OHCA Guideline

Medical Procedure Class:	**Hospice Services**
Initial Implementation Date:	October 1, 2021
Last Review Date:	November 7, 2025
Effective Date:	November 19, 2025
Next Review/Revision Date:	November 2028

* This document is not a contract, and these guidelines do not reflect or represent every conceived situation. Although all items contained in these guidelines may be met, this does not reflect or imply any responsibility of this agency or department to change the plan provision to include the stated service as an eligible benefit.

☐New Criteria ☒ Revision of Existing Criteria

Summary

Purpose:	To provide guidelines to assure medical necessity and consistency in the prior authorization process.

Definitions

Hospice Care: Is a comprehensive, holistic program of care and support for terminally ill patients and their families. Hospice care changes the focus to comfort care (palliative care) for pain relief and symptom management instead of care to cure the patient's illness.

Terminal Illness: Terminally ill is defined as a medical prognosis of limited expected survival, of six months or less at the time of referral to a hospice, of an individual who is experiencing an illness for which palliative care is appropriate.

Palliative care: Treatment for the relief of pain and other uncomfortable symptoms through the appropriate coordination of all aspects of care to maximize personal comfort and relieve distress.

Description

Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has a life expectancy of six months or less. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional, and spiritual stresses which are experienced during the final stages of illness and death. Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

Revenue Codes Covered Requiring Prior Authorization (PA)

Levels of Care Revenue Codes

651 - Routine Hospice Care: Member is at home and is not receiving continuous care

652 - Continuous Home Care: Member is not in an inpatient facility and receives hospice on a continuous basis at home (consists primarily of nursing care to achieve palliation and management of acute medical symptoms during a **brief period of crisis only** as necessary to maintain the terminally ill patient at home.) If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine hospice care.

655 - Inpatient Respite Care: Member receives care in an approved facility on a short-term basis for respite.

656 - General Inpatient Care: Member receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed at home. In this situation, at home can mean a participant's personal home, an assisted living facility, or a nursing home.

658 – **Hospice Room and Board Nursing Facility**: Member receives hospice care in a NF or ICF/IID. Hospice nursing facility or ICF/IID room and board per diem rates are reimbursed to the in-home hospice provider at a rate equal to 95% of the skilled nursing facility rate. The hospice provider is responsible for passing the room and board payment through to the NF or ICF/IID.

Service Intensity Add-On: Effective January 1, 2016, payment for the Service Intensity Add-On (SIA) will be made for a visit by a registered nurse (RN) or Social Worker when provided in the last seven (7) days of life.

Note: Processing for the Service Intensity Add-on payment requires the provider to submit an amendment form for the most recent PA approved for member's hospice care. The amendment should contain documentation of visit(s) performed by hospice RN and/or MSW including time and services performed. The PA will be updated to include any approved SIA reimbursement. SIA is reimbursed per hour, up to 4 hours per day for the last 7 days of a member's life.

Approval Criteria

I. GENERAL

Hospice services are designed to be provided in the participant's home, but for purposes of the Medicaid hospice benefit, a nursing facility or intermediate care facilities for individuals with intellectual disabilities (ICF-IID) may be considered a participant's home.

Members under 21 years of age - Hospice services are available to eligible members without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice. The member or authorized representative must sign an election statement of Hospice care but does not waive curative treatment of the condition for which a diagnosis of terminal illness has been made, in addition to the Hospice care.

Adult members - Choose Hospice care in lieu of curative care for the terminal illness. The member or authorized representative must sign an election statement, and by doing so waives his or her right to other Medicaid benefits, except for care not related to the terminal illness and care provided by the attending physician.

Services covered under hospice must be provided by a participating hospice program that meets Medicare certification requirements and has a valid OHCA Medicaid provider agreement.

Services must be **Prior Authorized**. A written Plan of Care must be established before services are provided. The Plan of Care should be submitted with the prior authorization request.

II. INDICATIONS

Eligibility for hospice care under Medicaid requires physician certification that the participant is terminally ill and includes a medical prognosis with a life expectancy of 6 months or less if the illness runs its normal course. The terminal prognosis also must be supported by clinical information in the medical record.

Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide services, and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. Services must be prior authorized.

III. FREQUENCY

Hospice care is available for two 90-day certification periods and an unlimited number of 60-day certification periods during the remainder of the member's lifetime.

Each certification period requires a **NEW Prior Authorization**.

IV. DOCUMENTATION

Initial Documentation Requirements for Requesting Services – Initial 90-Day Certification Period

Revenue Code 0651 (Routine Hospice Care)

- **Order for Hospice Care**
  Order for hospice care must be signed by a treating provider (physician, physician assistant, or nurse practitioner).

- **Certification of Terminal illness**
  A certification that the individual is terminally ill must be completed and signed by the Medical Director of the hospice or the physician member of the hospice interdisciplinary group (IDG), and the member's attending physician (if they have one).

- **Election of Hospice Care**
  The member must elect hospice benefits by completing an Election of Hospice Benefits form. It must be completed, dated, and signed by the member or legal representative.

- **Interdisciplinary Team (IDT) Plan of Care**
  Every member must have a written plan of care developed by the Hospice interdisciplinary team. All covered Hospice care must be consistent with the plan of care. The Plan of Care must be signed and dated by the attending MD or Medical Director at hospice and all applicable members of the IDT team.

Revenue Code 0652 (Continuous Home Care)

- Must meet the same requirements as Revenue Code 0651; **AND**
- The request for specialized hospice care needs to include:
  - Scope of care provided; and
  - Length of time provided.
- Clinical documentation that is submitted must include at least 51% of covered care that is documented by nursing.

Revenue Code 0655 (Inpatient Respite Care)

- Must meet the same requirements as Revenue Code 0651; **AND**
- Respite Care request which must include:

- Start and stop date; and
- Scope of respite care and facility respite care to be performed which should include all orders of care for the member.
- Medical records (nurse and physician visit notes) to support level of care to be provided to the member.

Revenue Code 0656 (General Inpatient Care)

- Must meet the same requirements as Revenue Code 0651; **AND**
- Request to include:
  - Date admitted through discharge date; and
  - What services are ordered for the member.
  - Medical records (nurse and physician visit notes) to support level of care to be provided to the member.

Revenue Code 0658 (Hospice Room and Board Nursing Facility)

- Must meet the same requirements as Revenue code 0651; **AND**
- Request to include documentation to support nursing facility residency

Documentation Requirements for Continuation of Services – Subsequent 90-Day Certification Period and 60-Day Certification Periods

Certification of Terminal illness
For the recertification, only the hospice medical director or the physician member of the IDG is required to sign and date the certification. The member's attending physician is not required to sign and date the recertification.

Election of Hospice
The form must be completed, dated, and signed by the member or legal representative.

IDT (Interdisciplinary Team) Plan of Care
The Plan of Care must be signed and dated by the attending MD or Medical Director at hospice and all applicable members of the IDT team.

Re-evaluation by Physician or Nurse Practitioner
The Hospice Physician or Nurse Practitioner must have a face-to-face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter; and attests that such visit took place.

Additional Information

The member and/or the family may voluntarily terminate hospice services.

The services will end upon revocation, allowing the member, if eligible, to resume Medicaid coverage of the benefits waived when hospice care was initially elected. A member may re-elect to receive hospice after a revocation at any time, provided the member is otherwise entitled to hospice care. Once hospice has been re-elected, a subsequent benefit period will ensue.

The election of benefits stays in effect as long as the participant remains in hospice, does not revoke the election, and is not discharged from hospice for other reasons. Reasons for discharge may include: the participant is no longer considered terminally ill, the participant transfers to another hospice, the participant moves out of the hospice service area, or the participant is not receiving the required or expected care from the hospice provider.

References

1. Oklahoma Health Care Authority; Policies & Rules, OAC 317:30-5-530 - Hospice
2. Oklahoma State Plan – *EPSDT Hospice Services; Hospice Care*
3. Centers for Medicare & Medicaid Services. (2021). *Hospice*. Retrieved from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice Hospice | CMS
4. LCD L34538, CGS, Hospice *Determining Terminal Status*, Revision date 08/07/2025