Hospice Prior Authorization

Plan: AmeriHealth Caritas Louisiana

Clinical Policy ID: CCP.4014

Recent review date: **1/2026**

Next review date: **5/2027**

Policy contains: Hospice; prior authorization; documentation.

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, on a case by case basis, 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.

Policy statement

Prior authorization (PA) is required upon the initial request for hospice coverage. PA requests must be submitted within 10 calendar days of the hospice election date. If the PA is approved, it covers 90 days. If another 90-day election period is required, the PA request must be submitted at least 10 days prior to the end of the current election period. This will ensure that requests are received and approved/denied before the preceding period ends. If this requirement is not met and the period ends, reimbursement will not be available for the days prior to receipt of the new request. **If approved, reimbursement will be effective the date the Prior Authorization Unit (PAU) receives the proper documentation.**

The completed PA (see *Required Documentation* in this section,) which includes the updated and signed "Hospice Certification of Terminal Illness" (BHSF Form Hospice CTI) and all related documents, must be received before the period ends. Any PA request received after the period has ended will become effective on the date the request is received by the PAU if the request is approved. This policy also applies to PA packets received after eligibility has ended. It is the responsibility of the provider to verify eligibility on a monthly basis. The PA only approves the existence of medical necessity, not member eligibility.

All requests for hospice PA must be submitted to the AmeriHealth Caritas Louisiana Utilization Management department.

NOTE: PA is not required for dual eligible beneficiaries (Medicare primary) during the two 90-day election periods and the subsequent 60-day election periods. However, providers must submit through the e-PA system a copy of the Medicare Common Working File screen showing the hospice segment, along with the signed CTI and Notice of Election (NOE) forms.

Levels of hospice care, each with particular criteria and payment rates, include:

- Routine Home Care. Defined as when an individual who has elected to receive hospice care is at home and is not receiving continuous home care. The routine home care rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

- Continuous Home Care. Defined as the individual receiving hospice care is not in an inpatient facility and receives care consisting predominantly of nursing care on a continuous basis at home. Continuous home care is only furnished during brief periods of medical crisis and only as necessary to maintain the terminally ill ~~beneficiary~~ **member** at home.

- Inpatient Respite Care. Defined as when the individual receives care in an approved facility on a short-term basis to relieve the family members or other persons caring for the individual at home. Payment is made for respite care for a maximum of five continuous days at a time. Payment for the sixth day, and any subsequent days, is made at the routine home care rate.

- General Inpatient Care. Defined as when an individual receives general inpatient care in an inpatient facility for the purpose of pain control or acute or chronic symptom management, which cannot be managed in other settings. Payment is made for inpatient care for a maximum of five continuous days at a time, including the date of admission, but not counting the date of discharge. The hospice is the professional manager of the ~~beneficiary's~~ **member's** care.

Required Documentation

Documentation should paint a picture of the member's condition by illustrating the member's decline in detail (e.g., documentation should show last month's status compared to this month's status and should not merely summarize the member's condition for a month). In addition, documentation should show daily and weekly notes and illustrate why the member is considered to be terminal and not "chronic". Explanation should include the reason the member's diagnosis has created a terminal prognosis and show how the systems of the body are in a terminal condition. Telephone courtesy calls are not considered face-to-face encounters and will not be reviewed for prior authorization.

The following information will be required upon the initial request for hospice services.

First Benefit Period (90 days)

- Hospice Election Form (primary diagnosis code(s) using the International Classification of Disease, Tenth Revision (ICD-10) or its successor; other codes);
- Hospice Certification of Terminal Illness form (BHSF Form Hospice – CTI);
- Clinical/medical information;
- Hospice provider plan of care:
    - Progress notes (hospital, home health, physician's office, etc.);
    - Physician orders for plan of care; and
    - Include Minimum Data Set (MDS) **or jRaven** form (original and current) if member is in a facility; weight chart; laboratory tests; physician and nursing progress notes. The MDS **or jRaven** form is

not required if the member has been in a long-term care facility less than 30 days. The MDS **or jRaven** form must be provided upon the subsequent request for continuation of hospice services;

- Documentation to support member's hospice appropriateness, including the following:
  - Paint picture of member's condition;
  - Illustrate why member is considered terminal and not chronic;
  - Explain why his/her diagnosis has created a terminal prognosis; and
  - Show how the body systems are in a terminal condition.

Second and Subsequent Periods

Providers requesting PA for the second period, and each subsequent period, must send the following packet for prior authorization:

- MDS **or jRaven** forms (original and current) are required; weight chart; laboratory tests; physician and nursing progress notes if the member resides in a nursing facility;
- An updated Hospice Certification of Terminal Illness form (BHSF Form Hospice-CTI) and **proof of** a face-to-face encounter signed and dated by the hospice provider's medical director or physician member of the interdisciplinary group (IDG) for the third and subsequent requested PA periods;
- An updated plan of care;
- Updated physician's orders;
- List of current medications (within last 60 days);
- Current laboratory/test results (within 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);
- A social evaluation;
- An updated scale such as: Karnofsky Performance Status Scale, Palliative Performance Scale or the Functional Assessment Tool (FAST);
- The member's current weight, vital sign ranges, lab tests and any other documentation supporting the continuation of hospice services. Documentation must illustrate the member's decline in detail. Compare last month's status to this month's status; and
- ~~Original MDS; current MDS form~~ **Original and current MDS or jRaven forms** if member is a resident in a facility.

This information must be submitted for all subsequent benefit periods and must show a decline in the member's condition for the authorization to be approved.

For PA, the prognosis of terminal illness will be reviewed. A member must have a terminal prognosis in addition to a completed Hospice Certification of Terminal Illness form and proof of the face-to-face encounter. Authorization will be made on the basis that a member is terminally ill as defined in federal regulations. These regulations require certification of the prognosis, rather than diagnosis. Authorization will be based on objective clinical evidence in the clinical record about the member's condition and not simply on the member's diagnosis.

A cover letter attached to the required information will not suffice for supporting documentation.

The supporting information must be documented within the clinical record with appropriate dates and signatures.

Example: A member receives hospice care during an initial 90-day period and is discharged or revokes his/her election of hospice care during a subsequent 90-day period, thus losing any remaining days in that election

period. If this member chooses to elect a subsequent period of hospice care, even after an extended period without hospice care, prior authorization will be required. The Notice of Election (NOE), Hospice Certification of Terminal Illness form, and all prior authorization documentation are due within the 10 day time frame. Reimbursement will be effective the date the required information is received by the PAU if receipt is past 10 days.

A provider, who anticipates the possibility of providing hospice care for a member beyond the initial 90-day election period, must submit a prior authorization packet to the PAU. The required information and any supporting documentation must be sent.

Written Notice of Prior Authorization Decision

PA requests will be reviewed using the Medicare criteria found in local coverage determination hospice determining terminal status (L34538) and approved or denied within five working days. Once the review process has been completed and a decision has been made, the hospice provider will receive a written notification of the decision. A denial does not represent a determination that further hospice care would not be appropriate, but that based on the documentation provided, the member does not appear to be in the terminal stage of illness. Providers are encouraged to submit prior authorization packets for the next subsequent period within the set time frame when there is evidence of a decline in health if a prior period had been denied.

NOTE: It is the hospice provider's responsibility to inform the nursing facility of approval or denial.

Reconsideration

If a member does not agree with the denial of a period or subsequent period, reconsideration may be requested. Documentation must be recent and may not include information previously omitted or previously submitted. All reconsideration requests will be reviewed within five working days of receipt.

References

Louisiana Department of Health. 2012. Hospice Provider Manual. Chapter 24, Section 24.6. https://www.lamedicaid.com/provweb1/Providermanuals/manuals/Hospice/Hospice.pdf. Issued **5/19/2025**.

Policy updates

Initial review date: 3/2/2021

1/2022: Coverage section updated.

1/2023: Coverage section updated.

1/2024: Coverage section updated.

1/2025: Coverage section updated.

1/2026: Coverage section updated. Coding section added.

Related Codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy CCP.4014. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

Code	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**
G0299	**Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes**
Q5001	**Hospice or home health care provided in patient's home/residence**
Q5002	**Hospice or home health care provided in assisted living facility**
Q5003	**Hospice care provided in nursing long term care facility (LTC) or non-skilled nursing facility (NF)**
Q5004	**Hospice care provided in skilled nursing facility (SNF)**
G0300	**Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes**
Q5005	**Hospice care provided in inpatient hospital**
Q5006	**Hospice care provided in inpatient hospice facility**
Q5007	**Hospice care provided in long term care facility**
Q5008	**Hospice care provided in inpatient psychiatric facility**
Q5009	**Hospice or home health care provided in place not otherwise specified (NOS)**
Q5010	**Hospice home care provided in a hospice facility**