condition of payment you will need to ensure that any necessary prior authorization has been obtained and/or Point32Health has received proper notification. If notification is required, providers may additionally be required to provide updated clinical information to qualify for continued service.

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.

Clinical Guideline Coverage Criteria

The Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) and MassHealth for coverage determinations for its Dual Product Eligible plan Members. MassHealth Medical Necessity Determinations and CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and

documentation included in the Medicare manuals are the basis for coverage determinations where available. For **Tuft's Health One Care** plan Members the following criteria is used: CMS Medicare Benefit Policy Manual Chapter 9 and MassHealth Hospital Manual for MassHealth Providers

To be eligible for hospice services, a Member must be diagnosed as being terminally ill. An individual is considered to be terminally ill if the medical prognosis is that his or her life expectancy is 6 months or less if the illness runs its normal course.

Routine Hospice Care

Tufts Health Public Plans may provide coverage for hospice services in the Member's home or residence when all the following criteria are met:

1. The PCP 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
2. There is an initial hospice evaluation that includes an individualized assessment with member goals and multidisciplinary plan of care
3. The Member elects hospice care
4. For home-based hospice services, there is a caregiver in the Member's home who is willing and capable of assisting the Member
5. The services are reasonable and necessary for the management and palliation of the terminal illness and related conditions
6. The plan of care must be established and periodically reviewed by the attending physician, the hospice medical director, and the interdisciplinary care team of the hospice program
7. The plan of care must be established before hospice care is provided. All services provided must be consistent with the plan of care
8. Services are provided by an appropriate, Medicare Certified Hospice Provider

Ongoing Hospice Care

For ongoing routine hospice care services beyond initial 90-day period to be covered the following requirements must be met:

1. The Member continues to elect hospice care
2. The Member continues to meet the criteria for hospice services
3. The services continue to be reasonable and necessary for the management and palliation of the terminal illness and related conditions
4. The established plan of care is periodically reviewed by the attending physician, the medical director, and the interdisciplinary group of the hospice program
5. The care provided is consistent with the plan of care
6. Coverage for standard hospice services may be provided for two 90-day periods and an unlimited number of 60-day periods if the above guidelines outlined above continue to be met

Limitations

1. 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.
2. During the 12-month period beginning November 1st of each year and ending October 31st of the following year, the aggregate number of inpatient days (for both general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate number of days of hospice services provided to the Member.
3. Inpatient respite care will be provided for a maximum of five consecutive days' stay including the date of admission but not counting the date of discharge.
4. Coverage for respite care may not be provided for Members who are receiving hospice care in or who reside in a facility.

Codes

The following code(s) require prior authorization:

Table 1: CPT/HCPCS Codes

Code	Description
T2042	Hospice routine home care; per diem
T2043	Hospice continuous home care; per hour
T2044	Hospice inpatient respite care; per diem
T2045	Hospice general inpatient care; per diem
T2046	Hospice long-term care, room and board only; per diem

Table 2: Revenue Codes

Code	Description
0650	Hospice
0651	Routine Home Care
0652	Continuous Home Care
0659	Other Hospice

References:

1. National Hospice and Palliative Care Organization, caringinfo.org. Accessed March 19, 2021.
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. Accessed March 26, 2021.
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. Accessed November 8, 2024.
4. Executive Office of Health and Human Services, Commonwealth of Massachusetts. MassHealth Provider Regulations. Hospice Manual. mass.gov/lists/hospice-manual-for-masshealth-providers. Accessed November 8, 2024.
5. Executive Office of Health and Human Services, State of Rhode Island. Medicaid Provider Manuals, Hospice Manual. eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/hospice_manual.pdf. Accessed March 20, 2021.

Approval And Revision History

March 27, 2020, reviewed. Effective March 30, 2020, per Clinical Decision Making and Execution Team prior authorization removed in response to COVID-19 consideration

Subsequent endorsement date(s) and changes made:

- April 1, 2020: Fax number for Unify updated
- October 21, 2020: Reviewed by IMPAC, renewed without changes
- March 17, 2021: Reviewed by IMPAC and Clinical Decision Making and Execution Team; Prior Authorization is being reinstated effective April 1, 2021
- December 21, 2021: Reviewed by Medical Policy Approval Committee (MPAC), renewed without changes
- April 6, 2022: Template updated
- December 1, 2022: Reviewed by MPAC, renewed without changes
- September 20, 2023: Reviewed by MPAC, renewed without changes
- November 2023: Rebranded Unify to One Care and updated One Care criteria effective January 1, 2024
- October 17, 2024: Reviewed by MPAC, renewed without changes effective December 1, 2024

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.