ND

Medical Policies

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Policy Number:	Q-9004		
Policy Name:	Hospice		
Policy Type:	Medical	**Policy Subtype:**	Ancillary
Effective Date:	09-15-2025	**End Date:**	11-02-2025

Description

This Policy does not apply to FEP

The Member's Benefit Plan language is the primary determinant of coverage.

General Inpatient Hospice care falls under the Member's available Hospice Benefit, not the Member's Inpatient Hospital Benefit.

Please refer to the Member's Plan Book for definitions.

Background

Hospice - an organization that provides medical, social and psychological services in the home or inpatient facility as palliative treatment for individuals with a terminal illness and life expectancy of less than six (6) months.

For purposes of this policy, coverage, and reimbursement, the following levels of Hospice care are considered:

- Routine Home Care (HRH)
- Continuous Home Care (HCH)
- Respite Home Care (HRC)
- Inpatient Respite Care (HIR)
- General Inpatient Care (HGI).

Various core services provided by Hospice, based on the individual member's needs include:

- Skilled nursing
- Social worker
- Pastoral care
- PT/OT/Speech therapy/respiratory therapy

- Home health aide
- Medical equipment
- Supplies
- Drugs and biologicals for the palliation and management of pain and symptoms of the terminal illness and related conditions
- Dietary counseling
- Volunteer coordination
- Bereavement counseling.

Criteria

Initial and Continued Hospice Admission

Coverage Criteria (Note: these are not Medical Necessity criteria, as the Hospice admitting Physician should already have determined medical necessity for Hospice prior to the preauthorization request)

Initial Hospice services may be covered when ALL of the following Points one (1) through three (3) are met.

- There is written certification from a physician that the medical prognosis is for a life expectancy of six (6) months or less, AND ;
- The primary focus of care is palliative and supportive, AND ;
- The Hospice provider is licensed and Medicare-certified, AND ;

Continued Hospice services may be covered beyond the initial approval period when the following Points are met:

- One (1) through three (3) continue to be met, AND
- For continuation of Hospice beyond a period of six (6) months, the Hospice physician documents that the member continues to be appropriate for Hospice.

If an individual improves and/or stabilizes sufficiently over time while in hospice such that he/she no longer has a prognosis of six (6) months or less from the most recent recertification evaluation or definitive interim evaluation, that individual should be considered for discharge from the hospice benefit. Such individuals can be re-enrolled when a decline in their clinical status is such that their life expectancy is again six (6) months or less. On the other hand, individuals in the terminal stage of their illness who originally qualify for the hospice benefit but stabilize or improve while receiving hospice care, yet have a reasonable expectation of continued decline for a life expectancy of less than six (6) months, remain eligible for hospice care benefits.

Levels of Hospice Care

Routine Home Care (HRH)

- The primary type of Hospice care. Typically, provided in the home setting and is not receiving continuous home care.

Continuous Home Care (HCH)

- Short-term care provided during periods of crisis to maintain the meber at home to achieve palliation or management of acute medical symptoms.

- HCH cannot be provided in a skilled nursing facility, inpatient hospice, inpatient hospice facility, long term care hospital, or an inpatient psychiatric facility.
- Requires at least eight (8) hours-per-day of direct individual care, including nursing and/or homemaker or aide services, in a 24-hour day, beginning at midnight.
    - Nursing care includes skilled observation and monitoring when necessary, and skilled care is needed to control pain and other symptoms, such as onset of uncontrollable pain, active bleeding, seizures, respiratory distress, uncontrollable anxiety or agitation, new or worsening delirium, uncontrolled nausea or vomiting
    - Care must be predominantly nursing (RN, LPN or LVN), and is billed daily. At least 50 percent of the total care provided must be provided by nursing, with the remaining hours supplemented by homemaker or aide services. When aide hours exceed the nursing hours, routine home care must be billed. When fewer than eight (8) hours of care are required, the services are covered as routine home care rather than continuous home care.

Home Respite Care (HRC)

- Provides up to five (5) days of relief or rest for the primary caregiver in the home setting per 30 calendar days
- Must be an interval of 21 days in-between the five (5)-day episodes of any respite care.

Inpatient Respite Care (HIR)

- Provides up to five (5) days of relief or rest for the primary caregiver in an inpatient setting per 30 calendar days.
- Must be an interval of 21 days in-between the (5)-day-day episodes of any respite care.

General Inpatient Care (HGI)

- Inpatient care when the individual is unable to be managed at home such as:
    - Imminent death or condition rapidly deteriorating- periods of unresponsiveness or coma, weak thready pulse and low blood pressure, chest congestion, agonal breathing, apnea, peripheral shutdown
    - Uncontrollable pain, active bleeding, frequent seizures, respiratory distress, uncontrollable anxiety or agitation, new or worsening delirium, open wounds requiring frequent skilled care, pathological fractures, uncontrolled nausea or vomiting.
        - Documentation should include both:
            - A precipitating event (onset of uncontrolled symptoms or pain), AND
            - The interventions tried in the home that have been unsuccessful at controlling the symptoms (frequent evaluation by a doctor or nurse, frequent medication adjustment, IV's that cannot be administered at home, aggressive pain management, complicated technical delivery of medication.
    - Equipment needs exceed what can be managed in the home setting, such as wall-mount suction, high-flow oxygen exceeding the capacity of an oxygen generator.
    - Family or caregiver inability or refusal to provide non-skilled care at home, or lack of availability of a caregiver does not necessarily constitute a skilled need for general inpatient hospice care. Frequent administration of pain medication by any route does not in-and-of itself constitute a skilled need for general inpatient hospice care.
    - HGI is not intended to be custodial or residential. Once the individual's symptoms are stabilized, or pain is managed, he/she must return to a routine level of care. The individual may remain in a facility due to safety, but benefits are not available for HGI unless the individual is in need of this level of care, and it is clearly documented in the medical records.

Not Covered

Hospice services are not a covered benefit when:

1. There is treatment being provided with curative intent
2. The treatment is 'aggressive'.
3. The member's condition is not terminal and/or they do not have a life expectancy of six (6) months or less
4. All other times when coverage criteria above are not met

- NOTE: There may be special circumstances dictated by law where children must be provided hospice benefits even when the condition is not terminal, the life expectancy is not six (6) months or less, the treatment has curative intent, or the treatment is aggressive. Benefits will follow applicable laws in these circumstances.

Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information.

Professional Statements and Societal Positions Guidelines

Not Applicable

Diagnosis Codes

Not Applicable

CURRENT CODING

HCPCS:

S9125	Respite care, in the home, p	Commercial
T1005	Respite care service 15 min	Commercial
T2044	Hospice respite care	Commercial

ND Committee Review

Internal Medical Policy Committee 7-22-2020 Annual Review *Effective September 7, 2020*

Internal Medical Policy Committee 11-29-2022 Language reviewed. *Effective January 2, 2023*

Internal Medical Policy Committee 5-23-2023 Annual Review - no changes in criteria *Effective July 3, 2023*

Internal Medical Policy Committee 7-26-2023 Revision - *Effective June 27, 2023*

- *Removed* section that states 'Where permitted under the Provider agreement, initial admissions or additional days performed without preauthorization approval and on review of clinical documentation are determined by BCBSND to not meet criteria in this policy will be denied as provider liable.'

Internal Medical Policy Committee 7-16-2024 Annual Review - no changes in criteria *Effective September 2, 2024*

Disclaimer

Current medical policy is to be used in determining a Member's contract benefits on the date that services are rendered. Contract language, including definitions and specific inclusions/exclusions, as well as state and federal law, must be considered in determining eligibility for coverage. Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information. Likewise, medical policy, which addresses the issue(s) in any specific case, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and the Company reserves the right to review and update medical policy periodically.