REIMBURSEMENT

With the exception of payment for physician services, Medicaid reimbursement for hospice care is made at one of four predetermined per diem rates for each day a Medicaid beneficiary is under the care of the hospice regardless of the amount of services furnished on any given day. The four rates are prospective rates; there are no retroactive adjustments other than the limitation on payments for inpatient care. The rates are calculated on a yearly basis and based on information provided by the Centers for Medicare and Medicaid Services (CMS) and in line with the provider requirements as set forth in 42 CFR Part 418.

The payment rates for each level of care are those used under Part A of Title XVIII (Medicare) of the Social Security Act, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. These rates are adjusted for regional wage differences. The hospice shall submit claims, for payment for hospice care only, on the basis of the geographic location (Metropolitan Statistical Area) where the services are furnished.

The rates are effective from October 1 through September 30 of each federal fiscal year. The provider should split bills if they span the effective date of the annual updates to the payment rates.

Claim Form

Bills are submitted on a Form UB-04. Claims-related information can be found in Section 24.10 of this Chapter.

Levels of Care

Payment rates are determined for the following four categories of hospice care into which each day of care is classified:

1. Routine Home Care;
2. Continuous Home Care;
3. Inpatient Respite Care; and
4. General Inpatient Care.

Routine Home Care (Revenue Code 651)

A routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous home care. The routine home care rate is paid for each day the beneficiary is under the care of the hospice and not receiving one of the other categories of care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

Routine home care is also paid when the beneficiary is receiving hospital care for a condition **unrelated** to the terminal condition. This rate is also paid in the following situations:

1. If the beneficiary is in a hospital that is not contracted with the hospice;

2. If the beneficiary is receiving outpatient services in the hospital; or

3. For the day of discharge from general inpatient care or respite level of care.

Reimbursement is based upon a two-tier payment system. Reimbursement begins at a higher rate and then decreases to a lower rate. The higher rate is payable for the first 60 days of an initial election of hospice services. If the member remains in hospice, on day 61, payment drops to the lower rate.

Examples include the following:

1. A member that is discharged or voluntarily revokes hospice elections and readmits to hospice in less than 60 days will have no disruption for the purpose of counting days;

2. A member that is discharged or voluntarily revokes hospice elections and readmits to hospice in 61 or more days constitutes a new hospice election and the higher rate of pay starts again; and

3. A member who transfers to another hospice, in either a managed care organization (MCO) or fee-for-service (FFS) Medicaid, continues the count of days from the original hospice provider.

An additional add-on rate may apply. (See Service Intensity Add-on in this section).

Service Intensity Add-On Rate (SIA) (Revenue Code 659)

A service intensity add-on (SIA) payment will be reimbursable for a visit by a registered nurse (RN) or a social worker, when provided during routine home care (HR651) in the last seven days of a patient's life. The SIA payment is in addition to the routine home care rate.

Claims for SIA services must be billed in units. Each unit is equal to 15 minutes. The maximum number of reimbursable units per day is 16 units. The seven-day maximum number of reimbursable units is 112 units. All claims must be submitted with documentation demonstrating the necessity of the services provided. Documentation submitted should reflect the arrival and departure time of the professional providing the services. Visits for the pronouncement of death only will not be reimbursed as an eligible visit.

Continuous Home Care (Revenue Code 652)

The individual receiving hospice care is not in an inpatient facility and receives care consisting predominantly of nursing care on a continuous basis at home. Continuous home care is only furnished during brief periods of medical crisis and only as necessary to maintain the terminally ill beneficiary at home. Routine home care code must be billed if less skilled care is needed on a continuous basis to enable the beneficiary to remain at home. Services should reflect direct beneficiary care during a period of crisis and should not reflect time related to staff working hours, time taken for meal breaks, time used for educating staff or time use for reporting. Continuous home care is not paid during a hospital, skilled nursing facility or inpatient hospice facility stay.

Criteria for continuous home care include the following:

1. A period of medical crisis is when a beneficiary requires continuous care, which is primarily nursing care, to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either an RN or a licensed practical nurse (LPN), and a nurse must be providing care for more than half of the period of care. Nursing care can include skilled observation and monitoring when necessary, and skilled care needed to control pain and other symptoms; or

2. A minimum of eight hours of care must be provided during a 24-hour day which begins and ends at midnight. If fewer than eight hours of continuous care are provided, the services are covered as routine care rather than continuous home care. This care need not be continuous (i.e. four hours could be provided in the morning and another four hours provided in the evening of that day). The care must be predominantly nursing care provided by either an RN or LPN. Homemaker and

aide services may also be provided to supplement the nursing care. Care by a hospice aide and/or homemaker cannot be discounted or provided "at no charge" in order to qualify for continuous home care.

NOTE: The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate.

Inpatient Respite Care (Revenue Code 655)

An inpatient respite care day is a day on which the individual receives care in an approved facility on a short-term basis to relieve the family members or other persons caring for the individual at home.

NOTE: An approved facility is one that meets the standards provided in 42 Code of Federal Regulations (CFR), Section 418.98(b). The inpatient respite care rate is paid for each day the beneficiary is in an approved inpatient facility and is receiving respite care. Payment is made for respite care for a maximum of **five** continuous days at a time in any election period, including the date of admission, but not counting the date of discharge. Payment for the sixth day, and any subsequent days, is made at the routine home care rate. Respite care may not be provided when the hospice beneficiary is a resident in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

Criteria for Inpatient Respite Care:

1. If the beneficiary, who resides in the home, goes into a nursing facility for respite care and returns home after the respite care, the beneficiary need not be in a nursing facility Medicaid bed;

2. Medicaid will pay the inpatient respite care rate for the day of death;

3. Services provided in the facility must conform to the hospice's plan of care (POC); and

4. The hospice is the professional manager of the beneficiary's care despite the physical setting of the care or the level of care.

General Inpatient Care (Revenue Code 656)

A general inpatient care day is a day on which an individual receives general inpatient care in an inpatient facility that meets the standards as provided in 42 CFR 418.98(a) and for the purpose of pain control or acute or chronic symptom management which cannot be managed in other settings. General inpatient care is a short-term level of care and is not intended to be a permanent solution to a negligent or absent caregiver or considered to be a beneficiary's permanent or temporary residence. Once symptoms are under control, a lower level of care must be billed. Payment is made for inpatient care for a maximum of five continuous days at a time, including the date of admission, but not counting the date of discharge. Extended periods of stay at the facility are considered the beneficiary's permanent or temporary residence. Routine home care shall be billed.

Criteria for general inpatient care include the following:

1. General inpatient care and room and board in a nursing facility or ICF/IID cannot be reimbursed for the same beneficiary on the same covered days of service;

2. The hospice must have a contract with the inpatient facility, delineating the roles of each provider in the beneficiary's POC; and

3. Services provided in the facility must conform to the hospice's POC.

The hospice is the professional manager of the beneficiary's care despite the physical setting of the care or the level of care.

Payment for Physician Services

In addition to the four basic payment rates for hospice care, hospices can also bill Medicaid for certain physician services. For purposes of Medicaid hospice, these physicians' services can be divided into the following three categories:

1. Professional services, or those actual procedures performed by the physician, are designated by the appropriate CPT-4 code. (Direct care services furnished to individual beneficiaries by hospice employees and for physician services furnished under arrangements made by the hospice unless furnished on a volunteer basis);

2. Administrative services include administrative and general supervisory activities generally performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group (IDG). Group activities

include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care and establishment of governing policies;

3. The four basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the beneficiary's terminal illness and related conditions. This includes the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice; and

4. Technical services include lab, x-ray and other non-professional services performed by the physician or other health care professionals.

NOTE: It should be noted that administrative and technical services are included in the four basic payment rates for hospice when the services are related to the terminal illness and related conditions.

Provision of Physician services

For purposes of Medicaid hospice, physicians providing these services are divided into two categories:

1. Attending Physician; and

2. Consulting Physician.

Only professional services are reimbursable outside of the four payment rates for hospice care.

The medical director of the hospice is to assume overall responsibility for the medical component of the hospice's beneficiary care program.

Attending Physician

During the election process, the patient designates the physician primarily responsible for his/her care while receiving hospice. This physician is the attending physician. The attending physician is not required to be an employee of the hospice.

Non-Employee

If the attending physician is not an employee of the hospice, the attending physician's professional services will be billed to Medicaid by the physician.

An independent attending physician is reimbursed in accordance with the usual Medicaid reimbursement methodology for physician services. Any other technical or administrative services are covered under the daily reimbursement rates paid to the hospice and are reimbursed by the hospice to the physician according to their agreement.

The attending physician can choose to bill Medicaid for physician care plan oversight if the coverage and documentation requirements are met.

Employee

If the attending physician is an employee of the hospice or a volunteer (such as medical director or physician member of the IDG), the physician's professional services are billed to Medicaid by the hospice. The hospice is responsible for reimbursing the physician.

The hospice must ensure that the services were professional and not technical or administrative.

The hospice is reimbursed in accordance with the usual payment rules for Medicaid physician services. The hospice must reimburse the physician for the technical component of the service out of the per diem rate as agreed upon in the physician's arrangement with the hospice.

Physicians who are designated by beneficiaries as the attending physician and who also volunteer services to the hospice are, as a result of their volunteer status, considered employees of the hospice. **Physician services furnished on a volunteer basis are excluded from Medicaid reimbursement.** The hospice may be reimbursed on behalf of a volunteer physician for specific services rendered which are not furnished on a volunteer basis (a physician may seek reimbursement for some services while furnishing other services on a volunteer basis). Liability rests with the provider to reimburse the physician for those physician services rendered.

In determining which services are furnished on a volunteer basis and which services are not, a physician must treat beneficiaries on the same basis as other beneficiaries in the hospice. For instance, **a physician may not designate all physician services rendered to non-Medicaid beneficiaries as volunteered and at the same time seek payment from the hospice for all physician services rendered to Medicaid beneficiaries.**

Example: Dr. Jones has an agreement with a hospice to serve as its medical director on a volunteer basis. Mrs. Smith, a Medicaid beneficiary, enters this hospice and designates Dr. Jones as her attending physician. Dr. Jones, who does not furnish direct beneficiary care services on a volunteer basis, renders a direct beneficiary care service to Mrs. Smith. Dr. Jones seeks reimbursement from the hospice for this service. The hospice is then paid by Medicaid in accordance with the usual payment rules for Medicaid physician services for the service that Dr. Jones rendered to Mrs. Smith. The hospice then reimburses Dr. Jones for that service.

Consulting Physician

Any physician services other than those rendered by the attending physician are classified as consulting physician services. The procedure for billing for consultant physicians is the same as for employee attending physicians. The hospice must have a contractual agreement with the physician.

The hospice is responsible for billing Medicaid for the physician's professional services and is to reimburse the physician for the services as indicated in their contractual agreement. The hospice can contract with a group of physicians as long as all the physicians in the group are listed in the contract.

Payment for Long-Term Care Facility Residents

The hospice provider will be paid an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility for a beneficiary who meets the following criteria:

1. Resides in a nursing facility or ICF/ IID;

2. Is eligible under the Medicaid State Plan for nursing facility services or services in an ICF/IID if he/she had not elected to receive hospice care;

3. Elects to receive hospice care; and

4. For whom the hospice provider and the nursing facility or ICF/IID have entered into a written agreement in accordance with the provisions set forth in the Licensing Standards for Hospices (LAC 48:I.Chapter 82), under which the hospice provider

takes full responsibility for the professional management of the individual's hospice care, and the facility agrees to provide room and board to the individual.

Payment to the facility is to be discontinued and effective as of the date of the resident's hospice election. Payment will be made to the hospice to take into account the room and board furnished by the facility for a Medicaid beneficiary. The hospice must then reimburse the facility for room and board. Dual eligible beneficiaries in a skilled nursing facility (bed) are ineligible for reimbursement for room and board by Medicaid. Hospice must submit claims to Medicare.

The amount to be paid is determined in accordance with the rates established under the Social Security Act, Section 1902(a) (13) (B). The rate of reimbursement is 95 percent of the per diem rate that would have been paid to the facility for that beneficiary in that facility under the Medicaid State Plan, except that any patient liability income (PLI) determined by the Medicaid Program will be deducted from the payment amount. It is the responsibility of the nursing facility or ICF/IID to collect the beneficiary's PLI.

This rate is designed to cover "room and board" which includes performance of personal care services, including assistance in the activities of daily living, administration of medication, maintaining the cleanliness of the beneficiary's environment, and supervision and assistance in the use of durable medical equipment (DME) and prescribed therapies. Certain DME is included in the "room and board" rate. A list of DME supplies can be found at the Louisiana Medicaid website at www.lamedicaid.com, under the fee schedules link (see Appendix D).

Nursing facilities are currently reimbursed on a case-mix methodology in which the rates can be adjusted from time to time. Hospice providers are subject to the same per diem rate adjustments as the nursing facilities, as deemed necessary. This may result in an overpayment or underpayment, and the claims will be reprocessed accordingly.

NOTE: See Section 24.10 - *Claims Related Information* of this manual chapter for additional claims related information regarding payment for nursing and ICF/IID residents.

Provider of First Choice

The nursing facility retains the right to decide if it wishes to offer the option of hospice. If the nursing facility chooses not to offer hospice care and a resident requests this service, the resident is to be informed that hospice is not available in the facility. The nursing facility is to assist with arrangements for transfer to another facility that offers the service, if the resident so chooses.

Non-Emergency Transportation for Non-Hospice Related Medical Appointments

It is the responsibility of the nursing facility to arrange for or provide transportation to all non-hospice related medical appointments. This includes wheelchair bound residents and those residents going to therapies. Transportation shall be provided to the nearest available qualified provider of routine or specialty care within reasonable proximity to the facility. Residents can utilize medical providers of their choice in the community in which the facility is located when they are in need of transportation services.

In cases where residents are bed bound and cannot be transported other than by stretcher, and the nursing facility is unable to provide transportation, an ambulance may be used. The nursing facility will reimburse the provider at the non-emergency transportation rate.

Emergency Transportation for Non-Hospice/Hospice Related Medical Conditions

It is the responsibility of the nursing facility to contact the hospice provider for any and all emergencies. **The hospice agency has full responsibility for the professional management of the individual's care.**

Medicare Coinsurance

For dual eligible beneficiaries (Medicare and Medicaid coverage) for whom Medicare is the primary payer for hospice services, Medicaid will also provide for payment of any coinsurance amounts imposed under §1813(a)(4) of the Social Security Act.

Additionally, hospice services should not be billed to Medicaid for dual eligible beneficiaries. These services are covered in the hospice Medicare reimbursement. Room and board for skilled nursing is billed to Medicare.

After providing a service to a dual eligible beneficiary, the provider sends a claim to its Medicare carrier or the intermediary. After Medicare processes the claim, it sends the provider an explanation of Medicare benefits. If Medicare has approved the claim, Medicaid will pay the deductible and/or coinsurance through its established Medicare crossover process.

Drugs and Biologicals Coinsurance (Dual Eligibles)

The amount of coinsurance for each prescription approximates five percent of the cost of the drug or biological to the hospice, determined in accordance with the drug co-payment schedule established by the hospice, except that the amount of coinsurance for each prescription may not exceed five dollars. The cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances.

To ensure the correct billing of drug services, it is imperative that the hospice provider communicate with the pharmacist to verify which drugs are related to the terminal illness (billed to the hospice) and which drugs are not related to the terminal illness (billed to Medicaid).

NOTE: Refer to the pharmacy provider manual, Chapter 37 for more information on prescription services and associated co-payments. The manual can be accessed on the Louisiana Medicaid website at www.lamedicaid.com.

Respite Care Coinsurance (Dual Eligibles)

The amount of coinsurance for each respite care day is equal to five percent of the payment made under Medicare for a respite care day. The amount of the individual's coinsurance liability for respite care during a hospice coinsurance period may not exceed the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began.

NOTE: Federal law mandates that Medicaid is the payer of last resort. Refer to Chapter 1 of the Louisiana Medicaid provider manual, *General Information and Administration*. The manual can be accessed on the internet at www.lamedicaid.com.

Telephone Calls and Consultations

Hospices may report some social worker calls as a visit. Hospices may not report any other types of phone calls.

Non-covered Days

Hospice providers are reimbursed for date of death only. Providers are not reimbursed for dates of discharge nor revocation.

Hospice Services to Medicaid/Medicare/Veteran's Eligible Beneficiaries

Medicaid beneficiaries that are dual eligible veterans and reside at home in their community may elect hospice services and have the services paid under the Medicare hospice benefits.

If a dual eligible veteran who had been receiving Medicare hospice services in his/her home is admitted to a Veterans Administration owned and operated inpatient facility, the beneficiary must revoke the Medicare hospice benefits. The same applies for a Medicaid-only beneficiary. Medicare and Medicaid are not allowed to pay for those services for which another federal entity is primary payer.