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: August 17, 2016
Next Review Date: August 2017

Related policies:
None.

ABOUT THIS POLICY: AmeriHealth Caritas Pennsylvania has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas Pennsylvania’s 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 Pennsylvania when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state and federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas Pennsylvania's 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 Pennsylvania’s clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas Pennsylvania will update its clinical policies as necessary. AmeriHealth Caritas Pennsylvania’s clinical policies are not guarantees of payment.

Coverage policy

AmeriHealth Caritas Pennsylvania 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 in the table on page three.
- Physician certification for palliative services is for relief of suffering and covered 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.

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 (see table on page three), but still have a life expectancy of six months or less.
- Patients may stabilize or improve in hospice and be considered for discharge if improvement is lengthy or temporary.
- 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.

Note: The following CPT/HCPCS codes are not listed in the Pennsylvania Medicaid fee schedule:

Q5001 - Hospice or home health care provided in patient’s home/residence
Q5002 - Hospice care provided in assisted living
Q5003 - Hospice care provided in nursing long-term care facility (LTC) or nonskilled nursing facility (NF)
Q5004 - Hospice care provided in skilled nursing facility (SNF)
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 a place not otherwise specified
Q5010 - Hospice home care provided in a hospice facility

**Alternative covered services:**

Palliative care delivered in a hospital, nursing home, or patient’s home.

**Background**

**Hospice or palliative care:**

New technologies that can prolong life without restoring full health have led to interest in alternative end-of-life care settings and a corresponding change in the site of death; in 1980, 80 percent of deaths among Americans occurred in hospital inpatient settings. By 2000, that rate had decreased to 40 percent. Deaths among hospice enrollees showed a corresponding increase, particularly marked among cancer patients and for younger or very aged individuals: 40 percent of hospice-enrolled patients die outside of the hospital or at home.

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 (COPD), 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.

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.

<table>
<thead>
<tr>
<th>Clinical indicators typically associated with appropriate referral to hospice care</th>
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<tr>
<td><strong>Indication</strong></td>
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<tr>
<td>Clinical status</td>
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<td>Laboratory (where available; testing not required for eligibility)</td>
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<td>Other tests, such as lactate clearance, are under investigation (Zhang 2014).</td>
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</tbody>
</table>

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 four quality domains are consistent and addressed in comprehensive assessment and needs screens, as well as in care planning. These are:

- Physical symptoms.
- Psychological symptoms.
- Social needs (i.e., interpersonal relationships, caregiving, and economic concerns).
- Existential or spiritual needs.
AmeriHealth Caritas Pennsylvania 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 July 14, 2016. Search terms were: “hospice,” “palliative care,” “prognostic indicators,” “terminal status definitions,” and “prediction model” [MeSH].

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 huge 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.

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.

Despite widespread support for models that better serve patient needs at the end of life, along with institutionalized (within national health services) preferences for death at home, only limited and moderate-quality evidence supports the effectiveness or costs of end-of-life home care.

The evidence base for palliative and end-of-life care currently centers on cancer, with few valid and reliable measures for patient or caregiver experiences in other conditions.

Much research is still needed and should address continuity of care, advance planning, spirituality, and support for grief and bereavement.
**Policy updates:**

2016-Updated LCD.

**Summary of clinical evidence:**

<table>
<thead>
<tr>
<th>Citation</th>
<th>Content</th>
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| Shibutani (2015)           | **Key points:**<br>  ● Studied 110 patients with unresectable metastatic colorectal cancer who underwent palliative chemotherapy.  
                      ● Evaluated the relationships between the survival/chemotherapeutic response and pre-/post-treatment markers of systemic inflammation.  
                      ● The overall survival rates were significantly worse in the group with high pre-treatment NLR/CRP/GPS.  
                      ● C-reactive protein (CRP) level can be used as a marker for predicting chemotherapeutic outcome and monitoring the progression of the tumor. |
| Ewing (2015)               | **Key points:**  
                      ● Thematic analysis was conducted.  
                      ● Twenty-nine staff members from two hospice home-care services.  
                      ● Identification of carer needs was informal and unstructured.  
                      ● The Carer Support Needs Assessment Tool delivered benefits through a change in practice.  
                      ● The Carer Support Needs Assessment Tool has the potential to normalize carer assessment and support, facilitate delivery of carer-identified support, and enable effective targeting of resources. |
| Antunes (2014)             | **Key points:**  
                      ● Narrative syntheses of 31 descriptive implementation studies.  
                      ● An assigned coordinator and provider education throughout process are essential. |
| Asiakson (2014)            | **Key points:**  
                      ● Relevant studies — 2012.  
                      ● Thirty-seven publications for 30 interventions.  
                      ● Heterogeneity precluded pooling.  
                      ● Inconsistent and inconclusive evidence. |
| Brinkman-Stoppelenburg     | **Key points:**  
                      ● 95% observational studies.  
                      ● Some evidence for improvements to quality. |
| (2014) Advance care planning |                                                                                             |
| Capurro (2014)             | **Key points:**  
                      ● Seventeen studies and no randomized controlled trials (RCTs).  
                      ● Insufficient evidence. |
| Leclerc (2014)             | **Key points:**  
                      ● Full-text, peer-reviewed studies in French, English, and Spanish.  
                      ● Limited number of high-quality studies permits only preliminary conclusions that teams improve patient satisfaction and a few organizational aspects of care. |
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<thead>
<tr>
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| Luckett (2014) | **Key points:**  
  - Palliative home nursing increased the rate of death at home without compromising symptom relief, quality of life (QOL), or costs. |
| Ventura (2014) | **Key points:**  
  - Relevant empirical studies,  
  - Fifteen studies, mostly qualitative.  
  - Most frequently reported need was effective communication with providers, particularly for suffering in psychosocial domains. |
| Barathi (2013) | **Key points:**  
  - Twelve studies (pro- or retrospective; no controlled studies were identified or included).  
  - No significant survival differences, sedated versus non-sedated. |
| Brown (2013) | **Key points:**  
  - Cross-sectional studies analyzing predictive factors.  
  - More agreement on factors that do not predict mortality (functional assessment staging) than on those that do. |
| Chan (Cochrane 2013) | **Key points:**  
  - No eligible studies available. |
| Gomes (Cochrane 2013) | **Key points:**  
  - RCTs and CCTs, –2012.  
  - Twenty-three studies (six high-quality RCTs); 37,561 subjects, mostly with advanced cancer but also heart failure, COPD, HIV/AIDS, and multiple sclerosis.  
  - 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.  
  - More research is needed for other conditions. |
| Hall (Cochrane 2013) | **Key points:**  
  - Multi-component palliative care service delivery interventions, –  
  - Three U.S. studies (735 subjects): two RCTs, one before-and-after.  
  - Promising but inconclusive; higher-quality research measuring standard outcomes and cost effectiveness is needed. |
| Herber (2013) | **Key points:**  
  - Relevant English-language studies, qualitative or quantitative,  
  - Nine studies after screening for quality.  
  - HCSWs divide their time between care provision and emotional and social support.  
  - HCSWs face emotional challenges and should be supported by induction and training programs, a defined period of preceptorship, support, supervision, and clearly defined boundaries. |
| Dy (Agency for Healthcare Research and Quality 2012) | **Key points:**  
  **Questions**  
  - Effectiveness of processes and outcomes for pain communication and decision-making for continuity, coordination, and transitions of care; and for patient and family distress.  
  - Effectiveness of different quality-improvement models. |
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<tr>
<th>Citation</th>
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<td><strong>Citation</strong></td>
<td><strong>Content</strong></td>
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<tr>
<td><strong>Searches</strong></td>
<td>- 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.</td>
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<tr>
<td><strong>Results</strong></td>
<td>- Twenty-three studies 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.</td>
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<td>- One RCT: feedback from standardized assessment and interdisciplinary team discussions improved one outcome.</td>
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<td>- Nursing homes: care pathways had inconsistent results.</td>
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<td>- Types of quality improvement: patient-centered interventions (patient, family, and caregiver education and promotion of self-management) improved satisfaction and QOL or health care utilization in some studies.</td>
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<tr>
<td><strong>Conclusions</strong></td>
<td>- Evidence is strongest for pain interventions and targets of communication, decision-making, and continuity for some outcomes.</td>
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<td>- Only a few well-designed and -conducted studies are available for improving patient outcomes in palliative care.</td>
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<td>- Available research is too heterogeneous and results inconsistent for firm conclusions.</td>
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| Jones (Cochrane 2012) | **Key points:** |
| Spiritual and religious interventions | - Insufficient evidence. |

| Shepperd (Cochrane 2012) | **Key points:** |
| **Home-based end-of-life care** | - RCTs, interrupted time-series, controlled before-and-after, |
| | - Outcomes considered: rates of dying in hospital and effects on symptoms, quality of life, health service costs, and caregivers versus hospital or hospice inpatient. |
| | - Four trials; patient mean age 63 – 74; blinding not possible in all trials, increasing risk of bias. |
| | - Three studies assessing effects on place of death: home care increased likelihood of death at home. |
| | - Patient outcomes: no significant effects on functional status, psychological well-being, or cognitive status. |
| | - 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. |
| | - No Significant differences in admission to hospital or hospital length of stay. |
| | - Use of other health services inconsistently reported. |
| | - Caregivers of home patients more stratified at one month but no difference at six months. |

| Candy (Cochrane 2012) | **Key points:** |
| Spiritual and religious interventions | - RCTs, |
| | - Five trials (1,130 subjects), some with incompletely reported intervention content, structure, or team members. |
| | - Inconclusive evidence. |

| Candy (Cochrane 2011) | **Key points:** |
| **Interventions for supporting family and friends** | - Eleven RCTs (1,836 caregivers): interventions involving emotional support and advice on coping. |
| | - Many trials were incompletely or inadequately reported. |
| | - Support may reduce psychological distress, but effects on physical health were not addressed. |
Clinicians should inquire about caregiver concerns.
Additional research and better reporting is needed.

**Downing (2007)**
Survival prediction with Palliative Performance Scale (PPS)

**Key points:**
- Relevant studies conducted in palliative care units, hospitals, and a community hospice.
- Four studies (1,808 subjects); mean patient age 64 – 78.
- Higher PPS associated with increased survival.
- Females lived longer than males. Additional factors are required for complete analyses.

**Mularski (AHRQ 2007)**
Measures of end-of-life care and its outcomes

**Key points:**
- English-language human studies.
- Excluded: pediatric subjects, case reports, narrative reviews, intervention studies, non-developed nation settings.
- Nine hundred thirty-one articles describing 261 potentially applicable measures: physical symptoms, QOL, emotional and cognitive symptoms, advance care planning, functional status, continuity of care, spirituality, grief and bereavement, satisfaction, quality of care, and caregiver well-being.
- Different studies rarely used same measures; only eight used in two or more studies.

**Glossary**

**Ascites** — Accumulation of fluid in the peritoneal (abdominal) cavity. Most commonly associated with liver disease (cirrhosis or cancer metastatic to the liver), it is one of the indicators of terminal status and may be treated by diuretics, removal of fluid via needle, or by treatments directed at the underlying cause.

**Carcino-embryonic antigen (CEA)** — A category of proteins involved in cell adhesion, CEA is normally produced in gastrointestinal tissues during fetal development but stops before birth, and thus is present in very low levels in healthy adults although increased in the presence of some cancers, such as colorectal, gastric, pancreatic, breast, medullary thyroid, and ovarian. It is used to monitor response to treatment and for staging.

**Dysphagia** — Abnormal or difficult swallowing, sometimes accompanied by aspiration of food or fluid into the lungs.

**Dyspnea** — Breathlessness or difficulty with breathing.

**Edema** — Swelling.

**Performance scales** — Standardized scoring systems, typically used for patients with cancer, that quantify general well-being and ability to perform self-care and other activities of daily living:
- **Karnovsky scale** — Runs from 100 (perfect health) to zero (death) and is usually scored in increments of 10.
- **Palliative performance scale** — Evaluates domains correlated with Karnovsky and with estimated survival for cancer patients. It also runs from 100 (full ambulation) to zero (death) in increments of 10 percentage points.

**Pericardial effusion** — Abnormal accumulation of fluid in the pericardial sac around the heart. It can negatively impact function by increasing pressure on the heart muscle.
**Pleural effusion** — Abnormal accumulation of fluid in the space surrounding the lungs. It can limit expansion of the lungs, thus negatively affecting breathing.

**Prostate-specific antigen (PSA)** — An enzyme (biochemical catalyst) produced by malignant and non-malignant prostate epithelial cells, making it prostate-specific but not prostate cancer-specific. It also increases from prostatitis and benign prostatic hyperplasia.

**References**

**Professional society guidelines/other:**


**Peer-reviewed references:**


**Clinical trials:**
Searched clinicaltrials.gov on July 18, 2016 using terms “hospice” and “palliative care,” “prognostic indicators,” “terminal status definitions,” | Open Studies. Three studies found, one relevant.


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


**Local Coverage Determinations (LCDs):**


**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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comment</th>
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<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>Z51.5</td>
<td>Palliative care</td>
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<tr>
<th>HCPCS Level II</th>
<th>Description</th>
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<tr>
<td>Q5001</td>
<td>Hospice or home health care provided in patient's home/residence</td>
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<td>Q5002</td>
<td>Hospice care provided in assisted living</td>
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<td>Code</td>
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<td>Q5003</td>
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<td>Q5010</td>
<td>Hospice home care provided in a hospice facility</td>
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<td>S9126</td>
<td>Hospice care, in the home, per diem</td>
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<td>Not covered by Medicare</td>
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