

Hospice Care

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[➔ Instructions for Use](#)

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Related Policy

- [Home Health, Skilled, and Custodial Care Services](#)

Coverage Rationale

[➔ See Benefit Considerations](#)

When an individual has a [Terminal Illness](#), Hospice Care is medically necessary.

Definitions

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

Curative Care: Health care practices that treat patients with the intent of curing them, not just reducing their pain or stress. (Medicare, 2023)

Palliative Care: Specialized medical care for people living with a serious illness, such as cancer or heart failure. Patients in Palliative Care may receive medical care for their symptoms, or Palliative Care, along with treatment intended to cure their serious illness. Palliative Care is meant to enhance a person's current care by focusing on quality of life for them and their family. (NIH, 2023)

Respite Care: Respite Care provides short-term relief for primary caregivers. (NIH, 2023)

Terminal Illness: Terminal Illness in the context of hospice means a life expectancy, certified by two Physicians, of six months or less. (COC, 2024)

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPSC Code	Description
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes
G0493	Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
G0494	Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting)
S9126	Hospice care, in the home, per diem
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

Description of Services

Hospice care focuses on caring and not curing. It is an integrated, structured, multi-disciplinary treatment approach for individuals who seek pain and symptom management for their Terminal Illness.

Palliative Care focuses on assessment and management of pain and other symptoms, assessment and support of caregiver needs, and coordination of care. Palliative Care attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. (NCHPC, 2018)

Benefit Considerations

Coverage includes hospice care that is recommended by a physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social, spiritual, and respite care for a terminally ill person (i.e., a terminally ill individual is commonly defined as someone who is expected to live six months or less.
- Short-term grief and bereavement counseling for immediate family members while the member is receiving hospice care.

Note: Some state mandates may require limits to coverage. Refer to the specific plan documents for coverage information.

Clinical Evidence

Hoff et al. (2023) performed a systematic review of the research on hospice care satisfaction among patients, families, and other caregivers. A total of 38 studies measuring hospice satisfaction based on communication, comfort and support were included. Eleven studies reported statistically significant findings connecting aspects of communication to higher levels of satisfaction with hospice care. The most positively related communication aspect to hospice satisfaction was keeping patients and family/caregivers informed about the care plan including care coordination; providing regular information on the patient's condition; providing information on the dying process; keeping patients and family/caregivers informed about medications being used; and communicating with patients and family regarding the patient's religious and spiritual beliefs. Emotional support was identified in 6 of the studies as an associated factor of higher satisfaction. The authors discovered overall the majority of studies reported either family and non-family caregiver satisfaction or patient, family, and non-family caregiver satisfaction. Additionally they noted there did not appear that any patterns in the levels of satisfaction reported related to when satisfaction surveys were performed with patients, family members, or non-family caregivers (i.e., pre vs post death). They concluded for many, the hospice care experience is perceived as beneficial as there is a consistently higher level of satisfaction over time with hospice care among patients, family members, and non-

family caregivers. This higher level of satisfaction was found across the entire time period of the review, and regardless of when (e.g., prior to or after the patient's death) or where (e.g., inpatient vs home hospice) it was assessed.

Ahluwlia et al. (2018) conducted a systematic review to provide synthesis of the evidence for palliative care interventions across the eight domains that structure the National Consensus Project clinical practice guidelines. The study included 139 systematic reviews that were published over the last five years. The inclusion criteria addressed the structure and process of care (interdisciplinary team care, 13 reviews; care coordination, 18 reviews); physical aspects (48 reviews); psychological aspects (26 reviews); social aspects (two reviews); spiritual, religious, and existential aspects (11 reviews); cultural aspects (three reviews); care of the patient nearing the end of life (grief/bereavement programs, six reviews; final days of life, two reviews); ethical and legal aspects (36 reviews). The authors found high-quality evidence for the impact of home-based palliative care on home death. It facilitated access to important services and allowed for patients to be cared for in their home which many expressed as their preference. There was moderate-quality evidence for the use of music and art therapies to improve anxiety and depression in patients. A moderate level of evidence found that interdisciplinary team care led to positive outcomes related to quality of life, advanced care practice (ACP), death at home, and patient/family satisfaction with care. Evidence for ethics consults and advance directive/physician order interventions showed the strongest evidence in the ethical and legal aspects of care domain. Grief/bereavement support services improved key outcomes for caregivers, but the evidence base for effective approaches for care in the last days of life was limited. Social needs assessment and culturally sensitive care remained limited. The authors concluded that a substantial body of evidence exists to support clinical practice guidelines for quality palliative care, but much of the evidence for palliative care remains with low-quality, due to inconsistency in study findings, the lack of precise effect estimates to support the effectiveness of interventions, and large variation in study designs.

Clinical Practice Guidelines

American Academy of Pediatrics (AAP)

The following 2013 AAP guidelines and recommendations for pediatric palliative and hospice care are based on a combination of published observational studies, expert opinion, and consensus statements.

- All large health care organizations serving children with life-threatening conditions should have dedicated interdisciplinary pediatric palliative care and pediatric hospice care (PPC-PHC) teams.
- PPC-PHC aims to relieve suffering, improve quality of life, facilitate informed decision-making, and assist in care coordination between clinicians and across sites of care.
- These teams should support decision-making, provide timely and effective interventions to minimize suffering while maximizing quality of life.
- Hospices caring for children should adhere to the National Hospice and Palliative Care Organization Standards of Practice for Pediatric Palliative Care and Hospice.
- The teams provide psychological, spiritual, and social support for the family.
- Bereavement care should be provided for anticipatory grief and continue after the death of a child throughout the bereavement period.
- PPC-PHC clinicians should facilitate clear, compassionate, and forthright discussions with patients and families about therapeutic goals and concerns, the benefits and burdens of specific therapies, and the value of advance care planning. (AAP, 2013)

American Society of Clinical Oncology (ASCO)

The 2017 ASCO Clinical Practice Guideline on the integration of palliative care into standard oncology care made the following recommendations:

- Individuals with advanced cancer should receive dedicated palliative care services, early in the disease course, concurrent with active treatment.
- Referral of patients to interdisciplinary palliative care teams is optimal, and services may complement existing programs.
- Providers may refer family and friend caregivers of patients with early or advanced cancer to palliative care services. (Ferrell, 2017)

National Consensus Project for Quality Palliative Care (NCP)

The 2018 NCP Clinical Practice Guidelines for Quality Palliative Care identified eight domains that allow the systematic appraisal of the multifaceted aspects of palliative care:

- Structures and processes of care:
 - Palliative care is shown to prevent and relieve suffering and optimize quality of life for patients and families.

- The foundation is a well-trained and well-supported interdisciplinary team (IDT) that performs comprehensive assessments and develops and implements palliative care plans in coordination with the patient, family, and other health care and community providers.
- Palliative care is delivered in a safe environment with respect for patient and family values, culture, preferences, and goals.
- Physical aspects of care:
 - Palliative care seeks to improve physical comfort and optimal functional status.
 - Symptom management focuses not only on physical factors but also emotional, spiritual, religious, and cultural factors.
- Psychological and psychiatric aspects of care:
 - Psychological and psychiatric issues are assessed and managed.
 - Team employs pharmacologic, nonpharmacologic, and complementary therapies as appropriate.
 - Grief and bereavement program is available to patients and families.
- Social aspects of care:
 - The IDT assesses the social and environmental strengths and vulnerabilities of patients and families to determine the effect on their ability to cope with serious illness and maximize quality of life.
 - The IDT plans for, arranges, and coordinates services that enable the patient to remain in the setting of their choice.
- Spiritual, religious, and existential aspects of care:
 - Spiritual care services including screening, history, and assessment are performed on admission and regularly thereafter.
- Cultural aspects of care:
 - The IDT assesses and aims to meet the culture-specific needs of patients and families.
 - Respects and accommodates range of language, dietary, habitual, and ritual practices of patients and families.
- Care of the imminently dying patient:
 - identify signs and symptoms of approaching death.
 - The IDT must assess for fears, address concerns, provide caregiver training, and support the family through the dying process and post-death.
- Ethical and legal aspects of care.
 - Patient's goals, preferences, and choices are respected and form basis for plan of care.
 - Team is aware of and addresses complex ethical issues.
 - Team is knowledgeable about relevant federal and state statutes and regulations. (NCP, 2018; Ferrell, 2017)

National Hospice and Palliative Care Organization (NHPCO)

The 2022 NHPCO Standards of Practice for Pediatric Palliative Care is a guide for palliative and/or hospice programs providing care to patients in the perinatal period, infancy, childhood, adolescence, and young adulthood; regardless of whether care is delivered in the home, hospital, long-term care, or a respite facility.

The 2022 NHPCO Standards of Practice for pediatric palliative care recommend the following:

- Health professionals providing pediatric palliative care and/or hospice have a responsibility to pursue comfort aggressively and minimize the child's physical, psychosocial, and spiritual pain and suffering in keeping with safe practice, acceptable standards, and patient/family agreement.
- The palliative care and/or hospice interdisciplinary team provides family-centered care that includes the child and family as one unit of care, respecting individual preferences, values, and cultural beliefs, with the child and family active in decision making regarding goals and plan of care.
- Communication with the child and family is open and honest, in accordance with each child's level of understanding and considering the child's and the family's cultural or religious values.
- The interdisciplinary team provides guidance and education to the child/family in choosing medically- and ethically appropriate treatment options that are consistent with their values and beliefs.
- Bereavement care must include age-appropriate bereavement services for children (e.g., siblings) who lose loved ones.
- Access to pediatric hospice and palliative care is enhanced by collaborating with community organizations to promote coordination of care.
- The program partners with community agencies and others that provide resources for children, including respite care.
- Ensure compliance with applicable laws, regulations and regulatory requirements and standards of practice, including, but not limited to the incorporation of concurrent care for pediatric patients under the Concurrent Care for Children Requirement (CCCR) pursuant to Section 2302 of the Affordable Care Act (ACA). (NHPCO, 2022)

National Hospice and Palliative Care Organization (NHPCO)

The 2022 NHPCO Standard of Practice for Patient and Family-Centered Care (PFC) outlined the following principles:

- Provide care and services focused on the dying person and the grieving family's unique experience.
- The patient, family, caregiver, and individuals identified by the patient comprise the hospice unit of care.
- The hospice interdisciplinary team along with the patient, family, caregiver, and other individuals identified by the patient develops, coordinates, and carries out the palliative plan of care.
- Grief and bereavement needs begin at the time of patient admission to hospice and continues throughout the 13-month period following patient's death, and beyond, if necessary.
- Anticipatory grief services and bereavement services are provided to help patients, families, caregivers, and other individuals identified by the patient cope with the losses that occur during the illness and eventual death. (NHPCO, 2022)

National Institute for Health and Care Excellence (NICE)

A 2021 NICE Quality Standard on the end of life care for adults:

- Use a systematic approach when identifying adults who are likely to be approaching their end of life.
- Provide opportunities to discuss advance care planning.
- Coordinate services between health and social care practitioners across different organizations.
- Along with their carers, provide adults approaching the end of their life with access to support 24 hours a day, 7 days a week.
- Offer support to carers providing end of life care at home by providing access to local services that can provide assistance. (NICE, 2021)

National Institute for Health and Care Excellence (NICE)

A 2017 NICE Quality Standard on the end of life care for infants, children and young people makes the following quality statements for infant, children, and young people with a life-limiting condition:

- Along with their parents or carers be involved in developing an advance care plan.
- Have a named medical specialist who leads and coordinates their care.
- Along with their parents or carers are given information about emotional and psychological support, including how to access it.
- Are cared for by a multidisciplinary team that includes members of the specialist pediatric palliative care team.
- Parents or carers of infants, children and young people approaching the end of life are offered support for grief and loss when their child is nearing the end of their life and after their death.
- If being cared for at home, have 24-hour access to both children's nursing care and advice from a consultant in pediatric palliative care. (NICE, 2017)

U.S. Food and Drug Administration (FDA)

Hospice care services are services rendered by licensed health care professionals and, therefore, not subject to regulation by the FDA.

References

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National Institute for Health and Care Excellence (NICE). qs160. End of life care for infants, children and young people. September 12, 2017.

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<https://www.nia.nih.gov/health/what-are-palliative-care-and-hospice-care>. Accessed March 14, 2024.

UnitedHealthcare Individual Exchange Health Benefit Plan Generic Certificate of Coverage 2024.

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual[®] criteria, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.