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# Hospice Care

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Hospice care is a medical multidisciplinary care designed to meet the unique needs of terminally ill individuals.

Hospice care is used to alleviate pain and suffering, and treat symptoms rather than to cure the illness. Items and services are directed toward the physical, psychological, social, and spiritual needs of the patient/family unit. Medical and nursing services are designed to maximize the patient's comfort, alertness, and independence so that the patient can reside in the home as long as possible.

Providers must enroll as a Medi-Cal Hospice provider. All claims are submitted using the *UB-04* claim. For additional hospice billing procedures and claim form instructions, refer to the appropriate Part 2 outpatient services manual.

## **Eligible Providers**

Hospice providers may include the following:

- Hospitals
- Skilled nursing facilities
- Intermediate care facilities
- Home health agencies
- Any licensed health provider who has been certified by Medicare to provide hospice care and is enrolled as a Medi-Cal hospice care provider

All services must be rendered in accordance with Medicare requirements.

## **Eligible Recipients**

Any Medi-Cal eligible recipient certified by a physician as having a life expectancy of six months or less may elect to receive hospice care in lieu of normal Medi-Cal coverage for services related to the terminal condition. Election of hospice care occurs when the patient (or representative) voluntarily files an election statement with the Hospice provider. This statement acknowledges that the patient understands that the hospice care relating to the illness is intended to alleviate pain and suffering rather than to cure, and that certain Medi-Cal benefits are waived by this election. The hospice provider is responsible for the coordination of hospice services and is responsible to assure that the election form is properly transmitted to the hospice clerk in the Medi-Cal Eligibility Division of the Department of Health Care Services.

A copy of the notification of election statement, signed by the recipient or the recipient's authorized representative, must be forwarded to:

Attn: Hospice Clerk  
Department of Health Care Services  
Medi-Cal Eligibility Division, MS 4607  
1501 Capitol Avenue, Room 4063  
P.O. Box 997417-7417  
Sacramento, CA 95899-7417

## **Recipients Younger Than Age 21**

In accordance with section 2302 of the Patient Protection and Affordable Care Act, any Medi-Cal eligible recipient younger than 21 years of age and certified by a physician as having a life expectancy of six months or less may elect to concurrently receive hospice care in addition to curative treatment of the hospice related diagnosis. Non-hospice providers will be able to bill Medi-Cal for medically necessary, curative treatments that are provided within their scope of practice and that are considered a benefit under the Medi-Cal program. All services are subject to current utilization review mechanisms.

A copy of the election statement signed by the patient or an authorized representative must be forwarded to:

Attn: Hospice Clerk  
Department of Health Care Services  
Medi-Cal Eligibility Division, MS 4607  
1501 Capitol Avenue, Room 4063  
P.O. Box 997417-7417  
Sacramento, CA 95899-7417

## **Periods of Care**

Hospice is a covered Medi-Cal benefit with the following periods of care:

- Two 90-day periods, beginning on the date of hospice election
- Followed by unlimited 60-day periods

A period of care starts the day the patient receives hospice care and ends when the 90-day or 60-day period ends.

## **Patient Certification/Recertification Required**

The attending physician (if one exists) and the medical director or physician member of the hospice interdisciplinary team must have certified in writing at the beginning of the first 90-day period that the patient was terminally ill. For all subsequent recertification periods, only a hospice physician may certify that the patient is terminally ill. Only a physician (patient physician or the hospice medical director) can certify that the patient is terminally ill with six months to live.

At the start of the first 90-day period of care, the Hospice provider must maintain an initial certification that the patient is terminally ill in the patient's medical record. At the start of each subsequent period of care, the Hospice provider must maintain a recertification that the patient is terminally ill in the patient's medical record.

### **Example:**

A patient has an end-stage liver disease and her attending physician told her she has six months to live. The patient elects hospice in lieu of curative treatment. She completes the election package and her attending doctor and the hospice medical director or the physician member of the hospice interdisciplinary team certifies she is terminally ill. The woman elects hospice on September 1, 2009, and begins receiving hospice care.

- Initial certification: September 1, 2009, through November 29, 2009 (first 90-day period). The patient remains alive and the hospice physician certifies her again as terminally ill. The Hospice provider must maintain the certification that the patient is terminally ill in the patient's medical record.
- Recertification: November 30, 2009, through February 27, 2010 (second 90-day period). The patient continues to live and the hospice physician certifies her again as terminally ill. The Hospice provider must maintain the recertification that the patient is terminally ill in the patient's medical record.
- Recertification: February 28, 2010, and again April 29, 2010, etc. (60-day periods, unlimited). Every 60 days the hospice physician must certify that the patient is terminally ill. The Hospice provider must maintain the certification that the patient is terminally ill in the patient's medical record.

## Face-To-Face Encounter

A hospice physician or nurse practitioner (NP) is required to have a face-to-face encounter with every hospice patient to determine the continued eligibility of that patient. The face-to-face encounter requirement is satisfied when the following criteria are met:

1. Timeframe of the encounter

The encounter must occur no more than 30 calendar days prior to the start of the third benefit period, and no more than 30 calendar days prior to every subsequent benefit period thereafter (refer to item four below for an exception to this timeframe).

2. Attestation requirements

A hospice physician or NP who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter.

The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. Where an NP performed the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician for use in determining whether the patient continues to have a life expectancy of six months or less, should the illness run its normal course.

3. Practitioners who can perform the encounter

A hospice physician or a hospice NP can perform the encounter. A hospice physician is a physician who is employed by the hospice or working under contract with the hospice. A hospice NP must be employed by the hospice. A hospice employee is one who receives a W-2 from the hospice or who volunteers for the hospice.

4. Timeframe exceptional circumstances for new hospice admissions in the third or later benefit period

In cases where a hospice newly admits a patient in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period.

For example, if the patient is an emergency weekend admission, it may be impossible for a hospice physician or NP to see the patient until the following Monday. Or, if CMS data systems are unavailable, the hospice may be unaware that the patient is in the third benefit period. In such documented cases, a face-to-face encounter that occurs within two days after admission will be considered timely. Additionally, for such documented exceptional cases, if the patient dies within two days of admission without a face-to-face encounter, a face-to-face encounter can be deemed as complete.

#### 5. Timeframe requirements when a patient transfers from one hospice to another

When a Medi-Cal hospice patient transfers from one hospice to another, it is sometimes difficult to determine what benefit period a patient is in. In such cases, the receiving hospice may not know if a face-to-face recertification is necessary.

The receiving hospice provider is required to document in the patient's medical record all efforts to obtain the previous hospice benefit period, either from the transferring hospice provider or from other sources. If the receiving hospice cannot determine the correct benefit period, the face-to-face recertification clock starts from the time the receiving hospice provider completes the intake process. This information must be maintained in the patient's medical record for auditing purposes.

The hospice must retain the certification statements, and have them available for audit purposes.

### **Patient Revokes**

If the patient revokes hospice care, the patient, as well as the hospice provider, must inform the Department of Health Care Services (DHCS) in writing by submitting the hospice revocation form signed by the patient. Subsequently, if the patient re-elects hospice care, the hospice provider must submit a new patient hospice election to DHCS at the address under "Eligible Recipients" on a preceding page. The hospice provider retains the initial certification of terminal illness from the hospice physician in the terminally ill patient's medical record. The hospice care period starts again with the two 90-day periods followed by the unlimited 60-day periods.

### **Patient Discharges**

If the patient is discharged from hospice care due to the patient's death or due to a decision made by the hospice care team, the hospice provider must inform DHCS in writing.

### **Service Restrictions**

The response from the eligibility verification system for recipients who elect to receive hospice care in lieu of curative treatment and services will state "Primary diagnosis/limited to hospice." The recipient is not eligible to receive services related to the terminal diagnosis from providers other than a hospice provider or the attending physician. Accordingly, whenever this phrase is returned from the eligibility verification system, other providers should identify the name of the patient's hospice provider, and inform the provider that the hospice patient is seeking other medical assistance related to the terminal diagnosis.

## Unrelated Services

The special message “Primary diagnosis/limited to hospice” does not mean Medi-Cal recipients are prohibited from receiving other services that are unrelated to the primary diagnosis, such as physician examinations, drugs, or other medical care.

For example, if a hospice patient suffers an injury or has a pre-existing condition, such as diabetes, all necessary medical care would be covered in the usual manner subject to applicable Medi-Cal restrictions and controls.

If the hospice provider determines that the recipient has revoked his/her election (even though the eligibility verification system response indicates otherwise) necessary services may be rendered in the usual manner subject to applicable Medi-Cal restrictions and controls.

## For All Status Changes

Though not required, providers are requested to enter the admission date in the *Admission Date* field (Box 12) and the appropriate patient status code in the *Status* field (Box 17) on the outpatient *UB-04* claim. Utilizing these fields will assist in providing accurate reimbursement. Data values allowed for the *Status* field are:

### «**Status Code Descriptions**»

<b>Status Code</b>	<b>Description</b>
01	Discharged to home or self care
30	Still a patient (for continuing hospice care for same recipient)
40	Expired at home
41	Expired in a medical facility, such as a hospice, Nursing Facility Level A, Nursing Facility Level B, or freestanding hospice
42	Expired, place unknown
50	Discharged/transferred to hospice, home
51	Discharged/transferred to hospice, medical facility

It is recommended that the *Remarks* field (Box 80), or an attachment to the claim, be utilized to report previous discharge, decertification, revocation or transfer information for this patient. Providers should include the NPI of the facility from which the recipient transferred, the dates the patient was admitted and the date that tenure ended.

It is also recommended that an occurrence code be entered in the *Occurrence Code* fields (Boxes 31–34). The occurrence code works in tandem with the patient status code to clarify the billing scenario. All occurrence code values are accessible in the *National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual*. The following are examples of scenarios in which occurrence codes are helpful:

**«Occurrence Code Descriptions»**

<b>Occurrence Code</b>	<b>Description</b>	<b>Application</b>
27	Date of hospice certification or recertification	Could be used in conjunction with patient status code 30 (still a patient) in a claim scenario in which the patient gets certified for a new benefit period.
42	Date of discharge	Could be used in conjunction with patient status code 01 (discharged to home or self care) in a claim scenario where the patient is determined to no longer be terminally ill and is discharged. Can also be used if a patient chooses to revoke the hospice benefit.
55	Date of death	Could be used in conjunction with patient status code 20 (expired), 40 (expired at home), 41 (expired in a medical facility) or 42 (expired in a place unknown) in a claim scenario in which the patient passes away.

## **Classification of Care**

Each day of hospice care is classified into one of four levels of care:

- Routine home care
- Continuous home care
- Inpatient respite care
- General inpatient care (no respite)/hospice general care

## **Level of Care Core Services**

Core services within each level of care include:

- Nursing services
- Physical and occupational therapy
- Speech-language pathology
- Medical social services, home health aide and homemaker/ attendant services
- Medical supplies and appliances
- Drugs and biologicals
- Physician services
- Short-term inpatient care
- Counseling

## **Routine Home Care**

Routine home care is received at the patient's home; it is not continuous home care. Routine home care (revenue codes 0650 [high rate for 0 – 60 days], 0659 [low rate for 61+ days] and 0552 [service intensity add-on (SIA) payment for last seven days of life]) is reimbursable to hospice providers for each day the recipient is under the care of the hospice and not receiving another level of care, whether or not the recipient is visited in the home by the hospice provider on the days being billed. Revenue codes 0650 and 0659 are reimbursable for days when no home visit is made, only if the service(s) provided are consistent with the recipient's plan of care.

## **Continuous Home Care**

Continuous home care consists of continuous, predominately skilled nursing care provided on an hourly basis, for a minimum of eight hours during brief crisis periods. Home health aide and/or homemaker services may also be provided.

## **Respite Care**

Respite care occurs when the patient receives care in an approved inpatient facility on a short-term basis to provide relief for family members or others caring for the individual. Each episode is limited to no more than five days.

## **General Inpatient Care**

General inpatient care occurs when the patient receives general care in an inpatient facility for pain control, or acute/chronic symptom management that cannot be managed in other settings.

## **Primary Care Physician Services**

Hospice providers are required to provide all necessary services related to the terminal diagnosis within the four levels of care – except for primary care physician services, that may be provided and billed directly by the attending physician, and special physician services related to the primary diagnosis, that may be billed separately by the hospice.

## **Services Covered**

Special physician services are those furnished by a physician hospice employee or a physician under arrangement with the hospice for managing symptoms that cannot be remedied by the patient's attending physician because of (1) immediate need or (2) the attending physician does not have the required special skills. (For example, a urologist assists the patient in voiding when the bladder is pathologically obstructed).

## Services Not Covered

When an individual is under the care of a hospice, separate payment will not be made, or treatment authorizations approved, for the following when they are directly related to the terminal diagnosis:

- Hospital
- Nursing Facility Level A or B
- Home Health Agency care
- Medical supplies and appliances
- Drugs and biologicals
- Durable Medical Equipment (DME)
- Medical transportation
- Any other services, as specified in *California Code of Regulations (CCR)*, Title 22, related to the individual's terminal diagnosis

**Note:** Individuals younger than the age of 21 and under the care of a hospice are eligible for curative treatment related to the terminal diagnosis as specified in the Patient Protection and Affordable Care Act, Section 2302.

## Copayments

In accordance with federal requirements, no Medi-Cal copayments may be collected from Medi-Cal recipients who are receiving hospice services for any Medi-Cal services, including services that are not related to the terminal illness.

## End of Life Services

Recipients who elect hospice care may also be eligible for end of life services if they meet the specified criteria. Refer to the *End of Life Option Act Services* section in the appropriate Part 2 manual for more information.

## Attending Physician and Unrelated Services

Services by the attending physician and services that are not related to the terminal diagnosis, such as treatment for injuries caused by an automobile accident, should be billed in the usual manner by the physician performing the services.

## **Emergency Services**

In the event a recipient who has elected hospice care seeks assistance at an emergency room or requests emergency transportation, the emergency service provider should obtain the name of the recipient's hospice and notify the hospice immediately. The hospice provider will take appropriate action.

## **Requirements**

Providers are reminded that *Health and Safety Code*, Section 1317, states that emergency services and care shall be provided to any person requesting such services or care, or for whom such services or care are requested, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any licensed health facility that maintains and operates an emergency department. In addition, emergency services and care shall be rendered without first questioning the patient regarding the ability to pay.

## **Residential Care Facilities for the Elderly (RCFE)**

The following revenue codes are reimbursable when rendered in Residential Care Facilities for the Elderly (RCFE).

### «RCFE Revenue Code Descriptions»

<b>Revenue Code</b>	<b>Description</b>
0552	Routine home care (service intensity add-on [SIA] rate)
0650	Routine home care (high rate)
0652	Continuous home care
0655	Inpatient respite care
0656*	General inpatient care (no respite)/hospice general care
0657	Physician's services
0659	Routine home care (low rate)

**Note:** Providers billing hospice care revenue codes 0552, 0650, 0652, 0655, 0656, 0657 or 0659 for Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service, may bill Medi-Cal directly. Medicare denial documentation is not required with these claims.

## **Billing Instructions**

Claims submitted for these services on the *UB-04* claim require type of bill code with the first two digits “86” and a third claim frequency digit as detailed in the *National Uniform Billing Data Element Specification* manual. Refer to the *UB-04 Completion: Outpatient Services* section in the appropriate Part 2 manual for additional information about *Type of Bill* field (Box 4).

For information on documenting coexisting or additional diagnoses related to a patient’s terminal illness on hospice claims, refer to the *Hospice Care: General Billing Instructions* section in the appropriate Part 2 manual

## **Room and Board Not Reimbursable**

Hospice providers rendering services in an RCFE may not be reimbursed for room and board revenue code 0658.

**<<Legend>>**

<<Symbols used in the document above are explained in the following table.>>

<b>Symbol</b>	<b>Description</b>
<<	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
>>	This is a change mark symbol. It is used to indicate where on the page the most recent change ends
*	Revenue code 0656 must be billed in conjunction with HCPCS code T2045. A <i>Treatment Authorization Request</i> (TAR) is required.