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Reimbursement Policy

Hospice

Policy Number: 4.8
Version Number: 12
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Product Applicability	☐ **All Plan⁺ Products**
Well Sense Health Plan ☐ Well Sense Health Plan	**Boston Medical Center HealthNet Plan** ☒ MassHealth MCO ☒ MassHealth ACO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.bmchp.org.

Definitions

Hospice Care – An integrated set of services and supplies designed to provide comfort measures and supportive care to terminally ill members and their families. Hospice care is a change in the treatment focus of a member from curative to palliative, resulting in care meant to alleviate symptoms and provide comfort measures, but not a cure.

⁺ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Provider Reimbursement

The Plan reimburses for hospice care based upon one of four levels of care that a member receives each day while under the care of the hospice.

Hospice providers that fail to submit required quality data in a given year will incur a two percentage point reduction to the compliant reimbursement rate.

The Plan reimburses the predetermined rate based upon these following four levels of care:

Routine Home Care

Routine home care is reimbursed for each day the member is at home, under the care of the hospice, and not receiving continuous home care. Reimbursement for routine home care will be reimbursed at a per diem rate, which includes all medical services and routine supplies provided.

- Routine Home Care (Days from 1 to 60)
  - The higher routine home care payment rate is paid for each day (1-60 days) when the member receives hospice in their private residence and is not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any day.
  - A 60 day gap in hospice service is required to reset the counter for a member to be qualified for the 1-60 payment category.
  - The Plan reimburses providers at the appropriate rate based upon the benefit period for the member, even if some or all of those services were provided by a different hospice agency.
- Routine Home Care (Days Greater than 60)
  - The lower routine home care payment rate is paid for each day (61+ days) when the member is receiving hospice in his or her private residence and is not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any day.
- Service Intensity Add-on (SIA)

  The SIA rate equals the continuous home care hourly payment rate, for a minimum of 15 minutes and up to 4 hours per day. The SIA rate is paid in addition to the routine home care rate when the following criteria are met:

  - The day is a Routine Home Care level of care;
  - The service is provided during the last 7 days of the member's life; and
  - Direct patient care is provided by a registered nurse or a social worker.

Continuous Home Care

Continuous home care is reimbursed at a per hour rate when services, consisting predominately of nursing care, are provided on a continuous basis in the member's home to achieve palliation or management of acute medical symptoms. Home health aide or homemaker services may also be provided on a continuous basis. Continuous home care is not intended to be used as respite care and

is reimbursed only during a period of crisis in an effort to maintain the terminally ill member at home. A minimum of eight hours of care must be provided within a 24-hour period and is not required to be continuous.

Inpatient Respite Care

Inpatient respite care is reimbursed at a per diem rate when short-term inpatient care is provided in an approved inpatient facility. Respite care reimbursement is allowed for a maximum of five consecutive days including the date of admission but not counting the date of discharge. Reimbursement for the sixth and any subsequent days is made at the routine home care rate.

General Inpatient Care

General inpatient care is reimbursed at a per diem rate when provided in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed in another setting. None of the other fixed payment rates will be applicable for a day on which the member receives general inpatient care, except for the day of discharge.

Services Included in the Hospice Rate

When authorized the following services are considered for reimbursement under the hospice benefit for a Plan member and are included in the per diem rate:

- Skilled nursing care provided by or under the supervision of a registered nurse
- Medical social services
- Physician services
- Counseling services, including:
  - Bereavement Counseling
  - Dietary Counseling
  - Spiritual Counseling
  - Other Additional Counseling
- Physical, Occupational, and Speech/Language Therapy
- Homemaker/Home Health Aide services
- Drugs/Durable Medical Equipment/Medical Supplies
- Short-Term Inpatient Care
- Other services covered by the Plan that are not related to Hospice but would otherwise be covered, as long as such services do not exclude the member from electing hospice care
- Volunteer services

Room and Board in a Nursing Facility

Reimbursement for room and board at a nursing facility is reimbursed to the hospice agency at a rate equal to the nursing facility's per diem rate. Room and board will be paid in addition to routine or continuous home care services.

Nursing Facility Medical Leave of Absence

Room and board reimbursement will be made for a period of absence that results from a short-term, acute care hospital admission. Payment for a medical leave of absence will be made at the nursing facility's lowest contractual rate. During a medical leave of absence, no hospice service reimbursement will be made. All leave of absence cases will be paid directly to the hospice agency that will be responsible for reimbursing the nursing facility.

Hospice Agency Subcontracts

A hospice provider may arrange for the provision of certain services on a contract basis. These services may not include nursing, medical social services, or counseling services.

All subcontracted services must be billed directly by the hospice agency and must not be billed by a subcontractor. All services billed as a result of a subcontract arrangement will be paid as a component of the hospice per diem payment structure and will not be reimbursed separately.

Hospice Reimbursement on the Date of Discharge

Reimbursement for the date of discharge, from respite care, inpatient hospice, or acute inpatient, will be subject to the below terms when the member is enrolled in hospice:

- When a member is discharged to home hospice, the applicable home hospice rate is considered for reimbursement, and the inpatient day will not be reimbursed.
- When the member's discharge status is expired, the inpatient rate will be considered for reimbursement through the date of death.

Care Unrelated to Hospice

The Plan will reimburse non-hospice providers when services are rendered to treat conditions that are unrelated to the member's terminal illness. In those cases, where a hospice member is admitted to an acute care facility for a diagnosis that is unrelated to the terminal illness of the member, the acute facility will be reimbursed at that facility's contractual rates, or at the rates paid to a non-participating acute care facility. During the period of admission, hospice is not covered. For guidelines for services unrelated to hospice care reference the Plan's other reimbursement policies.

Separately Reimbursed Immunizations

The Plan will reimburse hospice agencies separately for the following immunizations and their administration:

- Hepatitis B
- Pneumococcal pneumonia
- Influenza virus

Applicable Coding and Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the U.S.

Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

Rev Code	Description	Instructions
0651	Hospice Service-Routine Home Care	For billing less than 8 hours of care. Units equal to number of days Locator46
0652	Hospice Service-Continuous Home Care	Minimum 8 hours of routine home care in a 24-hour period. Units equal to number of hours
0655	Hospice Service-Inpatient Respite Care	Units equal to number of days
0656	Hospice Service-Inpatient General Care (non-respite)	Units equal to number of days
0657	Hospice-Physician Services	Provide CPT/HCPCS Level II code detail
0658	Hospice- Room and Board-Nursing Facility	Enter the number of days, in addition to Rev Code 0651 or 0652.

HCPCS Code	Description	Instructions
T2042	Hospice routine home care; per diem, Days 1-60	Must bill with revenue code 0651
T2042 UD	Hospice routine home care; per diem, Days 61+	Must bill with revenue code 0651
G0299	Service Intensity Add On; RN services	Must bill with revenue code 0651. Bill in hourly units.
G0155	Service Intensity Add On; Social Worker services	Must bill with revenue code 0651 Bill in hourly units.
T2043	Hospice continuous home care; per hour	Must bill with revenue code 0652
T2044	Hospice inpatient respite care; per diem	Must bill with revenue code 0655
T2045	Hospice general inpatient care; per diem	Must bill with revenue code 0656
T2046	Hospice long term care, room and board only; per diem	Must bill with revenue code 0658

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
04/24/2004	04/24/2004	Payment Policy	Payment Policy Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
06/02/2005	Coding Updates	06/02/2005	Payment Policy Committee
05/05/2006	Reformatting and reorganization	05/05/2006	Payment Policy Committee
11/01/2006	Updated to eliminate duplicative preauthorization information and to accommodate the implementation of Commonwealth Care	11/01/2006	Payment Policy Committee
01/24/2007	Added definition for home-bound, and updated to include reference for formatting purposes	01/24/2007	Payment Policy Committee
09/22/2011	Deleted definitions and applicable plan products table	09/22/2011	Payment Policy Committee
12/02/2013	Updated template, product applicability section, and references for BMC HealthNet Plan Qualified Health Plans, including ConnectorCare	12/02/2013	Payment Policy Committee
04/15/2014	Annual update	04/15/2014	Payment Policy Committee
01/20/2016	New template, Updated routine home care coding and SIA payment	04/01/2016	Payment Policy Committee
05/15/2018	New logo and product applicability box, annual update	06/01/2018	Payment Policy Committee
01/20/2020	New product applicability box, annual review, added wording for 2% reduction in payment rate for non-compliant providers	04/01/2020	Payment Policy Committee

Policy Revisions History			
8/17/2021	Annual review, clarified SIA is billed in hourly units. Alphabetized reference list	9/1/2021	Payment Policy Committee

Other Applicable Policies

- General Billing and Coding Guidelines, 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, 4.108
- Physician and Non-Physician Practitioner Services, 4.608

References

- 101 CMR 343.00: Hospice Services
- 101 CMR 350.00 – Home Health Services
- 130 CMR 403.00 – Home Health Agency
- 130 CMR 437.00 Hospice Services, Subchapter 6
- Administrative Bulletin 19-21 101 CMR 343.00: Hospice Rates
- BMC HealthNet Plan Qualified Health Plans, including ConnectorCare Evidence of Coverage
- CMS 100-02 Ch. 7 Sect. 50.4.1.2
- Contract between The Office of Health and Human Services (EOHHS), and Boston Medical Center HealthNet Plan MassHealth
- Evidence of Coverage, Form No. BMCHP CChoice-1
- Evidence of Coverage, Form No. BMCHP-CC-8
- Form of Contract between the Commonwealth Health Insurance Connector Authority and Boston Medical Center HealthNet Plan

Disclaimer Information

This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.

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