Local Coverage Determination (LCD): Hospice - Liver Disease (L31536)

Contractor Information

Contractor Name	Contract Number	Contract Type
Palmetto GBA opens in new window	11004	HHH MAC

Back to Top

LCD Information

Document Information

LCD ID
L31536

LCD Title
Hospice - Liver Disease

Jurisdiction
Alabama
Arkansas
Florida
Georgia
Illinois
Indiana
Kentucky
Louisiana
Mississippi
North Carolina
New Mexico
Ohio
Oklahoma
South Carolina
Tennessee
Texas

Original Effective Date
For services performed on or after 01/24/2011

Revision Effective Date
For services performed on or after 09/05/2014

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
12/09/2010

Notice Period End Date
N/A

CMS National Coverage Policy Title XVIII of the Social Security Act, §1861 (dd)(1) the term "hospice care" means the services provided to a hospice patient

Title XVIII of the Social Security Act, §1862 (a)(1)(A) allows coverage and payment for only those services that are considered to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member

Title XVIII of the Social Security Act, §1862 (a)(6), items and services which consitute personal comfort items (except, in the case of hospice care, as it otherwise permitted under paragraph (1)(C))

Title XVIII of the Social Security Act, §1862 (a)(9) items and services where such expenses are for custodial care (except in the case of hospice care, as is otherwise permitted under paragraph (1)(C))

Title XVIII of the Social Security Act, §1812 (a)(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each with an unlimited number of subsequent periods of 60 days each with respect to which the individual makes an election under subsection (d)(1)

Title XVIII of the Social Security Act, §1813 (a)(4)(A)(i) drugs and biologicals provided in a hospice program

Title XVIII of the Social Security Act, §1814 (a)(7)(A)(i) certifying the patient for hospice

42 CFR Part 418 Hospice Care

CMS Internet-Only Manual, Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, §60

CMS Internet-Only Manual, Pub 100-02, Medicare Benefit Policy Manual, Chapter 9, §§10, 20.1, 20.2, 20.2.1, 40, and 80

Coverage Guidance
Coverage Indications, Limitations, and/or Medical Necessity

Medicare coverage of hospice care depends upon a physician's certification of an individual's prognosis of a life expectancy of six months or less if the terminal illness runs its normal course. Recognizing that determination of life expectancy during the course of a terminal illness is difficult, this A/B MAC has established medical criteria for determining prognosis for non-cancer diagnoses. These criteria form a reasonable approach to the determination of life expectancy based on available research, and may be revised as more research is available. Coverage of hospice care for patients not meeting the criteria in this policy may be denied. However, some patients may not meet the criteria, yet still be appropriate for hospice care, because of other comorbidities or rapid decline. Coverage for these patients may be approved on an individual consideration basis.

Patients will be considered to be in the terminal stage of liver disease (life expectancy of six months or less) if they meet the following criteria (1 and 2 must be present; factors from 3 will lend supporting documentation):

1. The patient should show both a and b:

a. Prothrombin time prolonged more than 5 seconds over control, or International Normalized Ratio (INR)> 1.5

b. Serum albumin <2.5 gm/d1

2. End stage liver disease is present and the patient shows at least one of the following:

a. ascites, refractory to treatment or patient non-compliant

b. spontaneous bacterial peritonitis

c. hepatorenal syndrome (elevated creatinine and BUN with oliguria (<400ml/day) and urine sodium concentration <10 mEq/l)

d. hepatic encephalopathy, refractory to treatment, or patient non-compliant

e. recurrent variceal bleeding, despite intensive therapy

3. Documentation of the following factors will support eligibility for hospice care:

a. progressive malnutrition

b. muscle wasting with reduced strength and endurance

c. continued active alcoholism (> 80 gm ethanol/day)

d. hepatocellular carcinoma

e. HBsAg (Hepatitis B) positivity

f. hepatitis C refractory to interferon treatment

Patients awaiting liver transplant who otherwise fit the above criteria may be certified for the Medicare hospice benefit, but if a donor organ is procured, the patient must be discharged from hospice.

Back to Top

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

081x Hospice (non-Hospital based)
082x Hospice (hospital based)

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

0651 Hospice Service - Routine Home Care
0652 Hospice Service - Continuous Home Care
0655 Hospice Service - Inpatient Respite Care
0656 Hospice Service - General Inpatient Care Non-Respite
0657 Hospice Service - Physician Services

CPT/HCPCS Codes
Group 1 Paragraph: HCPCS codes for applicable physician services.

Group 1 Codes:
XX000 Not Applicable

ICD-9 Codes that Support Medical Necessity
Group 1 Paragraph: N/A

Group 1 Codes:
155.0 MALIGNANT NEOPLASM OF LIVER PRIMARY
571.2 ALCOHOLIC CIRRHOSIS OF LIVER
571.40 CHRONIC HEPATITIS UNSPECIFIED
571.41 CHRONIC PERSISTENT HEPATITIS
571.42 AUTOIMMUNE HEPATITIS
571.49 OTHER CHRONIC HEPATITIS
571.5 CIRRHOSIS OF LIVER WITHOUT ALCOHOL
571.6 BILIARY CIRRHOSIS
572.2 HEPATIC ENCEPHALOPATHY
572.4 HEPATORENAL SYNDROME

573.3 HEPATITIS UNSPECIFIED
573.5 HEPATOPULMONARY SYNDROME

ICD-9 Codes that DO NOT Support Medical Necessity
N/A

Back to Top

General Information

Associated Information
Documentation Requirements

1. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available to the A/B MAC upon request.

2. Documentation certifying terminal status must contain enough information to confirm terminal status upon review. Documentation meeting the criteria outlined in the ***Coverage Indications, Limitations and/or Medical Necessity*** section of this policy would meet this requirement.

3. If the patient does not meet the criteria outlined in the ***Coverage Indications, Limitations and/or Medical Necessity*** section of this policy, yet is deemed appropriate for hospice care, sufficient documentation of the patient's condition that justifies terminal status, in the absence of meeting the criteria, would be necessary.

4. Recertification for hospice care requires that the same standards be met as for initial certification.

Sources of Information and Basis for Decision
Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases. The National Hospice Organization. *Hosp J*.1996;11(2):47-63.

Consultants, and other Medicare Medical Directors
Back to Top

Revision History Information

Please note: Most Revision History entries effective on or before 01/24/2013 display with a Revision History Number of "R1" at the bottom of this table. However, there may be LCDs where these entries will display as a separate and distinct row.

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
09/05/2014	R3	Under **CMS National Coverage Policy** added Hospice Care to 42 CFR, Part 418. Changed all Manual Systems to read Internet-Only Manual. Under **Sources of Information and Basis for Decision** updated reference to follow AMA format.	• Provider Education/Guidance • Other (Maintenance Annual Validation)
11/15/2013	R2		• Provider Education/Guidance • Typographical Error

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
		Under ***CMS National Coverage Policy*** updated the following citations: Title XVIII of the Social Security Act §1961 (dd) added (1) and corrected a typographical error in the word provided. §1862 (a)(1)(6) was changed to (a)(6) and the definition was expanded to include "Items and services." §1862 (a)(1)(9) was changed to (a)(9) and the definition was expanded to include "items and services where such expense are .." §1812 (a)(4) changed 60 days to 90 days. The definition was expanded to read "with unlimited number of subsequent periods of 60 days each..". The word respect had a typographical error that was corrected. §1813 (a)(4) was changed to (a)(4)(A)(i). §1814 (a)(7) was changed to (a)(7)(A)(i). 42 CFR Part 418, removed Chapter IV. Pub 100-02, Medicare Benefit Policy Manual, Chapter 9, §20 was expanded to §§20.1, 20.2 and 20.2.1. CMS Manual System, Pub. 100-08 Medicare Program Integrity Manual, Chapter 13, §§13.1.1-13.13.14 was deleted. Under ***Coverage Indications, Limitations and/or Medical Necessity*** changed the word "Intermediary" to "A/B MAC." The word compliant had a typographical error that was corrected. ***Documentations Requirements*** and ***Utilization Guidelines*** were moved to ***Associated Information***. Under ***Associated Information*** #2 and 3 included the complete title of *Coverage Indications, Limitations and/or Medical Necessity*. Under ***Sources of Information and Basis for Decision*** corrections were made to the location of the citation. Revision #2, 11/29/2012 Under ***CMS National Policy*** the following citation is no longer valid: CMS Manual System, Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 4, §80 and CMS Manual System, Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, §§60, 60.1 and 60.2. Under ***Documentation Requirements*** changed the word "Intermediary" to "A/B MAC." This revision becomes effective on 11/29/2012	
11/29/2012 R1		Revision #1, 10/01/2011 Under ***ICD-9 Codes That Support Medical Necessity*** ICD-9 code 573.5 was added. This revision becomes effective 10/01/2011. **01/24/2011 - In accordance with Section 911 of the Medicare Modernization Act of 2003, Palmetto GBA Title 18 RHHI (00380) was removed from this LCD and implemented to Palmetto GBA J11 HH and H MAC (11004). Effective date of this Implementation is January 24, 2011.**	N/A

Back to Top

Associated Documents

Attachments N/A

Related Local Coverage Documents N/A

Related National Coverage Documents N/A

Public Version(s) Updated on 08/28/2014 with effective dates 09/05/2014 - N/A Updated on 11/08/2013 with effective dates 11/15/2013 - 09/04/2014 Some older versions have been archived. Please visit the MCD Archive Site opens in new window to retrieve them. Back to Top

Keywords

- Hospice Liver Disease
- Liver Disease
- Hospice

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