

Hospice Care

Policy Number: AD0330

Active policy, not scheduled for routine review.

Definition:

Hospice care is palliative care rendered at home to the terminally ill patient by a licensed hospice provider. A comprehensive program of care for terminally ill persons provided on a 24-hour, seven days per week basis. Hospice is a continuum of palliative, medically necessary, and supportive care, directed by the patient's physician and coordinated by the hospice care team.

Coverage:

Effective July 1, 1997, benefits are available for hospice services provided by contracting hospice agencies as outlined in the Blue Cross Blue Shield of North Carolina Contracting Hospice Agreement; covered hospice care includes, but is not limited to:

- a. nursing care
- b. home health aide services
- c. social work services
- d. pastoral services
- e. volunteer support
- f. bereavement services
- g. counseling services
- h. nutrition services
- i. all drugs, medical supplies and equipment related to the terminal illness
- j. speech therapy
- k. occupational therapy
- l. physical therapy
- m. in-home lab fees
- n. durable medical equipment
- o. educational services
- p. respite services

Approval Procedures:

1. Prior approval is required.
2. A written request for prior approval must be submitted to the Medical Review section immediately upon acceptance of the patient by the hospice provider.
3. A certification of life expectancy of six (6) months or less, and a referral and treatment plan, must be signed and dated by the referring physician and submitted with the request for prior approval.
4. Documentation must include:
 - a. Member identification number
 - b. Patient's mailing address
 - c. Medical diagnosis, including date of onset
 - d. Patient's date of birth
 - e. Proposed frequency of services
 - f. Proposed duration of services
 - g. Proposed services to be rendered

h. Name and license number of agency providing care

5. To ensure both the provider and the member know whether the service will be covered, the Medical Review section will respond to the request by letter.

Limitations and Exclusion:

1. The hospice agency must be licensed by the state or show proof that application is pending to qualify for payment.
2. The patient must have a life expectancy of six (6) months or less, certified by the attending physician.
3. Respite care is covered only under the contracted per diem for hospice services. Additional respite care services over and above the contracted amount are non-covered.
4. Bereavement or grief counseling after the patient's death is not covered.
5. Medically necessary care is defined as being:
 - a. consistent with symptoms or diagnosis and treatment of condition, illness, or injury
 - b. provided for purpose of restoring physiologic function
 - c. not considered to be investigational
6. Per diem rate includes all services provided directly by hospice provider and also services provided indirectly through subcontracting arrangement with other providers including all areas listed under coverage.
7. Continuous home care (a minimum of 8 hours a day of which 4 hours must be skilled nursing services) is only furnished during brief periods of crises to maintain the terminally ill patient at home.
8. Hospice services must be provided by contracting hospice agencies at the contracted per diem rate.
9. Non-contracting hospice agency services will be reimbursed at 75% of the contracting per diem rates.
10. The patient cannot receive concurrent benefits for hospice care and home health care or inpatient care.

Source:

G.S. 135-42(b)

G.S. 108A-70.21(b)

G.S. 135-40.1(7.1) (statute effective through 06/30/2008 for Predecessor Plan)

G.S. 135-40.6(8)q (statute effective through 06/30/2008 for Predecessor Plan)

G.S. 135-40.7(16a) (statute effective through 06/30/2008 for Predecessor Plan)

Contracting Hospice Agreement

Complete Review of Policy:

December 1989

March 2005

Revised:

June 1998

July 2004

December 2008