



# Hospice Payment Policy

## Policy

### **Commercial (as defined herein)**

FCHP will reimburse hospice services provided to commercial plan members, subject to the terms and conditions of the plan member's *Member Handbook/Evidence of Coverage*.

### **Fallon Senior Plan™ (as defined herein)**

Fallon Senior Plan™ members may receive hospice services from any Medicare-certified hospice agency.<sup>1</sup> While a hospice election is in effect for a Fallon Senior Plan member:

1. All Medicare-covered Part A and B services are reimbursed by Medicare Administrative Contractors (A/B MACs), intermediaries and/or carriers, subject to the usual Medicare payment rules. This includes the following services regardless of whether the provider is contracted or is not contracted with Fallon Senior Plan:
  - Hospice services provided by a Medicare-certified hospice.
  - Services provided by the member's designated attending physician, if the physician is not employed by or under contract with the hospice.
  - Services not related to the terminal condition while the hospice election is in effect.
  - Services provided to the Plan member after revocation or expiration of a hospice election until the first day of the month following the month during which the hospice election was revoked.
2. FCHP will reimburse the following services, subject to the terms and conditions of the Plan member's *Member Handbook/Evidence of Coverage*:
  - Mandatory supplemental services (i.e., those services provided by Fallon Senior Plan in addition to Medicare-covered Part A and B services), such as routine eye exams.
  - Part D prescription drugs not covered by Medicare under the hospice benefit (to the extent that the drugs are included on the Fallon Senior Plan prescription drug formulary).

A Fallon Senior Plan member may revoke a hospice election at any time. When a Fallon Senior Plan member revokes a hospice election, Fallon Senior Plan will begin reimbursing for all covered services on the first day of the month following the month during which the hospice election was revoked, as long as the member remains enrolled in and continues to pay the monthly premium for Fallon Senior Plan.

## Definitions

**Hospice services** – Palliative and supportive care and other services provided by an interdisciplinary team under the direction of an identifiable hospice administration to terminally ill Plan members (with a limited life expectancy of six months or less) and their families. Services are provided to meet physical, emotional and spiritual needs experienced during the course of the illness, death and bereavement, at home, in the community and in facilities.

**Attending physician** – When hospice coverage is elected, a Plan member may designate an attending physician (who may be the Plan member's PCP) who will have the most significant role in the determination and delivery of the Plan member's medical care, in addition to receiving care from hospice-affiliated physicians.

**Primary caregiver** – A person designated by the patient who is responsible for the patient's care and support in the home on a 24-hour basis.<sup>2</sup>

<sup>1</sup> Some Plan members may choose to disenroll from Fallon Senior Plan when they elect hospice. If plan member chooses to stay enrolled in Fallon Senior Plan while receiving hospice care, he or she must continue to pay the Plan premium.

<sup>2</sup> A primary care giver is not a requirement if the Plan member lives alone and is safe at present. However, the Plan member would need to be willing to make an alternative plan for when they may no longer be safe alone. The hospice agency will accept Hospice Payment Policy  
Policy number ADM0054, effective 11/01/09

**Hospice inpatient facility** – A palliative care facility that cares solely for hospice patients requiring short-term, general inpatient, residential or respite care and is owned and operated directly by a hospice program under the license issued to that program. Hospice inpatient facilities may be referred to as “residential hospice.”

**Inpatient care or services** – Short-term, general inpatient care provided either through a contract arrangement in a hospital or long-term care facility or directly by a hospice program in its hospice inpatient facility to provide pain control and symptom management that cannot be accomplished in the home setting.

**Mandatory supplemental services** – Fallon Senior Plan benefits that are not covered by Original Medicare, but are covered by Fallon Senior Plan for every person enrolled in the Plan. Mandatory supplemental benefits are paid for either in full, directly by, or on behalf of, Fallon Senior Plan enrollees by premiums and cost-sharing.

## **Benefits application**

### **Commercial**

- FCHP Direct Care/FCHP Select Care
- Commonwealth Care
- Companion Care
- FCHP MassHealth
- Major Medical
- Fallon Preferred Care

### **Senior Plan**

- Fallon Senior Plan™
- Fallon Senior Plan Preferred
- Summit ElderCare®

Note: Summit ElderCare manages end-of-life care services for enrolled participants. Please contact Summit ElderCare for more information.

## **Reimbursement**

### **Commercial**

#### *Hospice care*

For each day that a commercial plan member is receiving authorized hospice care, the hospice will be paid a daily rate depending of the level of care provided on that day. FCHP reimburses one level of hospice care per date of service. There are four levels of care:

- Routine home care
- Continuous home care
- Respite care (in-home and inpatient)
- Short-term general inpatient care

The number of units for each level of care is measured in days for routine home care, respite care and short-term general inpatient care. Continuous home care is reimbursed based on the number of hours of skilled nursing care, reported in 15-minute increments (units), that is provided to the Plan member on that day. Payment is based upon the number of 15-minute units that are billed for 32 or more units (i.e., 8 or more hours). Units should be rounded to the nearest 15-minute increment. Rounding to the next whole hour is not allowed.

#### **Routine home care includes all of the following services as defined in 105 CMR 141.204:**

- Physician’s administrative and supervisory services, as defined in 105 CMR 141.204 (C)
- Nursing care provided by or under the direction of a registered nurse

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someone who is safe at home and alone as long as they are agreeable to an alternative plan. This plan could be a hospice residence, long-term care facility, etc.

- Social services
- Volunteer services
- Counseling services
- As needed, the hospice will provide or arrange<sup>3</sup> for the following services:
  - Personal care homemaker
  - Home health aide (also known as hospice aide) services per day
  - Nutritional counseling
  - Physical, occupational and speech therapy
  - Respiratory therapy
  - Durable medical equipment
  - Medical supplies
  - Drugs and biologicals related to the terminal illness regardless of the method of administration for pain relief, symptom control, or hydration.

The routine home care per diem rate is paid for each day the Plan member is at home under the care of a hospice and not receiving continuous home care (continuous home care is defined as 8 or more hours of primarily nursing care provided in a 24-hour period), respite care or short-term general inpatient care.

**Continuous home care (revenue code 0652)** includes all of the services included in routine home care (continuous home care is not reimbursed in addition to routine home care). Continuous home care is covered only during a period of crisis and only as necessary to maintain the terminally ill plan member at home. A period of crisis is a period during which the Plan member requires care that is primarily nursing care to achieve palliation or manage symptoms. Continuous home care is not intended to be used as respite care. A minimum of 8 hours of primarily nursing care must be provided within a 24-hour period which begins and ends at midnight. Nursing care must be provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse. The 8 hours of care does not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of primarily nursing care is required. Homemaker or home health aide services may be provided to supplement nursing care. When fewer than 8 hours of continuous care are required in any day, the services are reimbursed as routine home care rather than continuous home care. Only direct patient care may be reported.

**Respite care** is provided to temporarily relieve the patient's family or other caregiver from unforeseen emergencies or the daily demands of caring for the patient. Respite care may be provided in a Plan member's home, or in an inpatient facility, such as a hospital, long-term care or hospice inpatient facility. Two separate episodes of respite care are covered per calendar year. (The two episodes cannot be concurrent.) Up to seven consecutive days may be authorized per episode. Unused days are forfeited. Reimbursement for any unauthorized respite days will be made at the routine home hospice per diem rate. Respite care is not reimbursed in addition to routine home care.

- **In-home respite care (revenue code 0659)** includes all of the services included in routine home hospice care plus respite labor. Respite labor is provided to replace the services that had been provided by the primary care giver (i.e., primarily homemaker and home health aide services, such as personal care services, household services essential to the member's comfort and hygiene, and maintenance of a safe and healthy home environment). The goal of in-home respite care is to provide temporary relief to the primary caregiver maintaining the Plan member at home.
- **Inpatient respite care (revenue code 0655)** includes all of the services included in routine home care plus room and board. The hospice agency will provide or arrange for inpatient respite care to be provided in a hospital licensed pursuant to MGL Chapter 111 § 51 or in a long-term care facility licensed pursuant to MGL Chapter 111 § 71 with whom the hospice has entered into a written agreement, or in a hospice inpatient facility directly owned and operated

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<sup>3</sup> The hospice agency may arrange for the provision of hospice services on a contract basis. When hospice services are not provided directly by a hospice, a written agreement must define the scope of contracted services and the manner of maintaining continuity of care between those services provided directly by the hospice and services provided by the contractor. When the hospice agency arranges for the provision of hospice services on a contract basis, FCHP will reimburse the hospice agency and the hospice agency will reimburse the contractor.

by the hospice agency. The hospice agency is paid the inpatient respite care rate for each day the member is receiving authorized inpatient respite care. (The hospice agency will reimburse the inpatient facility.)

**Short-term general inpatient care (revenue code 0656)** is covered for the control of pain and management of acute and severe clinical problems that cannot be managed in a home setting. The hospice agency will provide or arrange for short-term inpatient care in hospitals licensed pursuant to MGL Chapter 111 § 51 or in long-term care facilities licensed pursuant to MGL Chapter 111 § 71 with whom the hospice has entered into a written agreement, or in hospice inpatient facilities directly owned and operated by the hospice agency. For the day of discharge from short-term general inpatient care, the appropriate level of home care is reimbursed unless the plan member dies as an inpatient. (Short-term general inpatient care is not reimbursed in addition to any other level of hospice care).

#### *Physician's services*

Reimbursement for physician's services provided in conjunction with the hospice benefit is based on the type of service provided:

- Physician's administrative and supervisory services, as defined in 105 CMR 141.204 (C), are included in the hospice per diem payment.
- Patient care services provided by the Plan member's attending physician<sup>4</sup> that are medically necessary for the treatment or management of a Plan member's terminal illness are separately reimbursed.

Reimbursement for direct patient care services provided by the attending physician will be made as follows:

1. When the attending physician is the plan member's PCP (or another plan provider who has primary responsibility for the plan member's medical care), and the attending physician is contracted with FCHP, the physician may submit claims for patient care services to FCHP for reimbursement. Attach the -GV modifier (attending physician not employed or paid under agreement by the patient's hospice provider). Reimbursement for covered services will be made to the physician according to the terms of the physician's contract with FCHP.
2. When the attending physician is the medical director of the hospice (or employed by or under contract with the hospice), and the attending physician is contracted with FCHP, the attending physician may submit claims for direct patient care services to FCHP for reimbursement. Attach the -GV modifier (attending physician not employed or paid under agreement by the patient's hospice provider). Reimbursement for covered services will be made to the physician according to the terms of the physician's contract with FCHP.

#### *Room and board (revenue code 0658)*

Hospice care is most often provided in a Plan member's home. Room and board in a long-term care facility or hospice inpatient facility may be authorized for commercial plan members receiving routine or continuous hospice care when FCHP has determined that a primary care giver is unavailable or unable to provide needed care and when the hospice agency has a bed available. The hospice agency will provide or arrange for room and board to be provided in a hospital licensed pursuant to MGL Chapter 111 § 51 or in a long-term care facility licensed pursuant to MGL Chapter 111 § 71 with whom the hospice has entered into a written agreement, or in hospice inpatient facility directly owned and operated by the hospice agency. The hospice agency will be paid the room and board rate for each day room and board is authorized in addition to either the routine home care rate or the continuous home care rate. (The hospice agency will reimburse the inpatient facility.)

Plan members with Medicare as primary insurance and FCHP as secondary insurance are eligible for FCHP-covered services that are not covered under the Medicare hospice benefit, such as room and board.

Room and board hospice care is not covered for Commonwealth Care members.

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<sup>4</sup> Each commercial plan member who elects hospice must designate an attending physician who maintains primary responsibility for the plan member's medical care. This physician may be the Plan member's PCP or another plan provider (including the hospice medical director or another physician who is employed by or under contract with the hospice) who has primary responsibility for the Plan member's medical care.

## **Senior Plan**

### **Hospice services provided by the hospice agency**

When a Fallon Senior Plan member elects hospice, all of the following services related to the terminal condition are provided by the hospice agency:

- Physician's services<sup>5</sup>
- Nursing care provided by or under the direct supervision of a registered nurse
- Durable medical equipment, such as wheelchairs and walkers
- Medical supplies, such as bandages and catheters
- Drugs for symptom control or pain relief related to the terminal condition
- Home health aide and homemaker services
- Physical, occupational therapy and speech therapy for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills
- Social worker services
- Dietary counseling
- Grief counseling
- Short-term inpatient care for pain relief and symptom management
- Short-term respite care
- Any other Medicare-covered services needed to manage pain and symptoms recommended by the hospice team, including chemotherapy, radiation therapy, and other modalities for palliative purposes.

For each day that a hospice patient is under the care of a hospice, the hospice is reimbursed by Medicare for the services furnished to the patient for that day.

Room and board is not covered by Medicare or FCHP for Fallon Senior Plan members. A Fallon Senior Plan member whose place of residence is a long-term care facility may elect hospice as long as the room and board continues to be paid for by (or arrangement for payment is made by) the plan member.

A hospice agency may charge a hospice beneficiary coinsurance for Part B outpatient drugs and biologicals and inpatient respite care. No other cost-sharing may be imposed by the hospice agency for services furnished to a hospice beneficiary during the period of hospice election regardless of the setting of the services.

#### *Attending physician services*

When hospice is elected, a hospice beneficiary may designate an attending physician (who may be a nurse practitioner) who is not employed by nor receives compensation from the hospice, in addition to receiving care from hospice-affiliated physicians. The attending physician may provide direct patient care services related to the hospice patient's terminal illness. Attending physician services are not considered hospice services. These services are billed by the attending physician to A/B MACs, intermediaries and/or carriers. The attending physician codes services with the -GV modifier (attending physician not employed or paid under agreement by the patient's hospice provider).

If another physician covers for a hospice patient's designated attending physician, the services of the covering physician are billed by the designated attending physician under the reciprocal or locum tenens billing instructions. In such instances, the attending physician bills using the -GV modifier in conjunction with either the -Q5 or -Q6 modifier.

When the service is considered a hospice service (i.e., related to the terminal illness and furnished by someone other than the attending physician, the provider must look to the hospice for compensation. Services related to the patient's terminal illness furnished by someone other than the designated

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<sup>5</sup> Payment for physician's services provided in conjunction with the hospice benefit is made based on the type of service provided. Physician's administrative and supervisory services are included in the hospice per diem payment. Attending physician's services are separately reimbursed by Medicare. All other physicians must look to the hospice for payment.

attending physician (or a physician covering for the designated attending physician) are not reimbursed by Medicare or FCHP.<sup>6</sup>

#### *Services unrelated to the terminal condition*

Reimbursement for Original Medicare covered Part A/B services unrelated to the terminal condition (for Fallon Senior Plan members who have elected hospice) are made by Medicare as if the member were an Original Medicare beneficiary until the first day of the month following the month in which hospice is revoked (regardless of whether the provider is contracted or not contracted with Fallon Senior Plan). These services are coded with the -GW modifier (services not related to the hospice patient's terminal condition).

When providers bill A/B MACs, intermediaries and/or carriers for Medicare-covered services unrelated to the terminal illness during a hospice election period the provider will be reimbursed according to Original Medicare fee-for-service rules. As long as the member remains enrolled in and continues to pay the monthly premium for Fallon Senior Plan, FCHP will reimburse providers for coinsurance that is plan member responsibility under the standard rules of the Medicare program less any cost-sharing that would be member responsibility under Fallon Senior Plan. Claims for reimbursement for plan member coinsurance for Medicare-covered services should be submitted to FCHP with a -GW modifier (for services not related to the terminal condition) along with a copy of the Medicare RAS.

#### *Services furnished to a Fallon Senior Plan member after revocation of the Plan member's hospice election until the full monthly capitation payments begin again*

Federal regulations require that Medicare maintains financial responsibility for Medicare Advantage members who elect hospice. By regulation, the duration of payment responsibility extends from the date of hospice election until the first day of the month following the month in which hospice is revoked by the hospice beneficiary. Claims for Medicare-covered services should be submitted to Medicare with a -GW modifier (for services not related to the terminal condition).

When providers bill A/B MACs and/or carriers for services furnished to Fallon Senior Plan members after a hospice election has been revoked but prior to when Fallon Senior Plan's full monthly capitation payments from Medicare begin, the provider will be reimbursed according to Original Medicare fee-for-service rules. As long as the member remains enrolled in and continues to pay the monthly premium for Fallon Senior Plan, FCHP will reimburse providers for coinsurance that is Plan member responsibility under the standard rules of the Medicare program less any cost-sharing that would be member responsibility under Fallon Senior Plan. Claims for reimbursement for plan member coinsurance for Medicare-covered services should be submitted to FCHP with a -GW modifier (for services not related to the terminal condition) along with a copy of the Medicare RAS.

## **Referral/notification/preauthorization requirements**

### **Commercial**

A PCP referral and preauthorization is required for hospice care.

When a commercial member elects hospice, the hospice agency will mail or fax a copy of the Hospice Notice of Election Form to FCHP Case Management Department, fax number 1-508-368-9507 prior to beginning hospice care within 5 business days of election.

To obtain preauthorization for hospice services, the Hospice Agency must send the Universal Health Plan/Home Health Authorization Form to the FCHP Case Management Department, fax number 1-508-368-9507 prior to initiating services. The Hospice Agency must indicate which revenue code is being requested on the authorization form. FCHP may authorize hospice care services for up to a 21 day time period (for each member specific preauthorization request received).

All changes in hospice level of care must be preauthorized. For example, a change from routine hospice care to continuous hospice care, or a change from routine hospice care to inpatient respite care

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<sup>6</sup> When a hospice beneficiary's attending physician requests a consult from another physician, should the consultant's charges be billed to the hospice or the Part B carrier? If the consult is related to the terminal illness, the consultant's charges should be billed to the hospice.

requires preauthorization. Changes must be indicated on a new Universal Health Plan/Home Health Authorization Form.

In addition, preauthorization is required for room and board (revenue code 0658). The Hospice Agency must send an additional Universal Health Plan/Home Health Authorization Form to the FCHP Case Management Department, fax number 1-508-368-9507 prior to beginning room and board. FCHP may authorize room and board services for up to a 21 day time period (for each member specific preauthorization request received).

When a commercial member revokes hospice (or is discharged or decertified) the hospice agency will mail or fax a copy of the revocation form to FCHP Case Management Department, fax number 1-508-368-9507 within 5 days of the revocation.

### **Senior Plan**

Fallon Senior Plan members may receive hospice services from any Medicare-certified hospice agency. No referral or preauthorization is required.

When a Fallon Senior Plan member elects hospice, the hospice agency will mail or fax a copy of the Hospice Notice of Election Form to FCHP Case Management Department, fax number 1-508-368-9507 within 5 business days of election.

In addition, the revocation form should be mailed or faxed to FCHP Case Management Department, fax number 1-508-368-9507 within 5 days of the revocation.

## **Billing/coding guidelines**

Hospices use the UB-04 (CMS-1450) or electronic equivalent per industry standard to bill for covered hospice services. Claims for all other services should be submitted on a CMS-1500 claims form or HIPAA standard electronic equivalent per industry standard guidelines.

Hospices should use the appropriate hospice revenue code (0651-0659) to bill for hospice care. Hospices should also report a HCPCS code (Q5001-Q5009) along with the revenue code to identify the location where hospice care was provided. For routine hospice care, continuous hospice care and in-home respite care, place of residence can be an inpatient facility if the Plan member uses that facility as a place of residence. It is the level of care that is provided and not the location where the hospice services are provided that determines payment.

## **Place of service**

This policy applies to all places of service.

## **Policy history**

Origination date:	1/01/09
Previous revision date(s):	N/A
Connection date and details:	September 2009 - Updated Referral/notification/ preauthorization requirements; added note that room and board is not covered for Commonwealth Care members;

*This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for FCHP. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. FCHP reserves the right to apply this payment policy to all FCHP companies and subsidiaries.*