# 2018 Administrative Guide

## Physician, Health Care Professional, Facility and Ancillary

## KanCare Program

## Chapter 11: Hospice

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UnitedHealthcare® Community Plan

# Welcome

Welcome to the Community Plan provider manual. This complete and up-to-date reference PDF (manual/guide) allows you and your staff to find important information such as processing a claim and prior authorization. This manual also includes important phone numbers and websites on the How to Contact Us page. Operational policy changes and other electronic tools are ready on our website at **UHCprovider.com**.

Click the following links to access different manuals:

- **UnitedHealthcare Administrative Guide** for Commercial and Medicare Advantage member information. Some states may also have Medicare Advantage information in their Community Plan manual.
- A different Community Plan manual-go to **UHCCommunityPlan.com**, click For Health Care Professionals at the top of the screen. Select the desired state.

You may easily find information in the manual using the following steps:

1. Press CTRL+F.
2. Type in the keyword.
3. Press Enter.

If available, use the binoculars icon on the top right hand side of the PDF.

If you have any questions about the information or material in this manual or about any of our policies, please call Provider Services.

We greatly appreciate your participation in our program and the care you offer our members.

**Important Information about the use of this manual**
In the event of a conflict between your agreement and this care provider manual, the manual controls unless the agreement dictates otherwise. In the event of a conflict between your agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. UnitedHealthcare Community Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations.

This manual will be amended as policies change.

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# Chapter 11: Hospice

## 11.1 Introduction

This is the provider specific section of the manual. This chapter was designed to provide information and instructions specific to hospice providers.

**HIPAA compliance**

As a care provider in KanCare, you are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. You are required to furnish the Department of Health and Human Services all information required by the Department during its review and investigation. You are required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Kansas Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

If you receive a request for access to or inspection of documents and records, you must promptly and reasonably comply with access to the records and facility at reasonable times and places. You must not obstruct any audit, review or investigation, including the relevant questioning of employees. You shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

## 11.2 Hospice Billing Instructions

Hospice care providers must use the CMS-1500 red claim form or the appropriate electronic format for professional claim submission when requesting payment for medical services and supplies provided under KanCare.

Please see "Chapter 15: Claims" for billing instructions.

**Procedure Codes**
The following codes represent an all inclusive list of the services billable by a hospice care provider:
T2042, T2042 (U2 modifier), T2043, T2044, T2045, T2046, T2046 (U4 modifier), G0155, G0299 (U2 modifier)

Hospice care providers may also bill for influenza vaccinations using 90657 and 90658.

**Hospice Billing Information**
Hospice providers are required to bill the room and board charges for hospice beneficiaries residing in nursing facilities (NFs), intermediate care facilities for mental retardation (ICF/IDD), or hospital swing beds. NFs include skilled nursing facilities, nursing facilities, and nursing facilities for mental health. ICF/IDD included privately owned and state institution ICF/IDD.

These claims may be submitted on paper, electronically, or through the Internet. Automated processing allows these claims to process quickly and accurately by following the instructions below.

- **Paper claims:** Complete the claim as usual and document the NF, ICF/IID, or hospital swing bed name in Field 17, the NPI in Field 17b, or the provider identification (ID) in Field 17a.
- **Electronic claims (such as 837P):** Complete the claim as usual. NF, ICF/IID, or hospital swing bed providers must be included as the referring provider in loop 2310A or 2420A on hospice claims.
- **Internet claims:** Complete the claim as usual and document the NF, ICF/IID, or hospital swing bed name and NPI in the referring physician field.

- **Provider Electronic Solutions (PES):** Complete the claim as usual and document the NF, ICF/IID, or hospital swing bed in the referring provider field under Header 2.

We prefer the NPI is submitted for the referring physician/provider's identifier but the provider ID will be accepted until notified otherwise.

KanCare is the payor of last resort and is to be billed only after payment has been sought from primary insurance carriers (including Medicare). Here are examples.

- The beneficiary resides in a skilled NF and is covered by both Medicare and Medicaid. Election of hospice benefits from both carriers must occur concurrently.
- The beneficiary resides in a NF and has skilled NF insurance coverage. Payment must continue to be sought from the primary carrier. If additional payment is requested for room and board services following the primary carrier's payment, claims submitted must report the primary payment in the appropriate third-party liability (TPL) amount field.
- The beneficiary resides in a skilled NF and meets the criteria to receive Medicare's skilled nursing benefit for a condition unrelated to the diagnosis for which hospice care was elected. Billing to United Healthcare must occur only after payment has been sought from Medicare or after the exhaustion of benefits.

As the coordinator of all services, the hospice provider is responsible to ensure you accessed all payment sources prior to billing us. Failure to meet this standard and to report primary payments will result in the recoupment of monies.

## 11.3 Benefits and Limitations

### Benefit Plan

Please see "Chapter 3: Member Benefits & Eligibility" for information on KanCare beneficiaries and their benefits.

### Hospice Limitation

An individual may elect to receive hospice care during one or more of the following election periods:

- An initial 90-day period
- A subsequent 90-day period
- Unlimited subsequent 60-day periods with appropriate physician recertification for continued hospice care

### Benefits and Limitations

Hospice care provides an integrated program of appropriate hospital and home care for the terminally ill patient. It is a physician-directed, nurse-coordinated, interdisciplinary team approach to patient care which is available 24 hours a day, seven days a week. A hospice provides personal and supportive medical care for terminally ill individuals and supportive care to their families. Emphasis is on home care with inpatient beds serving as backup for the Home Care Program. Central to the hospice philosophy is self-determination by the patient in medical treatment and manner of death.

## Waiver of rights to Medicaid payment

The members waives all rights to the KanCare payments for the duration of the election of hospice care for the following services:

- Any KMAP-covered services that are either:
  - Related to the treatment of the terminal condition for which hospice care was elected or a related condition
  - Equivalent to hospice care **except** for services:
    - Provided directly or under arrangement by the designated hospice
    - Provided by another hospice under arrangement by the designated hospice
    - Provided by the beneficiary's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services
    - Hospice care provided by a hospice other than the hospice designated by the member

## Advance Directives

Hospice providers must comply with federal legislation concerning advance directives. Providers are permitted to contract with other entities to furnish this information, but are still legally responsible for meeting the section requirements. Such information must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the state law.

**Specific requirements**
Each hospice must:

1. Provide written information to every adult individual receiving medical care by or through the hospice. This information must contain:
   - The individual's right to make decisions concerning his or her own medical care
   - The individual's right to accept or refuse medical or surgical treatment
   - The individual's right to make advanced directives
   - The Kansas Department for Aging and Disability Services (KDADS) "Description of the Law of Kansas Concerning Advance Directives"
   - Policy on implementing these rights
2. Document whether the individual has executed an advanced directive in every medical record.
3. Not place any conditions on health care or otherwise discriminate against an individual based upon whether that individual has executed an advance directive.
4. Follow state law about advance directives.
5. Educate staff and the community about advance directives. This may be accomplished by brochures, newsletters, articles in the local newspapers, local news reports, or commercials.

**Incapacitated individuals**
An individual may be admitted to a facility in a comatose or otherwise incapacitated state, and be unable to receive information or articulate whether he or she has executed an advance directive. If this is the case, families of, surrogates for, or other concerned persons of the incapacitated individual must be given the information about advance directives. If the incapacitated individual is restored to capacity, the hospice must provide the information about advance directives directly to him or her even though the family, surrogate or other concerned person received the information initially.

If an individual is incapacitated, otherwise unable to receive information or articulate whether he or she has executed an advance directive, the hospice must note this in the medical record.

**Mandatory compliance with the terms of the advanced directive**
When a patient, relative, surrogate, or other concerned/related person presents a copy of the individual's advance directive to the hospice, the hospice must comply with the terms of the advance directive to the extent allowed under state law. This includes recognizing powers of attorney.

**Description of the Law of Kansas Concerning Advance Directives**
There are two types of "advance directives" in Kansas. One is commonly called a "living will" and the second is called a "durable power of attorney for health care decisions."

**The Kansas Natural Death Act, K.S.A. 65-28,101, et seq.**
This law provides that adult persons have the fundamental right to control decisions relating to their own medical care. This right to control medical care includes the right to withhold life-sustaining treatment in case of a terminal condition.

Any adult may make a declaration which would direct the withholding of life-sustaining treatment in case of a terminal condition. Some people call this declaration a "living will."

The declaration must be:

1. In writing
2. Signed by the adult making the declaration
3. Dated **and**
4. Signed in front of two adult witnesses or notarized

There are specific rules set out in the law about the signature in case of an adult who cannot write. There are specific rules about the adult witnesses. Relatives by blood or marriage, heirs, or people who are responsible for paying for the medical care may *not* serve as witnesses. A declaration has no effect during pregnancy. The declaration may be revoked in three ways:

1. By destroying the declaration
2. By signing and dating a written revocation and
3. By speaking an intent to revoke in front of an adult witness. The witness must sign and date a written statement that the declaration was revoked.

Before the declaration becomes effective, two physicians must examine the patient and diagnose that the patient has a terminal condition. The desires of a patient shall at all times supersede the declaration. If a patient is incompetent, the declaration will be presumed to be valid. The Kansas Natural Death Act imposes duties on physicians and provides penalties for violations of the laws about declarations.

**The Kansas Durable Power of Attorney for Health Care Decisions Law, K.S.A., 58-625 et seq.**
A "durable power of attorney for health care decisions" (Power), is a written document in which an adult gives another adult (called an "agent") the right to make health care decisions. The Power applies to health care decisions even when the adult is not in a terminal condition. The adult may give the agent the power to:

1. Consent or to refuse consent to medical treatment
2. Make decisions about donating organs, autopsies, and disposition of the body

3. Make arrangements for hospital, nursing home, or hospice care

4. Hire or fire physicians and other health care professionals or

5. Sign releases and receive any information about the adult

A Power may give the agent all those five powers or may choose only some of the powers. The Power may not give the agent the power to revoke the adult's declaration under the Kansas Natural Death Act ("living will"). The Power only takes effect when the adult is disabled unless the adult specifies that the Power should take effect earlier. The adult may not make a health care provider treating the adult the agent except in limited circumstances.

The Power may be made by two methods:

1. In writing
   a. Signed by the adult making the declaration
   b. Dated
   c. Signed in front of two adult witnesses

**OR**

2. Written and notarized

Relatives by blood or marriage, heirs, or people who are responsible for paying for the medical care may not serve as witnesses.

The adult, at the time the Power is written, should specify how the Power may be revoked.

**The Patient Self-Determination Act, Section 1902(w) of the Social Security Act**
Effective December 1, 1991, this law applies to all Medicaid and Medicare hospitals, nursing facilities, home health agencies, hospices, and prepaid health care organizations. It requires these organizations to take certain actions about a patient's right to decide about health care and to make advance directives. It also requires that each state develop a written description of the state law about advance directives.

## 11.4 Definitions

### Certification of terminal

A statement signed by the physician certifying the beneficiary has a medical prognosis with a life expectancy of six months or less if the illness runs its normal circle.

### Election statement

A revocable statement signed by a beneficiary or his/her legal representative which is filled with a particular hospice and consists of:

- Identification of the hospice selected to provide care to the beneficiary
- Acknowledgement the beneficiary has been given a full explanation of hospice and the palliative rather than curative nature of hospice care

- Acknowledgement by the patient that UnitedHealthcare payment for other services related to the terminal illness or related conditions are waived by the election of hospice care, with the exception of those Home and Community Based Services (HCBS) services that cannot be provided by the hospice care provider

  **Note:** Hospice care providers are responsible for the coordination of all services and communication with the HCBS Care Coordinator. Evidence of coordination with other care coordinator should be reflected in the hospice plan of care.
- Effective date of the election period
- Signature of the beneficiary of his/her legal representative

Hospice care providers are required to enter hospice assignment or revocation information through the KanCare website. Each care provider must keep a hard copy of the hospice assignment or revocation information on file. The hospice assignments must be entered within five calendar days of the date the beneficiary signed the election statement.

Election statements are submitted via the KanCare/KMAP web portal. When submitting a new hospice election, use the Verify/Add/Change LTC Facility button on the Hospice Election Assignment window to enter the NPI information for beneficiaries who reside in a nursing facility or hospital. Help windows are available from the toolbar for each hospice window. Contact KanCare Customer Service at 800-933-6593 or 785-274-5990 for questions or help using the KanCare website.

As a reminder, there is a five day grace period starting at the time of admission or election to hospice care during which you must submit a hospice election through the KanCare website. The website guides the user through the process of electronic submission. If the entry date of the hospice election is beyond the five day requirement, fax the election statement and a written request to the hospice coordinator at 800-913-2229. The election statement must include the following information:

- KanCare provider name and number
- Facility or hospital name and address if billing for room and board charges
- Effective date of the election period
- Signature of the beneficiary of his/her legal representative
- Beneficiary Medicaid ID number
- Beneficiary date of birth

The written request must include information regarding why the election was not entered using the KanCare website. This information is reviewed by the Prior Authorization (PA) department, using criteria established by the state program manager. An override to the five day requirement must meet strict guidelines set forth by the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF). If the override request is approved, the election is backdated to the start date of care. If the request is not approved, it is not backdated and the new approval date will be the date the notice of election was received at the fiscal agent. Claims will be processed using this approved date as the start of the hospice election.

## Hospice

A public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals and which meets the Medicare conditions of participation for hospices.

Hospice services are available to KanCare beneficiaries who:

- Have been certified terminally ill by the medical director of the hospice or the physician member of the hospice interdisciplinary team
- Have been certified terminally ill by the beneficiary's attending physician
- Have filed an election statement with a hospice which meets Medicare conditions of participation for hospices

## Hospice Care

A comprehensive set of services described in 1861 (dd) of the Social Security Act, identified and coordinated by an interdisciplinary group (IDG) to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and /or family members, as delineated in a specific patient plan of care.

## Palliative Care

The provision of patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

**Note:** In accordance with 42 Code of Federal Regulation (CFR) 418.569 (b) hospice must ensure each patient and the primary care giver (s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.

# 11.5 Duration of Coverage

- Hospice coverage must be certified by a physician. It may be subdivided into three or more election periods. For the first period and any subsequent periods, the signed certification statement must be obtained no later than five calendar days after hospice care is initiated.
- Election to receive hospice care will be considered to continue through the initial election period and any subsequent election periods without a break in care, under the original signed election statement, as long as the beneficiary remains in the care of the hospice and does not revoke the election.
- A beneficiary may revoke hospice care at any time he or she chooses by filing a document with the hospice. This document must include a signed statement that the beneficiary revokes the election of Medicaid coverage of hospice care and the date the revocation is effective.
- Upon revoking the election of Medicaid coverage of hospice care, the beneficiary resumes KanCare coverage of the benefits waived when hospice care was elected.
- A beneficiary may change the designation of a particular hospice from which he or she elects to receive hospice care only once.

## 11.6 Forms

**Forms which must be kept on file at the hospice:**

- CERTIFICATION STATEMENT - certifies the beneficiary is terminally ill.
- ELECTION STATEMENT - verifies the beneficiary has elected hospice care and the name of the hospice which will provide care.
- REVOCATION STATEMENT - shows the beneficiary has revoked hospice care and is entitled to regular KanCare benefits.
- CHANGE OF HOSPICE - shows the beneficiary has elected another hospice to provide care.
- NOTIFICATION OF DEATH - verifies the beneficiary's date of death.

**All forms must include the following information:**

- Beneficiary name
- Beneficiary date of birth
- Beneficiary Medicaid ID number
- Hospice provider's name and ID number
- Hospice start of care/effective date
- Beneficiary's or legal representative's signature
- Date of signature

## 11.7 Hospice Levels of Care Defined

Hospice providers are paid a per diem rate based on the number of days and level of care provided during the election period.

### Routine Home Care:

A routine home care day is a day an individual who has elected to receive hospice care is at home and is not receiving continuous home care.

Effective with dates of service on and after Jan. 1, 2016, the payment methodology for Hospice Routine Home Care (HRHC) will change to include two rates that result in a higher base payment for the first 60 days of hospice care and a reduced base payment rate for days thereafter. Days one through 60 will be paid at the HRHC "high" rate, while days 61 and after will be paid at the HRHC "low" rate.

A hospice day billed at the HRHC level of care will be paid one of two rates based upon the following:

- The day is billed as a HRHC level of care day.
- If the day occurs during the first 60 days of an episode, the HRHC rate will be equal to the high rate.
- If the day occurs on day 61 or after, the HRHC rate will be equal to the low rate.
- For a hospice patient discharged and readmitted within 60 days, prior hospice days will continue to count as patient days for the receiving hospice in determining if the receiving hospice can bill at the high or low HRHC rate upon hospice election.

- For a hospice patient discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the patient's 60-day window, paid at the HRHC high rate upon the new hospice election.

Care providers must bill procedure code T2042 for the first 60 days of hospice care and procedure code T2042 with modifier U2 for hospice care beginning on the 61st day.

## Continuous Home Care:

A continuous home care day is a day an individual who has elected to receive hospice care is not in an inpatient facility (hospital, SNF, or hospice inpatient unit) and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Hospice aide, homemaker services, or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill patient at home.

## Inpatient Respite Care:

An inpatient respite care day is a day the individual who has elected hospice care receives care in an approved facility on a short-term basis for respite.

## General Inpatient Care:

A general inpatient care day is a day individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

## SIA For End of Life Care

Effective with dates of service on and after Jan. 1, 2016, Medicaid will cover a Service Intensity Add-on (SIA) payment for end of life care. The SIA payment will be made for a visit by a registered nurse (RN) or social worker (SW) when provided during routine home care in the last seven days of life. The SIA payment is in addition to the routine home care rate. The following procedure codes will be used: G0299 with modifier U2 (RN) and G0155 (SW). Both codes are designated for 15-minute intervals.

Care providers may submit claims for SIA end of life care if the following criteria are met:

- The day is a HRHC level of care day.
- The day occurs during the last seven days of life (and the beneficiary is discharged deceased).
- Service is provided by an RN or SW that day for at least 15 minutes, up to four hours total, not to exceed 16 combined 15-minute increments per day.
- The service is not covered if provided by a social worker via telephone.

Hospices are expected to furnish these services to the extent specified by the plan of care for the individual.

## 11.8 Services

**The following services must be provided:**

### Core Services

With the exception of physician services, all core services must be provided directly by hospice employees on a routine basis. These services must be provided in a manner consistent with acceptable standards of practice. These hospice core services are:

**Physician services**

- Basic payment rates for hospice are designed to reimburse the hospice for the costs of all covered services related to the treatment of the beneficiary's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice. These functions are performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. This includes participation in the establishment, periodic review, and updating of plans of care, supervision of care and services, and establishment of governing policies. The costs for these services performed by the physician are included in the reimbursement rates for the four levels of care.
- Claims submitted by any physician providing direct patient care to a hospice-enrolled beneficiary will be reimbursed. Direct patient care services provided by a hospice physician are allowable charges that must be billed under the physician's provider number.

**Nursing services**

- Nursing services (routinely available and/or on call on a 24-hour basis, seven days a week) provided by or under the supervision of an RN functioning within a plan of care developed by the hospice IDG in consultation with the patient's attending physician, if the patient has one.
- To be covered as nursing services, the services must require the skills of an RN, licensed practical nurse (LPN), or licensed vocational nurse (LVN) under the supervision of an RN and must be reasonable and necessary for the palliation and management of the patient's terminal illness and related conditions.

**Medical social services**

Medical social services must be provided by a qualified social worker under the direction of a physician. Medical social services must be provided by a person who meets the criteria given in the Conditions of Participation at 42CFR418.114(b)(3).

Covered services of these professionals may include but are not limited to:

- Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care
- Assessment of the relationship of the patient's medical and nursing requirements to the patient's home situation, financial resources, and availability of community resources
- Appropriate action to obtain available community resources to assist in resolving the patient's problem
- Counseling services that are required by the patient
- Medical social services furnished to the patient's family member or caregiver on a short-term basis when the hospice can demonstrate that a brief intervention (that is, two or three visits) by a medical social worker is necessary to remove a clear and direct impediment to the effective palliation and management of the patient's terminal illness and related conditions

**Note:** To be considered "clear and direct," the behavior or actions of the family member or caregiver must plainly obstruct, contravene, or prevent the patient's medical treatment. Medical social services to address general problems that do not clearly and directly impede treatment as well as long-term social services furnished to family members, such as ongoing alcohol counseling, are not covered.

**Counseling services**

- Counseling services (including but not limited to bereavement, dietary, and spiritual counseling) with respect to care of the terminally ill individual and adjustment to death. The hospice must make bereavement services available to the family and other individuals identified in the bereavement plan of care up to one year following the death of the patient.
- Counseling services are provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care and for the purpose of helping the individual and those caring for the individual to adjust to the individual's approaching death. Bereavement counseling is available to the patient and his or her immediate family to provide emotional, psychosocial, and spiritual support and services before and after the death of the patient and to assist with issues related to grief, loss, and adjustment for up to one year after the patient's death.

## Non-Core Services

In addition to the hospice core services (physician services, nursing services, medical social services, and counseling), the following services must be provided by the hospice, either directly or under arrangements, to meet the needs of the patient and family:

**Physical and occupational therapy and speech language pathology services**

Physical therapy, occupational therapy, and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

**Hospice aide services**

- A hospice aide employed by a hospice, either directly or under contract, must meet the qualifications required by §1891(a)(3) of the Act and implemented at 42CFR418.76.
- Duties of the hospice aide include personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reports of changes in the patient's condition and needs, and appropriate record completion. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed linens, cleaning, and laundering, which are essential to the comfort and cleanliness of the patient.
- A hospice aide is assigned to a specific patient by an RN who is a member of the interdisciplinary group.
- An RN must visit the home site at least every two weeks when aide services are being provided. This visit must include a written assessment of the aide service.
- Written patient care instructions for a hospice aide must be prepared by the RN who is responsible for the supervision of a hospice aide.

**Homemaker services**

Services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed linens, cleaning, and laundering, which are essential to the comfort and cleanliness of the patient.

**Volunteers**

**Medical supplies** (including drugs and biologicals on a 24-hour basis) and the use of medical appliances related to the terminal illness and related conditions

- All drugs related to the terminal illness of the patient are covered by the hospice program and are included in the daily rate. All drugs not related to the terminal illness or related conditions for beneficiaries receiving hospice care require PA.
- A signed statement from the hospice provider will be needed for all drug PA requests for beneficiaries assigned to that hospice provider. The statement must include rationale for non-coverage of the drug(s) by the hospice provider.
- The signed statement from the hospice provider can be faxed or mailed directly to the PA department or sent to the pharmacy.

**Short-term inpatient care** (including respite care and interventions necessary for pain control and acute and chronic symptom management) in a Medicare/Medicaid participating facility

**Home and Community Based Services**

- Beneficiaries receiving hospice services may also be eligible to receive services through the HCBS program. However, HCBS cannot duplicate services being rendered by the hospice provider.
- To ensure services are not duplicated and the hospice beneficiary is receiving the quality of care that he or she is entitled to, United Healthcare may ask for written care plans from hospice and HCBS providers. Hospice is the coordinator of all care services that the hospice beneficiary receives. When a beneficiary is admitted to hospice services while receiving targeted case management (TCM) services, providers do not need to obtain PA for TCM services. Care coordination provided through the hospice benefit and TCM are separate and distinct services and are not duplicative. Evidence of coordination with other case managers should be reflected in the hospice plan of care.

### Inpatient Care

- **Hospice must notify the KMAP PA department of any hospital admission**. Care must be available for pain control, symptom management, and respite purposes. It may be provided in a participating hospice inpatient unit, hospital, or nursing facility the hospice has contracted with that meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings.
- The provider must seek PA for inpatient hospital admissions that are for conditions unrelated to the hospice diagnosis. Once the beneficiary has elected hospice services, the expectation is that hospice will coordinate all services and will provide education to the beneficiary, family, and caregivers regarding unforeseen changes in the beneficiary's health condition.
- The hospice must assume responsibility for professional management of the resident's hospice services, in accordance with the hospice plan of care and make any arrangements necessary for hospice-related inpatient care.

## 11.9 Hospice Coverage in Nursing Facilities

- We reimburse room and board services for eligible members who reside in NFs that participate in KanCare. You are paid at 95% of the per diem rate that Medicaid would have paid to the NF for the individual in the facility as state plan benefit. Reimbursement is provided when a member elects hospice benefits and the hospice and facility have a written agreement under which the hospice is responsible for the professional management of the member's hospice care and the facility agrees to provide room and board. The room and board component of hospice coverage is a covered service. Payment is made to the hospice for room and board, in addition to routine home care and continuous home care, for those who have elected hospice coverage. No payment will be made to the NF.

- **The NF/ICF or ICF/IDD must not bill KanCare during the hospice-election time frame.** Entering NF/ICF or ICF/IDD dates of service (DOS) which overlap with hospice dates on any portion of a claim will result in the entire claim being denied.
- For UB-04 claims, the entire claim will be denied based on the header DOS. However, the edit will post on each detail regard less of whether the detail DOS is within the hospice assignment. Services provided during the dates of a beneficiary's hospice assignment must be billed separately from services provided outside the hospice assignment period.
- **Routine nursing facility supplies are content of the per diem room and board reimbursement.**

## 11.10 Inpatient Respite Care

- This type of care is provided only when necessary to relieve family members or other persons caring for the individual at home. It may not be reimbursed for more than five consecutive days at a time and may be provided only on an occasional basis. A hospice patient may enter a NF which has contracted with the hospice for the purposes of receiving respite care.
- Certification that the beneficiary is terminally ill must be completed and filed with the hospice providing care. Hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. A plan of care must be established before services are provided. To be covered, services must be designated in the plan of care.
- In establishing the initial plan of care, the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member before writing the initial plan of care. At least one of the persons involved in developing the initial plan of care must be a nurse or physician.
- Other insurance is primary and must be billed first.

## 11.11 Leave Days

- We have updated our claims processing system to facilitate accurate billing and to monitor the limitations for hospital leave days.
- Reservation of a bed is allowed for up to ten days per confinement when an NF, nursing facility/mental health (NF/MH), or ICF/IID patient leaves the facility and is admitted to an acute care facility when conditions under the reserve day regulations are met. KMAP reimburses hospice providers 67% of the room and board rate.

**Note:** To ensure accurate payment, you must bill hospital leave days consecutively, to begin with the date of admission to an acute care facility.

## 11.12 Provider Requirements

- The hospice must comply with the KMAP provider agreement and meet all other hospice regulatory guidelines for participation.
- All services provided by the hospice must be performed by appropriately qualified personnel. However, it is the nature of the service, rather than the qualifications of the person who provides it, that determines the coverage category of the service. Hospice services must be reasonable and necessary for the palliation or management of the terminal illness, as well as related conditions, in order to be allowed.

## Reimbursement Criteria

We reimburse at one of four predetermined rates for each day in which a beneficiary is under the care of the hospice. Physician services in excess of hospice physician services will be billed and reimbursed in accordance with benefits and limitations. There will be one attending physician designated for each hospice beneficiary.

**Routine home care**

The hospice is reimbursed at the routine home care rate for each day the patient is at home, under the care of the hospice, and not receiving continuous home care. Routine home care is paid without regard to the volume or intensity of services provided on any given day.

**Continuous home care**

- The hospice is reimbursed at a continuous home care rate when continuous home care is provided. The continuous home care rate is divided by 24 in order to arrive at an hourly rate. A minimum of eight hours per day must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.
- Continuous home care is covered when it is provided to maintain an individual at home during a medical crisis. A period of crisis is a time when a patient requires continuous care (primarily professional nursing care) to achieve palliation or the management of acute medical symptoms.
- Nursing care must be provided by an RN or LPN. The RN or LPN must be providing care for more than half of the period of care.
- A minimum of eight hours of care must be provided during a 24-hour day which begins and ends at midnight. The care need not be continuous (such as, four hours can be provided in the morning and another four hours can be provided in the evening of that day). Homemaker and home health aide services can also be provided to supplement the nursing care.

**Inpatient respite care**

The hospice is reimbursed at the inpatient respite care rate for each day the beneficiary is in an inpatient facility, as previously defined, and is receiving respite care. Payment for respite care may be made for a maximum of five days at a time (including the date of admission, but excluding the date of discharge) at the respite care rate.

**General inpatient care**

Payment at the inpatient rate is made when general inpatient care is provided. None of the other fixed payment rates are applicable for a day on which the patient receives hospice inpatient care, except for the day of discharge from an inpatient unit when the appropriate home care rate is to be paid. When the patient is discharged deceased, we pay the inpatient rate (general or respite) for the discharge date.

**Reimbursement of hospice room and board on date of death**

We reimburse room and board (T2046) on the date of death for a hospice beneficiary residing in an NF, ICF/IID, and hospital swing bed. Regular payment rules continue on the date of death with the additional payment being made to the hospice for room and board which is then paid out to the NF, ICF/IID, or hospital swing bed.

## 11.13 Hospital Limitation Audits

- Limitation audits are in place to help ensure accurate payment of hospice services. KanCare will not allow reimbursement to exceed one unit per day for the following per diem hospice level of care codes: T2042 T2044 T2045 T2046
- Reimbursement of hospice level of care code combinations that are billable on the same date of service will remain unchanged.
- Reimbursement for level of care code T2043 is billable when a minimum of eight hours of continuous care is provided in a 24-hour period. Reimbursement will not exceed 24 hours of care per day.
- SIA services for end of live care are limited to a combined total of up to 16 units per day of codes G0155 and G0299 US, not to exceed a total of 112 units during the last seven days of hospice care and the patient is discharged deceased.

## 11.14 Services not Related to the Terminal Illness

Services for illnesses or conditions not related to the terminal illness of the beneficiary and which are usually covered are considered separately. They may be reimbursed by United Healthcare, with PA if the service is determined to be unrelated to the terminal illness of the patient. All services provided related to the terminal illness are the responsibility of the hospice provider and should be billed to the hospice provider directly.

## 11.15 Transportation Services for Hospice Beneficiaries

Transportation to hospice-related services is the responsibility of the hospice provider. Medical services unrelated to hospice treatment or diagnosis may be covered if medical criteria are met.

## 11.16 Hospice Care for Children in Medicaid

Beneficiaries receiving services reimbursed by Medicaid and Children's Health Insurance Program (CHIP) can continue medically necessary curative services, even after the election of the hospice benefit by or on behalf of children receiving services. Section 2302 of the Affordable Care Act, entitled "Concurrent Care for Children," allows curative treatment upon the election of the hospice benefit by or on behalf of children enrolled in Medicaid or CHIP.

The Affordable Care Act does not change the criteria for receiving hospice services. However, prior to enactment of the new law, curative treatment of the terminal illness ended upon election of the hospice benefit. This new provision requires states to make hospice services available to children eligible for Medicaid and Medicaid-expansion CHIP programs without terminating any other service which the child is entitled to under Medicaid for treatment of the terminal condition.

### Limitations

- An initial 90-day period
- A subsequent 90-day period
- Unlimited subsequent 60-day periods with appropriate physician recertification for continued hospice care

A provider must submit a copy of the physician recertification statement with their first claim for the subsequent 60-day periods. Claims will deny unless that document is submitted.

## Medical Services and Concurrent Care for Children Receiving Hospice Services

Children receiving hospice services may continue to receive other reasonable and necessary medical services, including curative treatment for the terminal hospice condition.

- Prior authorization is only required if the services rendered are on the UnitedHealthcare prior authorization list.
- Hospice care providers will be responsible for coordinating all services related to the hospice diagnosis and assisting non-hospice care providers to obtain authorization when required on UnitedHealthcare's Prior Authorization list.
- Hospice care providers will be responsible for all durable medical equipment, supplies, and services related to the hospice diagnosis.
- Non-hospice care providers must first communicate and coordinate with hospice care providers regarding needed services or procedures prior to rendering concurrent care for children.
- Non-hospice care providers must bill hospice first to receive a payment or denial for the service provided.
- If payment is denied by hospice, non-hospice care providers must submit a paper claim, documentation of medical necessity and the hospice denial form to the PA department for review.
- If PA cannot be obtained prior to rendering services to children, you may be allowed a backdated approval for services upon submission of a paper claim for the service with documentation attached to support medical necessity and hospice denial of the service.

Hospice patients (0 through 20 years of age) may receive the services identified below as long as the services are not duplicative of services provided by the hospice facility.

- Case management services when provided and billed by an ARNP enrolled in KanCare
- Technology Assisted (TA) waiver program attendant care services

Hospice care providers will continue to be responsible for all durable medical equipment and supplies.