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1.0 Description of the Procedure, Product, or Service

Hospice care is palliative care rendered at home to the terminally ill recipient by a licensed hospice provider. Hospice is 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 recipient's physician and coordinated by the hospice care team.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

NCHC covers hospice when the following criteria are met:

- a. The recipient must have a life expectancy of six (6) months or less, certified by the attending physician.
- b. Services provided must be medically necessary care. Medically necessary care is defined as being:
 1. consistent with symptoms or diagnosis and treatment of condition, illness, or injury;
 2. provided for purpose of restoring physiologic function; and
 3. not considered to be investigational.

3.3 Covered Hospice Care

Covered hospice care includes:

- 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.

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

Hospice care is not covered for the following

- a. Respite care is covered only under the contracted per diem for hospice services. Additional respite care services over and above the contracted amount are not covered.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. Prior approval is required for hospice care.
- b. A written request for prior approval shall be submitted to DMA's vendor immediately upon acceptance of the recipient by the hospice provider.
- c. A certification of life expectancy of six (6) months or less, a referral and treatment plan shall be signed and dated by the referring physician and submitted with the request for prior approval.
- d. Documentation must include:
 1. Recipient demographics, including name, address, NCHC ID, date of birth
 2. Medical diagnosis, including date of onset
 3. Proposed services to be rendered
 4. Proposed frequency of services
 5. Proposed duration of services
 6. The name and license number of the agency providing care

5.2 Limitations

- a. 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 recipient at home.
- b. The recipient cannot receive concurrent benefits for hospice care and home health care or inpatient care.
- c. Hospice services must be provided by contracting hospice agencies at the contracted per-diem rate.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

The hospice agency must be licensed by the state or show proof that application is pending to qualify for payment.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010		Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

Revenue Codes				
650	651	652	655	656
657	658	659		

Claims for hospice services will deny if prior approval is not obtained.

Recipient must first be enrolled in home hospice to qualify for inpatient services below.

Inpatient Respite Care: Recipient admitted for no greater than 5 days for relief to the regular family caregivers. Revenue code 655

General Inpatient Care: Recipient admitted for round-the-clock care. Short-term--not intended as permanent solution when recipient doesn't have a caregiver at home. Revenue code 656

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

- a. Per diem rate includes all services provided directly by hospice provider and also services provided indirectly through subcontracting arrangements with other providers including all areas listed under coverage.
- b. Non contracting hospice agency services will be reimbursed at 75% of the contracting per diem rates.

F. Place of Service

Home

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

H. Reimbursement

Providers must bill their usual and customary charges.