



# Hospice Payment Policy

## Policy

### **Commercial**

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™**

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 provider, if the provider 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expiration of a hospice election until the first day of the month following the month during which the hospice election was revoked.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for all covered services on the first day of the month following the month during which the hospice election was revoked, as long as the member remains enrolled in and continues to pay the monthly premium for Fallon Senior Plan.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 provider** – When hospice coverage is elected, a Plan member may designate an attending provider (who may be the Plan member's PCP) who will have the most significant role

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<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.

in the determination and delivery of the Plan member's medical care, in addition to receiving care from hospice-affiliated providers.

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

**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 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**

- FCHP Direct Care/FCHP Select Care
- Commonwealth Care
- Companion Care
- FCHP MassHealth
- Major Medical
- Fallon Preferred Care
- Fallon Senior Plan™
- Fallon Senior Plan Preferred
- Summit ElderCare®
- NaviCare<sup>SM</sup>

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

### **Reimbursement - Commercial**

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.

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<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 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.

**Routine home care (revenue code 0651)**

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, respite care or short-term general inpatient care. FCHP does not pay the routine home care rate for the day of discharge; FCHP will pay the routine home care rate for day of death.

**Continuous home care (revenue code 0652)**

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. The continuous home care rate is paid by the hour. The hospice payment on a continuous care day varies depending on the number of hours of continuous services provided. The number of hours of continuous care provided during a continuous home care day is multiplied by the hourly rate to yield the continuous home care payment for that day. A minimum of 8 hours of care must be furnished on a particular day to qualify for the continuous home care rate.

**Respite care**

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)**

The goal of in-home respite care is to provide temporary relief to the primary caregiver maintaining the Plan member at home. *This service is not covered for FCHP MassHealth members.*

- **Inpatient respite care (revenue code 0655)**

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 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.) FCHP pays respite care for a maximum of seven consecutive days, including the date of admission but not the date of discharge. FCHP will pay the inpatient respite care rate for the day of death. *This service is limited to 5 consecutive days for FCHP MassHealth members.*

**Short-term general inpatient care (revenue code 0656)**

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. FCHP pays the hospice inpatient care rate for the date of admission and all subsequent inpatient days. FCHP does not pay the general inpatient care rate for the day of discharge; the appropriate level of home care is reimbursed. FCHP will pay the general inpatient care rate for the day of death. (Short-term general inpatient care is not reimbursed in addition to any other level of hospice care).

**Provider's services**

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

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

- Provider'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 provider 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 provider will be made as follows:

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

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

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.)

Commercial Plan members with Medicare as their primary insurance and an FCHP Commercial product 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.*

## **Reimbursement – Senior Plan**

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

When a Fallon Senior Plan member elects hospice, for each day that a patient is under the care of the hospice, Medicare reimburses the hospice agency for the services furnished to the Plan member 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 provider services**

When hospice is elected, a hospice beneficiary may designate an attending provider (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 providers. The attending provider may provide direct patient care services related to the hospice Plan member's terminal illness. Attending provider services are not considered hospice services. These services are billed by the attending provider to A/B MACs, intermediaries and/or carriers. The attending provider codes services with the -GV modifier (attending provider not employed or paid under agreement by the Plan member's hospice provider).

If another provider covers for a hospice Plan member's designated attending provider, the services of the covering provider are billed by the designated attending provider under the reciprocal or locum tenens billing instructions. In such instances, the attending provider 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 provider, the provider must look to the hospice for compensation. Services related to the Plan member's terminal illness furnished by someone other than the designated attending provider (or a provider covering for the designated attending provider) are not reimbursed by Medicare or FCHP.<sup>3</sup>

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

Reimbursement for 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 Plan member'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 resume.** 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).

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<sup>3</sup> When a hospice beneficiary's attending provider requests a consult from another provider, 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.

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/prior authorization requirements**

### **Commercial**

When hospice services are ordered by a provider, prior authorization is required.

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 initial authorization for hospice care, the Hospice Agency must send the Universal Health Plan/Home Health Authorization Form to the FCHP Case Management Department, fax number 508-368-9507 within 5 business days of the start of care. The period of time authorized will be indicated on the Notification of Prior Authorization Decision form.

To obtain prior authorization for continued 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 the existing authorization's end date. The Hospice Agency must indicate which revenue code is being requested on the authorization form. The period of time authorized will be indicated on the Notification of Prior Authorization Decision form.

All changes in hospice level of care must be prior authorized. For example, a change from routine hospice care to continuous hospice care, or a change from routine hospice care to inpatient respite care requires prior authorization. Changes must be indicated on a new Universal Health Plan/Home Health Authorization Form.

In addition, prior authorization 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.

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

### **Senior Plan**

Fallon Senior Plan members may receive hospice services from any Medicare-certified hospice agency. No referral or prior authorization 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, discharge summary, or decertification form should be mailed or faxed to FCHP Case Management Department, fax number 1-508-368-9507, within 5 days.

## **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:	1/01/2009
Previous revision date(s):	11/01/2009 - Updated Referral/notification/ preauthorization requirements; added note that room and board is not covered for Commonwealth Care members.
Connection date and details:	September 2010 – Updated language in the Reimbursement section to remove references to criteria that are outlined in the FCHP Medical Policy for Hospice Services, to identify services that are limited or not covered for Commonwealth Care and FCHP MassHealth members, and to more clearly identify differences between Commercial and Senior Plan.

*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.*