Hospice

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Application:	All participating hospitals and providers
Page Number(s):	1 of 3

Disclaimer

Highmark Health Options reimbursement policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

Highmark Health Options may provide coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary benefits.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Delaware Department of Health and Social Services (DHSS) and all applicable state and federal regulations.

POLICY PURPOSE

This policy was written with the intent to help give guidance to providers for billing hospice services for the HHO population.

DEFINITIONS

Highmark Health Options (HHO) – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently services Delaware Medicaid: Delaware Healthy Children Program (DHCP) and Diamond State Health Plan Plus LTSS (DSHP Plus LTSS) members.

Hospice – Comprehensive, holistic program of care and support for terminally ill patients and their families

POLICY POSITION

Prior authorization is required for any type of hospice; however it is not required for active Medicare hospice certified election period.

Hospice is covered when Physician certification for hospice care states that life expectancy is six months or less if the life limiting illness runs its clinically anticipated course.

Case manager must be aware of the following regarding members eligible to receive hospice services:

- Members may elect to receive hospice services, which may be covered by private insurance or Medicare, if the member has part A, or by the contractor if there is no other payor source available.
- Medicare hospice benefit is divided into two 90-calendar day election periods. Therefore, the member may continue to receive hospice care in 60-calendar day increments. (**Note** that a physician must recertify hospice eligibility at the beginning of each election period.)
- The hospice agency is responsible for providing covered services to meet the needs of the member related to the members hospice-qualifying condition.
- Case manager must communicate with the hospice case manager on transition and end of life care needs as needed to ensure coordination and continuity of services.

PAYMENT

For any hospice services provided in a nursing facility, the contractor may either pay the nursing facility and require the nursing facility to pay the hospice provider or pay the hospice provider using state's 95 percent Medicaid Fee for service Custodial Care rate.

LEVELS OF CARE HOSPICE

Routine Home Care – The hospice is paid the routine home care rate for each day the patient is under the care of the hospice when no other level of care applies. This rate is paid without regard to the volume or intensity of services provided on any given day.

Continuous Home Care – The hospice is paid the continuous home care rate when continuous home care is provided. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of 8 hours per day must be provided. The hospice will be paid for every hour or part of an hour of continuous care furnished up to a maximum of 24 hours a day.

Inpatient Respite Care – The hospice will be paid the inpatient respite care rate for each day the beneficiary is in an approved inpatient facility and is receiving respite care. Respite care is paid for a maximum of 5 days at a time, including the date of admission but not counting the date of discharge. Pay for the sixth and any subsequent days at the routine home care rate.

General Inpatient Care – DMAP will pay at the general inpatient rate when general inpatient care is provided.

QUALIFYING HOSPICE SETTINGS

The following are qualified types of hospice settings for members:

- Inpatient Hospital
- Skilled Nursing Facility
- Hospice Stand Alone Facility
- Nursing Home
- Home

RE-ENROLLMENT

Case manager shall review member placement and services onsite with the member and/or member representative present at least every 180 calendar days for members receiving hospice services in a nursing facility and those residing in a nursing facility.

For members who are not receiving services in a skilled nursing facility, services will need to be re enrolled every seven days for inpatient and every 30 days for outpatient services.

Facility providing hospice services will be responsible for reassessment of services.

REVENUE CODES

Code	IP/OP	Description
0651	OP	Routine home care.
0652	OP	Continuous home care (A minimum of 8 hours, not necessarily consecutive, in a 24 hour period is required. Less than 8 hours is routine home care for payment purposes. A portion of an hour is 1 hour).
0655	IP	Hospice – inpatient respite care.
0656	IP	Hospice – general inpatient care.
0657	OP	Physician services – PHY Ser (must be accompanied by a physician procedure code).
0658	IP	Hospice– room and board–nursing facility.

Note that revenue code 657 must be billed in conjunction with an appropriate HCPCS code.

Note that Inpatient and Outpatient services cannot be billed on the same claim.

References

https://www.medicaid.gov/medicaid/benefits/hospice-benefits/hospice-payments/index.html

POLICY UPDATE HISTORY

5.18.2023	Approved in Reimbursement Policy Committee
5.22.2023	Approved in Governance Policy Committee