Clinical Policy: Palliative Care Services

Reference Number: HI.CP.MP.506
Date of Last Revision: 01/25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
This policy describes the medical necessity requirements for community palliative care services delivered in non-hospital settings.

Policy/Criteria
I. It is the policy of Ohana Health Plan that palliative care services are **medically necessary** for members of all ages when all of the following indications are met:
- A. Palliative care services are delivered in a non-hospital setting;
- B. One of the following:
  1. Provider referral received;
  2. Both of the following:
     - a. Member has one or more of the following qualifying conditions:
       - i. Cancer, with evidence of malignant disease; (e.g., locally advanced, relapsed or metastatic cancer; Hematologic Malignancies (leukemia, lymphoma, myeloma, other);
       - ii. Cardiac Disease/Conditions (e.g., chronic heart failure, complex congenital heart disease or acquired cardiovascular disease, other congenital syndromes which significantly affects cardiac status);
       - iii. Pulmonary Diseases/Conditions (e.g., COPD, compromised pulmonary status also known as respiratory compromise, Examples would include but not limited to severe cystic fibrosis, or oxygen dependence;
       - iv. Renal Disease (e.g., Chronic kidney disease stage 5 or end-stage renal disease;
       - v. End-stage liver disease (Diagnosis of ESLD or Decompensated Cirrhosis);
       - vi. Neurologic/Neuromuscular/Neurodegenerative Disease or Conditions (e.g., Diagnosis or motor neuron disease, Parkinson's Disease, Muscular Dystrophy, Multiple Sclerosis, progressive neurologic disorder, or another neurodegenerative condition, traumatic or anoxic brain injury, brain reduction syndromes, etc.);
       - vii. Genetic Disorders (Diagnosis of Trisomy 13, 15, 18, Asphyxiating thoracic dystrophy, etc.);
       - viii. Metabolic/Inclusion Disease (such as Tay Sachs Disease, Krabbe's Disease, Hunter's Disease, or other severe mitochondrial or metabolic disorder, etc.);
       - ix. Gastrointestinal Disease or Conditions (chronic gastrointestinal dysfunction with multi-visceral organ transplant under consideration, biliary atresia, progressive hepatic or uremic encephalopathy, TPN dependence, etc.);
       - x. Orthopedic Disorders (Thanatophoric dwarfism, severe progressive scoliosis, severe osteogenesis imperfecta, etc.);
       - xi. Neonatal (complications of extreme prematurity or birth asphyxia, hypoxic ischemic encephalopathy, etc.);

xii. Infectious Disease (HIV/AIDS, Hepatitis, long-COVID.

b. Member demonstrates functional decline as evidenced by one or more of the following:
   i. Karnofsky Performance Scale (KPS) score ≤ 70;
   ii. Eastern Cooperative Oncology Group (ECOG) Grade of 3 or higher;
   iii. Palliative Performance Scale (PPS) score ≤ 70;
   iv. Model for End-Stage Liver Disease (MELD) score > 19;
   v. Functional Assessment Staging Tool (FAST) score of 5 or higher;
   vi. Durable Medical Equipment-Utilization or Dependency- at least one of the following:
      a) 24-hour oxygen requirement;
      b) Hospital bed;
      c) Wheelchair dependence;
      d) Ventilator dependence;
      e) Feeding tube dependence;
      f) Catheter dependence;
      g) Tracheostomy dependence;
   vii. Clinical Biomarkers-at least one of the following:
      a) Severe airflow obstruction: Forced Expiratory Volume (FEV)1<35% predicted;
      b) Albumin < 3.0;
      c) International Normalized Ratio (INR) >1.3;
      d) Estimated Glomerular Filtration Rate (eGFR) of 25 or less;
      e) Ejection Fraction < 30 for systolic heart failure;
   viii. Evidence of Comorbid Conditions, at least one of the following:
      a) Chronic infections;
      b) Progressive weight loss;
      c) Evidence of pressure ulcers;
      d) Ascites;
      e) Subacute bacterial peritonitis;
      f) Hepatic encephalopathy;
      g) Coronary artery disease;
      h) Diabetes;
      i) Dementia;
      j) Underlying neurologic/chromosomal diagnoses;
      k) Frailty;
      l) Extracorporeal membrane oxygenation (ECMO) or transplant candidate;
      m) Bronchiolitis obliterans;
   ix. Acute Healthcare Utilization-at least one of the following:
      a) One or more acute hospitalizations within the past 12 months;
      b) One or more skilled nursing facility stays within the past 12 months.
      c) Two or more emergency department visits within the past 6 months
      d) Home health episode within the past six months;
      e) Member has already received two lines of standard chemotherapy;
      f) Consideration for lung transplant.

II. It is the policy of Ohana Health Plan that palliative care services are **medically necessary** for members *under the age of 21* when all of the following indications are met:

A. Prognosis for life expectancy is less than 12 months;
B. Palliative care services are delivered in a non-hospital setting;
C. One or more of the following qualifying conditions:
   1. Cardiac disease/conditions (e.g., chronic heart failure, complex congenital heart disease, or acquired cardiovascular disease, other cardiac syndromes, which significantly affect cardiac status);
   2. Pulmonary disease/conditions (e.g., COPD, compromised pulmonary status, also known as respiratory compromise, complications from Cystic Fibrosis, etc.);
   3. Neurologic/Neuromuscular/Neurodegenerative Disease or Conditions (Diagnosis of motor neuron disease, Parkinson's Disease, Muscular Dystrophy, Multiple Sclerosis, progressive neurologic disorder or other neurodegenerative condition, traumatic or anoxic brain injury, brain reduction syndromes, etc.);
   4. Genetic disorders (Diagnosis of Trisomy 13, 15, 18, Asphyxiating thoracic dystrophy, etc.);
   5. Metabolic/Inclusion disease (such as Tay Sachs Disease, Krabbe's Disease, Hunter's Disease, or other severe mitochondrial or metabolic disorder, etc.);
   6. Gastrointestinal disease or conditions (chronic gastrointestinal dysfunction with multi-visceral organ transplant under consideration, biliary atresia, progressive hepatic, or uremic encephalopathy, TPN dependence, etc.);
   7. Orthopedic disorders (Thanatophoric dwarfism, severe progressive scoliosis, severe osteogenesis imperfecta, etc.);
   8. Neonatal (complications of extreme prematurity or birth asphyxia, hypoxic ischemic encephalopathy, etc.);
D. Both of the following:
   1. One of the following diagnoses:
      a. Cancer, with evidence of malignant disease (e.g., locally advanced, relapsed or metastatic cancer; hematologic malignancies, (e.g., leukemia, lymphoma, myeloma, other);
      b. Renal disease (e.g., Chronic kidney disease stage 5 or end-stage renal disease);
      c. End-Stage Liver Disease (Diagnosis of ESLD or Decompensated Cirrhosis);
      d. Infectious Disease (HIV/AIDS, Hepatitis, long-COVID).
   2. One of the following:
      a. Karnofsky Performance Scale (KPS) score ≤ 70;
      b. Palliative Performance Scale (PPS) score ≤ 70;
      c. Eastern Cooperative Oncology Group (ECOG) grade of 3 or higher;
      d. Model for End-Stage Liver Disease (MELD) score > 19;
      e. Functional Assessment Staging Tool (FAST) score of 5 or higher;
      f. Durable Medical Equipment Utilization or Dependency, at least one of the following:
         i. 24-hour oxygen requirement;
         ii. Hospital bed

iii. Wheelchair dependence;
iv. Ventilator dependence;
v. Feeding tube dependence;
vi. Catheter dependence;
vii. Tracheostomy dependence;

g. Clinical biomarkers, at least one of the following:
   i. Severe airflow obstruction: Forced Expiratory Volume (FEV)1 < 35% predicted;
   ii. Albumin < 3.0;
   iii. International Normalized Ratio (INR) > 1.3;
   iv. Estimated Glomerular Filtration Rate (eGFR) of 25 or less;
   v. Ejection Fraction < 30 for systolic heart failure;

h. Evidence of Comorbid Conditions, at least one of the following:
   i. Chronic infections;
   ii. Progressive weight loss;
   iii. Evidence of pressure ulcers;
   iv. Ascites;
   v. Subacute bacterial peritonitis;
   vi. Hepatic encephalopathy;
   vii. Coronary artery disease;
   viii. Diabetes;
   ix. Dementia;
   x. Underlying neurologic/chromosomal diagnoses;
   xi. Frailty;
   xii. Extracorporeal membrane oxygenation (ECMO or transplant candidate;
   xiii. Bronchiolitis obliterans;

i. Acute Healthcare Utilization, at least one of the following:
   i. One or more hospitalizations within the past 12 months;
   ii. One or more skilled nursing facility stays within the past 12 months;
   iii. Two or more emergency department visits within the past six months;
   iv. Home health episode within the past six months;
   v. Member has already received two lines of standard chemotherapy;
   vi. Consideration of lung transplant.

III. It is the policy of Ohana Health Plan that palliative care services *will be considered* for **medical necessity** for other conditions not mentioned in this policy on a case-by-case basis.

IV. It is the policy of Ohana Health Plan that palliative care services are considered **not medically necessary** when at least one of the following indications is met:
A. Member is in the State of Hawaii Organ and Tissue Transplant (SHOTT) program;
B. Member is receiving both hospice and palliative care at the same time.

V. It is the policy of Ohana Health Plan that **discharge** from community palliative care services is appropriate when any of the following criteria are met:
A. Member becomes eligible and accepts hospice services;

B. Member becomes eligible and accepts transplant services.
C. Member no longer wishes to receive palliative care services.
D. Member no longer meets eligibility criteria for palliative care services.

Note: When discharged, members must be transitioned to receive services under the new benefit or program. The reason for discharge must be documented as part of services.[2]

Background

Palliative care is defined as patient and family-centered care that improves quality of life by anticipating, preventing, and treating suffering. It is specialized medical care focused on providing symptom and stress relief for people living with a serious illness. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and other needs and to facilitate patient autonomy, access to information, and choice.

The Hawaii Med-QUEST Division (MQD) conducted an engagement process to identify evidence based practices that offered better support to members and a needs assessment to identify potential gaps. Findings included the following:

- Palliative care was identified as a high-value approach that improves the quality of care and lowers costs;
- Inpatient palliative care services are currently a covered benefit;
- Hospice care is covered and addresses the needs of individuals at the end of life; and
- A gap in care was identified: There currently is not a palliative care benefit to support members with serious illness in their homes and/or community settings that do not meet criteria for hospice.

Community palliative care is designed to be an additional option across the continuum of care. Health plans are responsible for educating providers and members about various services across the continuum of care that support members with serious illnesses (e.g., Home and Community Based Services, hospice, home health, health coordination services, etc.). One way community palliative care differs from hospice is timing. Palliative care can be provided alongside curative treatment, whereas hospice care begins when curative care is no longer pursued.[2]

Community palliative care is a set of services that are provided by an interdisciplinary team. These services are delivered in non-hospital settings including, but not limited to:

- Clinics/office settings;
- Community Health Centers;
- Assisted living facilities;
- Long-term care facilities;
- Skilled nursing facilities;
- Other residential settings;
- The member's residence;
- Wherever the member resides or is located, including houseless members.

The providers shall provide the services in at least one setting listed above. MQD encourages providers to deliver at least some of the services at the member's residence and/or wherever the member resides or is located in alignment with member preference.

Children (defined as under the age of 21)

Palliative care is currently provided as a part of the hospice care for members under the age of 21 if their prognosis for life expectancy is less than 12 months.[2] MQD adopted the concurrent care provisions of Section 2302, of the Affordable Care Act, which amended Section 1905(o)(1) of the Social Security Act. Under this provision, members under the age of 21 may receive hospice services concurrently with curative treatment.

Children are covered for all services that are medically necessary under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit and the Medicaid State Plan and shall provide those services in compliance with all MQD and health plan guidance. Providers may only bill for palliative care services, or hospice services.[1]

Discharge from palliative care services is expected for members who are no longer eligible or appropriate for services. For members who are transitioning to hospice or transplant services, coordination of services to facilitate a smooth transition for the member is expected and essential. MQD requires documentation of the reason for the member's discharge as part of services.[2]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description	Modifier
S0311	Comprehensive management and care coordination for advanced illness, per calendar month FOR DUAL ELIGIBLES (Medicare and Medicaid)	HB
S0311	Comprehensive management and care coordination for advanced illness, per calendar month FOR NON-DUAL ELIGIBLE	HC
S0280	Medical home program, comprehensive care coordination and planning, initial plan - Initial Assessment	

HCPCS Codes	Description	Modifier
	Providers must use diagnosis code Z51.5, Palliative Care Encounter, to specify that the assessment is for palliative care services	
S0281	Medical home program, comprehensive care coordination and planning, ongoing maintenance – Reassessment Providers must use diagnosis code Z51.5, Palliative Care Encounter, to specify that the assessment is for palliative care services	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date	1/25	

References

1. State of Hawaii Department of Human Services. Med-Quest Division. Palliative care implementation memorandum. Released November 8, 2024. Accessed December 19, 2024.
2. State of Hawaii Department of Human Services. Med-Quest Division. Memo No. QI-2430-Community Palliative Care Benefit Implementation. Released December 31, 2024. Accessed January 8, 2025.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment by providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.