SERVICE LIMITATIONS

Services Unrelated to Terminal Illness

Once a recipient elects to receive hospice services, the hospice agency is responsible for either providing or paying for all covered services related to the treatment of the recipient's terminal illness and related conditions. Although a recipient may present with multiple medical conditions, the attending physician certifies that at least one condition has created a terminal situation with a life expectancy of less than six months. It is incorrect to state a patient can elect hospice for one diagnosis and not another. A recipient must be enrolled in hospice for a terminal illness. If the recipient elects hospice, he/she has given up the option for therapeutic care for any and all of the related conditions. For example, if the recipient has cancer and chronic obstructive pulmonary disease (COPD) and wants active treatment for the COPD, he/she should not elect hospice. He/she should stay in regular Medicaid/Medicare. Recipients (and more particularly providers) cannot pick and choose among their diagnoses for hospice election; it is the life expectancy related to the recipient's overall terminal condition that is the controlling factor. Recipients under 21 years of age who are approved for hospice may continue to receive curative treatments for their terminal illness; however, the hospice provider is responsible for coordinating all curative treatments related to the terminal illness. Refer to Section 24.2 – Election of Hospice Care of this manual chapter for recipients under 21 years of age.

"Clinical condition" is defined as a diagnosis or a patient state (physical and/or mental) that may be associated with more than one diagnosis or that may be as yet undiagnosed. Therefore, any claim for services submitted by a provider other than the elected hospice agency will be denied if the claim does not have attached justification that the service was medically necessary and was not related to the terminal condition for which hospice care was elected. However, claims for prescription drugs and home and community based waiver services will not deny but will be subject to post-payment review. If documentation is attached to the claim, then the claim will be pending review.

Determining Hospice Liability

Hospice providers are held liable for payments to non-hospice providers in the following situations:

- The medical consultant with the fiscal intermediary (FI) determines which services rendered are actually hospice related;

- Services rendered to a recipient on the same day an election for hospice is made; and

- Charges incurred by recipients who receive services while in an inpatient facility (hospital, long term care acute care facility, etc.) or other services (transportation) if the services are/were rendered on the same day a recipient elects/elected hospice. The time of day is not factored in when recipient information is processed and claims are submitted for payment. Hospice providers bill Medicaid for the whole day and not a partial day. **Providers are reimbursed for date(s) of service.**

Required Documentation

Any information necessary to justify that the service was medically necessary and was not related to the terminal condition must be attached to the claim. Such documentation must include:

- A statement/letter from the physician confirming that the services were not related to the recipient's terminal illness;

- Documentation of the procedure and diagnosis which illustrates why the service was not related to the recipient's terminal illness; and

- Hospital admission and discharge documentation information.

Review of Documentation

The claim will deny if the information does not justify that the service was medically necessary and not related to the terminal condition for which hospice care was elected.

The provider must resubmit the claim with attached justification if a claim is denied and is for a covered service not related to the terminal condition for which hospice care was elected.

NOTE: This information must be submitted as a hard copy. **Do not submit electronically**.

If review of the claim and attachments justify that the claim is for a covered service not related to the terminal condition for which hospice care was elected, the claim will be released for payment. If prior authorization is required for any covered Medicaid services not related to the treatment of the terminal condition, the prior authorization must be obtained just as in any other case.

Final determination of non-hospice related charges does not rest with the hospice provider. Hospice providers cannot deny payments to non-hospice providers based on not knowing the

recipient received services from a non-hospice provider, services were not authorized or merely stating the services were not related to the hospice diagnosis.

The claim will go through a physician review at the fiscal intermediary, and a final determination will be made at that time. The claim may still be denied as being hospice related. If denied, the non-hospice provider must then submit charges to the hospice provider. The hospice provider is responsible for payment of services rendered. Refusing to pay for these charges or any charges submitted from a non-hospice provider puts the provider out of compliance with the provider agreement. Non-compliance with the provider agreement could place the provider in a position of sanctions being imposed which include, but is not limited to denial or revocation of enrollment, withholding of payments, exclusion from the program, recovery of overpayments and imposing administrative fines. For additional information please refer to Section 24.13 – *Administrative Sanctions*.