

Medical Policy



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BCN Policy Effective Date: 7/14/26
(See policy history boxes for previous effective dates)

Title: Hospice Care

Description/Background

Hospice care is designed to provide comfort and support to individuals and their families when a life-limiting illness no longer responds to cure-oriented treatments. Hospice care does not prolong life or hasten death. The hospice staff offers specific medical knowledge, especially palliative care and pain management. Their goal is to improve the individual's quality of life during their last days and offer comfort and dignity to both the individual and family.

Hospice is not a place but a concept of care. Most commonly, hospice care is provided in the individual's or family member's home. Care is provided by a team oriented to dealing with the emotional, social and spiritual impact of the disease on the individual and the individual's family.

The member is evaluated by the hospice staff and placed at the appropriate level of care with BCN approval. Hospice care is provided at the following levels of intensity:

- Routine (hospice) home care – consists of services provided intermittently to members who are living at home or in a long-term care facility.
- Continuous (hospice) home care – consists of providing intensive service, usually by the nursing staff, for a minimum of eight hours/day to address acute medical symptoms for a member who wishes to stay at home.
- Respite (hospice) care – provides a brief “rest period” for the primary caregiver, limited to five consecutive days, by admitting the individual to an institutional setting without meeting “inpatient” or “skilled care” criteria. This is usually provided in an extended care facility (ECF) or inpatient hospice facility. Respite is provided only on an intermittent, non-routine basis and usually not more than twice during the individual's time in hospice care. Respite hospice care benefits the primary caregiver who may become ill, injured, exhausted or have a special need. Respite care includes coverage for room 'nd board.

- General inpatient (hospice) care – consists of inpatient services for symptom control or for family breakdown that cannot be managed in a less-intensive setting. This level of care is usually reserved for the active dying process. The care may be provided by one of the following facilities:

- Hospice inpatient unit,
- Hospital contracted with the member's specified hospice, or
- Skilled nursing facility contracted with the member's specified hospice

Note: Room and board are covered while the member is receiving approved general inpatient hospice care, regardless of the location.

Hospice care is provided as a global program and may include any of the following services:

- Professional visits (such as physician, nursing, social work, home-health aide and physical therapy).
- Durable medical equipment (DME) related to the terminal illness
- Medications related to the terminal illness (e.g., pain medications, anti-emetics)
- Medical/surgical supplies related to the terminal illness

Regulatory Status:

N/A

Medical Policy Statement

Hospice is an established form of specialized care for terminally ill individuals. A member is eligible for hospice care when a physician certifies the member has a life-limiting disease with an estimated life expectancy of 6 months or less. A member elects to receive hospice care by filing an election statement with a BCN contracted hospice program.

In electing hospice services the member acknowledges that:

- All care is to be directed by the designated hospice.
- Care is designed to alleviate or reduce physical and psychosocial symptoms of the terminal illness. Palliative radiation and some chemotherapy (usually oral) may be delivered while receiving hospice care.
- No further treatment to cure the disease will be offered as long as the member is in the hospice program. In the event life-saving technology becomes available and the member elects to pursue treatment, the member must revoke hospice care.
- Benefits for conditions not related to the terminal illness are maintained.

In the event the member presents for care without hospice direction and the care is determined to be curative or resuscitative in nature, the member or designee must sign a revocation of the hospice election benefit. The member may re-elect hospice benefits at a later date, when the member and family are again ready to elect comfort care only.

Inclusionary and Exclusionary Guidelines

Inclusions:

Hospice services must be delivered by a BCN contracted provider.

- All care is to be directed by the designated hospice.
- Written certification by the physician that the member has a life-limiting disease with a life expectancy of 6 months or less.

NOTE: life expectancy criteria is outlined in joint Clinical Practice Guidelines for Quality Palliative Care (joint guidelines of the National Consensus Project for Quality Palliative Care and the National Coalition for Hospice and Palliative Care [2018]).³

Medicare defines applicable criteria (decline in clinical status guidelines; non-disease specific and disease specific guidelines) in the Local Coverage Determination document, under the "Indications" section. Karnofsky Performance Status or Palliative Performance Scale thresholds vary based on condition.

KARNOFSKY PERFORMANCE STATUS SCALE DEFINITIONS RATING (%) CRITERIA

Able to carry on normal activity and to work; no special care needed.	100	Normal no complaints; no evidence of disease.
	90	Able to carry on normal activity; minor signs or symptoms of disease.
	80	Normal activity with effort; some signs or symptoms of disease.
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.	70	Cares for self; unable to carry on normal activity or to do active work.
	60	Requires occasional assistance, but is able to care for most of his personal needs.
	50	Requires considerable assistance and frequent medical care.
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.	40	Disabled; requires special care and assistance.
	30	Severely disabled; hospital admission is indicated although death not imminent.
	20	Very sick; hospital admission necessary; active supportive treatment necessary.
	10	Moribund; fatal processes progressing rapidly.
	0	Dead

- The member may receive hospice services for greater than 6 months when recertified by their physician.

- Care is designed to alleviate or reduce physical and psychosocial symptoms of the terminal illness. Palliative radiation and some chemotherapy (usually oral) may be delivered while receiving hospice care.
- No further treatment designed to cure the disease will be offered as long as the member is in the Hospice program. In the event life-saving technology becomes available and the member elects to pursue treatment, the member must revoke hospice care.
- Benefits for conditions not related to the terminal illness are maintained.

NOTE: Room and board are covered while the member is receiving approved general inpatient hospice care regardless of the location.

Exclusions:

These services may be included in hospice care but are not separately reimbursable:

- Housekeeping, homemaker and chore services
- Food, food supplements and home delivered meals
- Room and board at an extended care facility or hospice facility for purposes of delivering routine home hospice care

Note: Please refer to member's specific certificate for coverage.

CPT/HCPCS Level II Codes *(Note: The inclusion of a code in this list is not a guarantee of coverage. Please refer to the medical policy statement to determine the status of a given procedure)*

Established codes:

0651	0652	0655	0656	0657
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Other codes (investigational, not medically necessary, not a benefit, etc.):

N/A

Rationale

Hospice is an established form of specialized care for terminally ill individuals and has been recognized by Medicare since 1982. Hospice is a standard of care for those individuals who elect palliative rather than curative care for a terminal illness.

Government Regulations

National:

Medicare Benefit Manual 100-02

Chapter 9 Coverage of Hospice Services Under Hospital Insurance (Rev. 13664, Issued: 03-05-26)

Hospice care is a benefit under the hospital insurance program. To be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is 6 months or less if the illness runs its normal course. Only care provided by (or under arrangements made by) a Medicare certified hospice is covered under the Medicare hospice benefit.

The hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician (if any).

In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:

- (1) Diagnosis of the terminal condition of the patient.
- (2) Other health conditions, whether related or unrelated to the terminal condition.
- (3) Current clinically relevant information supporting all diagnoses.

Section 1814(a)(7) of the Social Security Act (the Act) specifies that certification of terminal illness for hospice benefits shall be based on the clinical judgment of the hospice medical director or the physician member of the interdisciplinary group (IDG) and the individual's attending physician if he/she has one, regarding the normal course of the individual's illness. No one other than a medical doctor or doctor of osteopathy can certify or re-certify a terminal illness. Predicting of life expectancy is not always exact. The fact that a beneficiary lives longer than expected in itself is not cause to terminate benefits. "Attending physician" is further defined in Section 20.1 and 40.1.3.1.

An individual (or his authorized representative) must elect hospice care to receive it. The first election is for a 90-day period. An individual may elect to receive Medicare coverage for two 90-day periods, and an unlimited number of 60-day periods. If the individual (or authorized representative) elects to receive hospice care, he or she must file an election statement with a particular hospice. Hospices obtain election statements from the individual and file a Notice of Election with the Medicare contractor, which transmits them to the Common Working File (CWF) in electronic format. Once the initial election is processed, CWF maintains the beneficiary in hospice status until a final claim indicates a discharge (alive or due to death) or until an election termination is received.

For the duration of the election of hospice care, an individual must waive all rights to Medicare payments for the following services:

- Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice); and
- Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition, or services that are equivalent to hospice care, except for services provided by:
 1. The designated hospice (either directly or under arrangement);
 2. Another hospice under arrangements made by the designated hospice; or

3. The individual's attending physician, who may be a nurse practitioner (NP) or a physician assistant (PA), if that physician, NP, or PA is not an employee of the designated hospice or receiving compensation from the hospice for those services.

Medicare services for a condition completely unrelated to the terminal condition for which hospice was elected remain available to the patient if he or she is eligible for such care.

[See the entire chapter for specific information regarding certification, election requirements, revocation and discharge.]

Local:

**National Government Services, Inc., 06004 – HHH MAC
Local Coverage Determination Hospice – Determining Terminal Status (L33393)
Effective date 10/01/2015; Revision date 11/14/2019**

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Medicare coverage of hospice depends on a physician's certification that an individual's prognosis is a life expectancy of six months or less if the terminal illness runs its normal course. This LCD describes guidelines to be used by National Government Services (NGS) in reviewing hospice claims and by hospice providers to determine eligibility of beneficiaries for hospice benefits. Although guidelines applicable to certain disease categories are included, this LCD is applicable to all hospice patients. It is intended to be used to identify any Medicare beneficiary whose current clinical status and anticipated progression of disease is more likely than not to result in a life expectancy of six months or less.

Clinical variables with general applicability without regard to diagnosis, as well as clinical variables applicable to a limited number of specific diagnoses, are provided. Patients who meet the guidelines established herein are expected to have a life expectancy of six months or less if the terminal illness runs its normal course. Some patients may not meet these guidelines, yet still have a life expectancy of six months or less. Coverage for these patients may be approved if documentation otherwise supporting a less than six-month life expectancy is provided.

Section 322 of BIPA amended section 1814(a) of the Social Security Act by clarifying that the certification of an individual who elects hospice "shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness." The amendment clarified that the certification is based on a clinical judgment regarding the usual course of a terminal illness and recognizes the fact that making medical prognostications of life expectancy is not always exact.

However, the amendment regarding the physician's clinical judgment does not negate the fact that there must be a basis for a certification. A hospice needs to be certain that the physician's clinical judgment can be supported by clinical information and other documentation that provide a basis for the certification of 6 months or less "f the illness runs its normal course.

If a patient improves and/or stabilizes sufficiently over time while in hospice such that he/she no

longer has a prognosis of six months or less from the most recent recertification evaluation or definitive interim evaluation, that patient should be considered for discharge from the Medicare hospice benefit. Such patients can be re-enrolled for a new benefit period when a decline in their clinical status is such that their life expectancy is again six months or less. On the other hand, patients in the terminal stage of their illness who originally qualify for the Medicare 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 months, remain eligible for hospice care.

Indications

A patient will be considered to have a life expectancy of six months or less if he/she meets the non-disease specific **“Decline in clinical status”** guidelines described in Part I. Alternatively, the baseline non-disease specific guidelines described in Part II plus the applicable disease specific guidelines listed in Part III will establish the necessary expectancy.

Part I. Decline in clinical status guidelines

Patients will be considered to have a life expectancy of six months or less if there is documented evidence of decline in clinical status based on the guidelines listed below. Since determination of decline presumes assessment of the patient’s status over time, it is essential that both baseline and follow-up determinations be reported where appropriate. Baseline data may be established on admission to hospice or by using existing information from records. Other clinical variables not on this list may support a six-month or less life expectancy. These should be documented in the clinical record.

These changes in clinical variables apply to patients whose decline is not considered to be reversible. They are examples of findings that generally connote a poor prognosis. However, some are clearly more predictive of a poor prognosis than others; significant ongoing weight loss is a strong predictor, while decreased functional status is less so.

- A. Progression of disease as documented by worsening clinical status, symptoms, signs and laboratory results.

Clinical Status:

- a. Recurrent or intractable serious infections such as pneumonia, sepsis or pyelonephritis;
- b. Progressive inanition as documented by:
 - 1. Weight loss of at least 10% body weight in the prior six months, not due to reversible causes such as depression or use of diuretics;
 - 2. Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics;
 - 3. Observation of ill-fitting clothes, decrease in skin turgor, increasing skin folds or other observation of weight loss in a patient without documented weight;
 - 4. Decreasing serum albumin or cholesterol.

5. Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption.

Symptoms:

- a. Dyspnea with increasing respiratory rate;
- b. Cough, intractable;
- c. Nausea/vomiting poorly responsive to treatment;
- d. Diarrhea, intractable;
- e. Pain requiring increasing doses of major analgesics more than briefly.

Signs:

- a. Decline in systolic blood pressure to below 90 or progressive postural hypotension;
- b. Ascites;
- c. Venous, arterial or lymphatic obstruction due to local progression or metastatic disease;
- d. Edema;
- e. Pleural/pericardial effusion;
- f. Weakness;
- g. Change in level of consciousness.

Laboratory (When available. Lab testing is not required to establish hospice eligibility.):

- a. Increasing pCO₂ or decreasing pO₂ or decreasing SaO₂;
- b. Increasing calcium, creatinine or liver function studies;
- c. Increasing tumor markers (e.g. CEA, PSA);
- d. Progressively decreasing or increasing serum sodium or increasing serum potassium.

- B. Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) due to progression of disease.
- C. Progressive decline in Functional Assessment Staging (FAST) for dementia (from 7A on the FAST).
- D. Progression to dependence on assistance with additional activities of daily living (see Part II, Section 2).
- E. Progressive stage 3-4 pressure ulcers in spite of optimal care.
- F. History of increasing ER visits, hospitalizations, or physician visits related to the hospice primary diagnosis prior to election of the hospice benefit.

Part II. Non-disease specific baseline guidelines (both A and B should be met)

- A. Physiologic impairment of functional status as demonstrated by: Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) < 70%. Note that two of the disease specific guidelines (HIV Disease, Stroke and Coma) establish a lower qualifying KPS or PPS.
- B. Dependence on assistance for two or more activities of daily living (ADLs):
 1. Ambulation;
 2. Continence;
 3. Transfer;
 4. Dressing;
 5. Feeding;
 6. Bathing.

- C. Co-morbidities – although not the primary hospice diagnosis, the presence of disease such as the following, the severity of which is likely to contribute to a life expectancy of six months or less, should be considered in determining hospice eligibility.
1. Chronic obstructive pulmonary disease
 2. Congestive heart failure
 3. Ischemic heart disease
 4. Diabetes mellitus
 5. Neurologic disease (CVA, ALS, MS, Parkinson's)
 6. Renal failure
 7. Liver Disease
 8. Neoplasia
 9. Acquired immune deficiency syndrome
 10. Dementia
 11. Acquired Immune Deficiency Syndrome/HIV
 12. Refractory severe autoimmune disease (e.g. Lupus or Rheumatoid Arthritis)
- D. See Part III for disease specific guidelines to be used with these baseline guidelines. The baseline guidelines do not independently qualify a patient for hospice coverage.

Note: The word “should” in the disease specific guidelines means that on medical review the guideline so identified will be given great weight in making a coverage determination. It does not mean, however, that meeting the guideline is required. The only requirement is that the documentation supports the beneficiary's prognosis of six months or less, if the illness runs its normal course.

Part III. Disease Specific Guidelines

Note: These guidelines are to be used in conjunction with the “Non-disease specific baseline guidelines” described in Part II.

Cancer Diagnoses

- A. Disease with metastases at presentation **OR**
- B. Progression from an earlier stage of disease to metastatic disease with either:
1. A continued decline in spite of therapy; or
 2. Patient declines further disease directed therapy.

Note: Certain cancers with poor prognoses (e.g., small cell lung cancer, brain cancer and pancreatic cancer) may be hospice eligible without fulfilling the other criteria in this section.

Non-Cancer Diagnoses

Amyotrophic Lateral Sclerosis

General Considerations:

1. ALS tends to progress in a linear fashion over time. Thus the overall rate of decline in each patient is fairly constant and predictable, unlike many other non-cancer diseases.
2. However, no single variable deteriorates at a uniform rate in all patients. Therefore, multiple clinical parameters are required to judge the progression of ALS.
3. Although ALS usually presents in a localized anatomical area, the location of initial presentation does not correlate with survival time. By the time patients become end-

stage, muscle denervation has become widespread, affecting all areas of the body, and initial predominance patterns do not persist.

4. Progression of disease differs markedly from patient to patient. Some patients decline rapidly and die quickly; others progress more slowly. For this reason, the history of the rate of progression in individual patients is important to obtain to predict prognosis.
5. In end-state ALS, two factors are critical in determining prognosis: ability to breathe, and to a lesser extent ability to swallow. The former can be managed by artificial ventilation, and the latter by gastrostomy or other artificial feeding, unless the patient has recurrent aspiration pneumonia. While not necessarily a contraindication to Hospice care, the decision to institute either artificial ventilation or artificial feeding may significantly alter six month prognosis.
6. Examination by a neurologist within three months of assessment for hospice is advised, both to confirm the diagnosis and to assist with prognosis.

Patients are considered eligible for Hospice care if they do not elect tracheostomy and invasive ventilation and display evidence of critically impaired respiratory function (with or without use of NIPPV) and / or severe nutritional insufficiency (with or without use of a gastrostomy tube).

Critically impaired respiratory function is as defined by:

1. FVC < 40% predicted (seated or supine) and 2 or more of the following symptoms and/or signs:
 - Dyspnea at rest;
 - Orthopnea;
 - Use of accessory respiratory musculature;
 - Paradoxical abdominal motion;
 - Respiratory rate > 20;
 - Reduced speech / vocal volume;
 - Weakened cough;
 - Symptoms of sleep disordered breathing;
 - Frequent awakening;
 - Daytime somnolence / excessive daytime sleepiness;
 - Unexplained headaches;
 - Unexplained confusion;
 - Unexplained anxiety;
 - Unexplained nausea.
2. If unable to perform the FVC test patients meet this criterion if they manifest 3 or more of the above symptoms/signs.

Severe nutritional insufficiency is defined as:

Dysphagia with progressive weight loss of at least five percent of body weight with or without election for gastrostomy tube insertion.

These revised criteria rely less on the measured FVC, and as such reflect the reality that not all patients with ALS can or will undertake regular pulmonary function tests.

Dementia due to Alzheimer's Disease and Related Disorders

Patients will be considered to be in the terminal stage of dementia (life expectancy of six months or less) if they meet the following criteria.

1. Patients with dementia should show all the following characteristics:
 - a. Stage seven or beyond according to the Functional Assessment Staging Scale;
 - b. Unable to ambulate without assistance;
 - c. Unable to dress without assistance;
 - d. Unable to bathe without assistance;
 - e. Urinary and fecal incontinence, intermittent or constant;
 - f. No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words.
2. Patients should have had one of the following within the past 12 months:
 - a. Aspiration pneumonia;
 - b. Pyelonephritis;
 - c. Septicemia;
 - d. Decubitus ulcers, multiple, stage 3-4;
 - e. Fever, recurrent after antibiotics;
 - f. Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin < 2.5 gm/dl.

Note: This section is specific for Alzheimer's disease and Related Disorders, and is not appropriate for other types of dementia.

Heart Disease

Patients will be considered to be in the terminal stage of heart disease (life expectancy of six months or less) if they meet the following criteria. (1 and 2 should be present. Factors from 3 will add supporting documentation.)

1. At the time of initial certification or recertification for hospice, the patient is or has been already optimally treated for heart disease, or are patients who are either not candidates for surgical procedures or who decline those procedures. (Optimally treated means that patients who are not on vasodilators have a medical reason for refusing these drugs, e.g., hypotension or renal disease.)
2. Patients with congestive heart failure or angina should meet the criteria for the New York Heart Association (NYHA) Class IV. (Class IV patients with heart disease have an inability to carry on any physical activity. Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.) Significant congestive heart failure may be documented by an ejection fraction of less than or equal to 20%, but is not required if not already available.
3. Documentation of the following factors will support but is not required to establish eligibility for hospice care:
 - a. Treatment-resistant symptomatic supraventricular or ventricular arrhythmias;
 - b. History of cardiac arrest or resuscitation;
 - c. History of unexplained syncope;
 - d. Brain embolism of cardiac origin;
 - e. Concomitant HIV disease.

HIV Disease

Patients will be considered to be in the terminal stage of their illness (life expectancy of six

months or less) if they meet the following criteria. (1 and 2 should be present; factors from 3 will add supporting documentation.)

1. CD4+ Count < 25 cells/mcl or persistent (2 or more assays at least one month apart) viral load >100,000 copies/ml, plus one of the following:
 - a. CNS lymphoma;
 - b. Untreated, or persistent despite treatment, wasting (loss of at least 10% lean body mass);
 - c. Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment, or treatment refused;
 - d. Progressive multifocal leukoencephalopathy;
 - e. Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy;
 - f. Visceral Kaposi's sarcoma unresponsive to therapy;
 - g. Renal failure in the absence of dialysis;
 - h. Cryptosporidium infection;
 - i. Toxoplasmosis, unresponsive to therapy.
2. Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale, of less than or equal to 50%.
3. Documentation of the following factors will support eligibility for hospice care:
 - a. Chronic persistent diarrhea for one year;
 - b. Persistent serum albumin < 2.5;
 - c. Concomitant, active substance abuse;
 - d. Age > 50 years;
 - e. Absence of or resistance to effective antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease;
 - f. Advanced AIDS dementia complex;
 - g. Toxoplasmosis;
 - h. Congestive heart failure, symptomatic at rest;
 - i. Advanced liver disease.

Liver Disease

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 should 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/dl.
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 (< 400 ml/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.

Pulmonary Disease

Patients will be considered to be in the terminal stage of pulmonary disease (life expectancy of six months or less) if they meet the following criteria. The criteria refer to patients with various forms of advanced pulmonary disease who eventually follow a final common pathway for end stage pulmonary disease. (1 and 2 should be present. Documentation of 3, 4, and 5, will lend supporting documentation.)

1. Severe chronic lung disease as documented by both a and b:
 - a. Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough; (Documentation of Forced Expiratory Volume in One Second (FEV1), after bronchodilator, less than 30% of predicted is objective evidence for disabling dyspnea, but is not necessary to obtain.)
 - b. Progression of end stage pulmonary disease, as evidenced by increasing visits to the emergency department or hospitalizations for pulmonary infections and/or respiratory failure or increasing physician home visits prior to initial certification. (Documentation of serial decrease of FEV1>40 ml/year is objective evidence for disease progression, but is not necessary to obtain.)
2. Hypoxemia at rest on room air, as evidenced by pO2 less than or equal to 55 mmHg, or oxygen saturation less than or equal to 88%, determined either by arterial blood gases or oxygen saturation monitors, (these values may be obtained from recent hospital records) OR hypercapnia, as evidenced by pCO2 greater than or equal to 50 mmHg. (This value may be obtained from recent [within 3 months] hospital records.)
3. Right heart failure (RHF) secondary to pulmonary disease (Cor pulmonale) (e.g., not secondary to left heart disease or valvulopathy).
4. Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.
5. Resting tachycardia > 100/min.

Renal Disease

Patients will be considered to be in the terminal stage of renal disease (life expectancy of six months or less) if they meet the following criteria.

Acute Renal Failure (1 and either 2, 3 or 4 should be present. Factors from 5 will lend supporting documentation.)

1. The patient is not seeking dialysis or renal transplant, or is discontinuing dialysis. As with any other condition, an individual with renal disease is eligible for the Hospice benefit if that individual has a prognosis of six months or less, if the illness runs its normal course. There is no regulation precluding patients on dialysis from electing Hospice care. However, the continuation of dialysis will significantly alter a patient's prognosis, and

thus potentially impact that individual's eligibility.

When an individual elects Hospice care for end stage renal disease (ESRD) or for a condition to which the need for dialysis is related, the Hospice agency is financially responsible for the dialysis. In such cases, there is no additional reimbursement beyond the per diem rate. The only situation in which a beneficiary may access both the Hospice benefit and the ESRD benefit is when the need for dialysis is not related to the patient's terminal illness.

2. Creatinine clearance < 10 cc/min (<15 cc/min. for diabetics); or < 15cc/min (< 20cc/min for diabetics) with comorbidity of congestive heart failure.
3. Serum creatinine > 8.0 mg/dl (>6.0 mg/dl for diabetics).
4. Estimated glomerular filtration rate (GFR) <10 ml/min.
5. Comorbid conditions:
 - a. Mechanical ventilation;
 - b. Malignancy (other organ system);
 - c. Chronic lung disease;
 - d. Advanced cardiac disease;
 - e. Advanced liver disease;
 - f. Immunosuppression/AIDS;
 - g. Albumin < 3.5 gm/dl;
 - h. Platelet count < 25,000;
 - i. Disseminated intravascular coagulation;
 - j. Gastrointestinal bleeding.

Chronic Kidney Disease (1 and either 2, 3 or 4 should be present. Factors from 5 will lend supporting documentation.)

1. The patient is not seeking dialysis or renal transplant, or is discontinuing dialysis; As with any other condition, an individual with renal disease is eligible for the Hospice benefit if that individual has a prognosis of six months or less, if the illness runs its normal course. There is no regulation precluding patients on dialysis from electing Hospice care. However, the continuation of dialysis will significantly alter a patient's prognosis, and thus potentially impact that individual's eligibility.

When an individual elects Hospice care for end stage renal disease (ESRD) or for a condition to which the need for dialysis is related, the Hospice agency is financially responsible for the dialysis. In such cases, there is no additional reimbursement beyond the per diem rate. The only situation in which a beneficiary may access both the hospice benefit and the ESRD benefit is when the need for dialysis is not related to the patient's terminal illness.

2. Creatinine clearance <10 cc/min (< 15 cc/min for diabetics); or < 15cc/min (< 20cc/min for diabetics) with comorbidity of congestive heart failure.
3. Serum creatinine > 8.0 mg/dl (>6.0 mg/dl for diabetics).
4. Signs and symptoms of renal failure:
 - a. Uremia;
 - b. Oliguria (< 400 cc/24 hours);
 - c. Intractable hyperkalemia (> 7.0) not responsive to treatment;

- d. Uremic pericarditis;
 - e. Hepatorenal syndrome;
 - f. Intractable fluid overload, not responsive to treatment.
5. Estimated glomerular filtration rate (GFR) <10 ml/min.

Stroke and Coma

Patients will be considered to be in the terminal stages of stroke or coma (life expectancy of six months or less) if they meet the following criteria:

Stroke

1. Karnofsky Performance Status (KPS) or Palliative Performance Scale (PPS) of < 40% .
2. Inability to maintain hydration and caloric intake with one of the following:
 - a. Weight loss > 10% in the last 6 months or > 7.5% in the last 3 months;
 - b. Serum albumin < 2.5 gm/dl;
 - c. Current history of pulmonary aspiration not responsive to speech language pathology intervention; Sequential calorie counts documenting inadequate caloric/fluid intake;
 - d. Dysphagia severe enough to prevent patient from continuing fluids/foods necessary to sustain life and patient does not receive artificial nutrition and hydration.

Coma (any etiology):

1. Comatose patients with any 3 of the following on day three of coma:
 - a. abnormal brain stem response;
 - b. absent verbal response;
 - c. absent withdrawal response to pain;
 - d. serum creatinine > 1.5 mg/dl.
2. Documentation of the following factors will support eligibility for hospice care:
 - a. Documentation of medical complications, in the context of progressive clinical decline, within the previous 12 months, which support a terminal prognosis:
 1. Aspiration pneumonia;
 2. Pyelonephritis;
 3. Refractory stage 3-4 decubitus ulcers;
 4. Fever recurrent after antibiotics.
3. Documentation of diagnostic imaging factors which support poor prognosis after stroke include:
 - a. For non-traumatic hemorrhagic stroke:
 1. Large-volume hemorrhage on CT:
 - a. Infratentorial: greater than or equal to 20 ml.;
 - b. Supratentorial: greater than or equal to 50 ml.
 2. Ventricular extension of hemorrhage;
 3. Surface area of involvement of hemorrhage greater than or equal to 30% of cerebrum;
 4. Midline shift greater than or equal to 1.5 cm.;
 5. Obstructive hydrocephalus in patient who declines, or is not a candidate for, ventriculoperitoneal shunt.

- b. For thrombotic/embolic stroke:
 - 1. Large anterior infarcts with both cortical and subcortical involvement;
 - 2. Large bihemispheric infarcts;
 - 3. Basilar artery occlusion;
 - 4. Bilateral vertebral artery occlusion.

National Government Services, Inc., 06004 – HHH MAC
Local Coverage Article: Billing and Coding: Hospice: Determining Terminal Status (A52830)
Effective date 10/01/2015; Revision date 11/14/2019

Please see this article for billing and coding information.

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

Home Health Care

References

1. Centers for Medicare and Medicaid Services (CMS). Medicare Benefit Policy Manual, Chapter 9, Coverage of Hospice Services Under Hospital Insurance. Revised 12696: 03/02/26. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c09.pdf> Accessed 5/28/26.
2. Centers for Medicare and Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 11, Processing Hospice Claims, Section 30 Billing and Payment for General Hospice Services. Revised 04/24/25. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf> Accessed 5/28/26.
3. National Consensus Project for Quality Palliative Care: Clinical Practice Guidelines for Quality Palliative Care, 4th edition (2018) <https://www.nationalcoalitionhpc.org/ncp/> Accessed 5/28/26.
4. National Government Services, Inc. Local Coverage Determination. Hospice – Determining Terminal Status, L33393, Effective date 10/01/2015; Revision date 11/14/2019.
5. National Government Services, Inc. Local Coverage Article. Billing and Coding Hospice: Determining Terminal Status, A52830, Effective date 10/01/2015; Revision date 11/14/2019.
6. The National Hospice Organization. Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases. 1999. http://paliativossinfronteras.org/wp-content/uploads/THE-NHO-MEDICAL-GUIDELINES-FOR-NON-CANCER-DISEASES_1.pdf Accessed 5/28/26.

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 5/28/26, the date the research was completed.

BCN Medical Policy History

Date	Rationale
11/05/01	Original policy
7/26/04	Routine maintenance update
8/15/05	Routine maintenance
09/24/06	Routine maintenance
10/27/07	Routine maintenance
10/15/08	Routine maintenance
11/2/09	Routine maintenance
11/17/10	Routine maintenance
3/16/11	Routine maintenance
3/21/12	Routine maintenance
3/20/13	Routine maintenance
11/19/14	Routine maintenance
11/18/15	Routine maintenance
11/16/16	Routine maintenance
11/15/17	Routine maintenance
11/14/18	Routine maintenance
9/24/19	Routine maintenance
7/9/20	Routine maintenance
7/15/21	Routine maintenance
7/7/22	Routine maintenance
7/13/23	Routine maintenance (jf) Vendor Managed: NA
7/11/24	Routine maintenance (jf)

	Vendor Managed: NA
7/10/25	Routine maintenance (jf) Vendor Managed: NA
7/14/26	Routine maintenance (jf) Vendor Managed: NA, retire policy

Next Review: NA/ Policy Retired

RETIRED

MEDICAL POLICY TITLE: HOSPICE CARE BCN BENEFIT ADMINISTRATION

I. Coverage Determination

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Hospice care is a benefit under all BCN certificates when the patient meets the criteria listed in this policy. Copayments and deductibles may apply.
BCNA (Medicare Advantage)	Management of hospice care reverts back to Medicare when a BCNA member elects hospice care.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.

II. Administrative Guidelines

- The member's contract must be active at the time the service is rendered.
- Coverage is based on each member's certificate and is not guaranteed. Please consult the member's certificate for details. Additional information regarding coverage or benefits may also be obtained through customer or provider inquiry services at BCN.
- The service must be authorized by the member's PCP except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Services must be performed by a BCN-contracted provider, if available, except for Self-Referral Option (SRO) members seeking Tier 2 coverage.
- Payment is based on BCN payment rules, individual certificate and certificate riders.
- Appropriate copayments will apply. Refer to certificate and applicable riders for detailed information.
- CPT - HCPCS codes are used for descriptive purposes only and are not a guarantee of coverage.