Payment Policy: Hospice VBID		
Original Date Approved: 12/31/2020	**Effective Date** 01/01/2021	**Date Revised:** N/A
Scope: Commonwealth Care Alliance (CCA) Product Lines: ☒ Senior Care Options ☐ One Care		

PAYMENT POLICY SUMMARY:

Commonwealth Care Alliance (CCA) has been chosen to participate in the Center for Medicare and Medicaid Innovation Center's (CCMI) three-year Hospice Value-based Insurance Design(VBID). Due to CCA's involvement in this program, the plan will begin to cover medically necessary hospice services for terminally ill members participating in CCA's Senior Care Options product. This payment policy and the subsequent directives are only applicable to SCO members with a hospice election on or after 01/01/2021.

REIMBURSEMENT REQUIREMENTS:

Hospice benefit periods consist of an initial 90-day period, a subsequent 90-day period, or an unlimited number of subsequent 60-day periods. Hospice care will be reimbursed at the Medicare per diem rate. CCA will follow the appropriate Medicare/Medicaid reimbursement guidelines for all Commonwealth Care Alliance (SCO) members in accordance with Section 1814(i) of the Social Security Act (the Act). Hospice providers are required to submit claims on a monthly frequency with the appropriate date range and unit amount. The unit amount must reflect the date range billed. Hospice providers should not submit claims comprising more than one month of service. CCA allows an exception of the frequency of billing if a member revokes their hospice election, or if the member expires.

The hospice election admission date must be the start date of a benefit period unless a transfer occurs. The hospice admission date submitted can never precede a physician's certification by more than 2 calendar days. If a certification by a physician is not completed timely the admission date is the equivalent of the certification date. Under the circumstances of a new hospice admission following revocation or discharge, the new revocation may not be the same as the revocation or discharge date from the patient's previous benefit period. Section 1814(i) of the Social Security Act § 418.22(b)(3) requires that the certification and recertification forms include a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less.

Members of Commonwealth Care Alliance Senior Care Options (SCO) bear no cost-sharing for hospice services.

All hospice claims require the submission of the applicable discharge status codes as per Medicare guidelines.

Per the VBID demonstration project with CMS, all hospice providers rendering care to CCA SCO members will be compliant with the Medicare Hospice Benefit manual 100-02 Chapter 9 as well as the Medicare Claims Processing manual 100-04 Chapter 11. Upon request by CCA, a copy of the original NOE including but not limited to any addendum will be furnished by the hospice provider to CCA within 7 business days.

Concordant with updates to the manual for hospice care rendered after 10/1/2020, services unrelated to the terminal illness and related conditions are exceptional and unusual and the hospice should be providing virtually all care needed by the individual who has elected hospice.

Guidelines below for all notice submission requirements containing condition codes/occurrence codes apply to the electronic Medicare submission only. CCA requires a copy of the Medicare submission sent securely to CCA's Eligibility Inbox (in the format of a .txt file, PDF, or Excel spreadsheet). In-network providers must submit all notices within 7 days from the hospice admission date, the hospice discharge date, or by other date requirements specified in the guidance below. Out-of-network providers must follow the same submission guidance within 5 business days. The submission to the eligibility inbox may include data for more than one patient, however, all individual patient data should be submitted on a single line.

All notices (Notice of Election, Notice of Termination/Revocation, Notice of Transfer, Notice of Cancellation, and Change of Ownership notification) outlined in this policy **MUST** be submitted to both Medicare and the CCA Eligibility Inbox: Eligibility@commonwealthcare.org

NOTICE OF ELECTION (NOE]

A Notice of Election (NOE) is required and must be filed to both Medicare and CCA prior to beginning Hospice care or within 5 business days of the hospice admission date for out-of-network providers and within 7 business days of the hospice admission date for in-network providers. The election must be signed by the patient or their authorized representative.

If the NOE is not received timely by CCA, services will be denied. CCA will not cover and pay for the days of hospice care from the hospice admission date to the date the NOE is submitted to, and accepted by, CCA. Claims that do not fit the timely filing exception criteria below should be submitted as non-covered with occurrence span code 77.

Per CMS guidelines, the following circumstances are eligible for the review of exceptions to timely filing:

- Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice's ability to operate
- An event that produces a data-filing problem due to a CCA system issue that's beyond the control of the hospice
- Other circumstances determined by CMS to be beyond the hospice's control

If the hospice provider believes the criteria for an exception has been met, the required documentation (as per Medicare guidelines) for each scenario above must be submitted to CCA in order to support and demonstrate the exception.

An NOE should be submitted with the applicable Type of Bill (TOB):

- 81A – Non-hospital based Hospice Initial Election Notice
- 82A – Hospital based Hospice Initial Election Notice

Initial submission of an NOE does not require condition codes. The hospice should report occurrence code 27 accompanied by the admission date. If a previously submitted NOE requires modification to correct an election date, the hospice provider should submit occurrence code 56 and condition code D0.

For CCA SCO members that are discharged and readmitted to hospice services within 60 days of the discharge, the hospice days will continue to follow the member. If the hospice patient is discharged from hospice care for more than 60 days a new election to hospice will initiate a reset of the member's 60-day window, paid at the routine home care high rate upon the new admission. The new admission will require resubmission of the NOE to Medicare and CCA.

NOTICE OF TERMINATION/REVOCATION (NOTR)

A Notice of Election Termination/Revocation (NOTR) is used when a patient is discharged from Hospice alive or chooses to revoke their hospice election. NOTR must be filed **within 5 business days after the effective date of discharge for out-of-network providers and 7 business days** after the effective date of discharge for in-network providers. The NOTR must include the appropriate date range containing the "From" and "To" dates applicable to revocation.

The following scenarios will affect the Hospice end date:

- When there is no change in the provider number during the election, the hospice must submit the start date of the election period as the "From date" on the NOTR
- If the revocation follows a transfer, the "From" date on the NOTR must match the START DATE on the benefit period that initiated the transfer
- If the revocation follows a change of ownership, the "From" date on the NOTR must match the OWNER CHANGE start date on the benefit periods. This process is to ensure that only the provider currently rendering hospice services to the member can submit the NOTR

Condition codes are not required for the initial submission of the NOTR. If the date of termination/revocation requires correction by the hospice provider, occurrence code 56 and condition code D0 should be submitted.

An NOTR should be submitted with the applicable Type of Bill (TOB):

- 81B — Non-hospital based Hospice Notice of Election Termination/Revocation

- 82B — Hospital based Hospice Initial Election Notice Termination/Revocation

NOTICE OF TRANSFER

If a CCA SCO member transfers their hospice care to another hospice provider, a transfer notice must be submitted by the admitting hospice provider. The transfer notice should be submitted with the applicable bill type outlined below and should not be submitted until the previous hospice provider has finalized their billing:

A notice of transfer should be submitted with the applicable Type of Bill (TOB):

- 81C – Non-hospital based Hospice Change of Provider
- 82C – Hospital Based Hospice Change of Provider

Occurrence code 27 is not required for notice of transfer unless the transfer date is the first day of the next hospice benefit period.

NOTICE OF CANCELLATION

CCA requires a notice of cancellation submission by the hospice provider if a SCO member decides not to receive services from the provider and an admission date has already been submitted to Medicare and CCA for that member. Cancellation can also be submitted to correct a change of ownership submitted in error. If there has been no change of the hospice provider during the election period, the hospice provider should submit the initial admission date as the election date of the election period being canceled.

A notice of cancellation should be submitted with the applicable Type of Bill (TOB):

- 81D – Non-hospital based Hospice Notice of Cancellation
- 82D – Hospital Based Hospice Notice of Cancellation

Condition codes are not required for initial submission, occurrence code 56 for any subsequent correction.

CHANGE OF OWNERSHIP DURING THE HOSPICE ELECTION PERIOD

If a hospice provider is purchased during a member's election period, a notice to denote the change of ownership is required. The effective date of the change in ownership should be listed as the "From" date.

Change of Ownership notice must be submitted with the applicable Type of Bill (TOB):

- 81E – Non-hospital based Hospice Change of Ownership
- 82E – Hospital Based Hospice Change of Ownership

Condition codes are not required unless there is a correction of the effective date of the change in ownership. If a correction is necessary occurrence code 56 should be submitted with condition code D0. If these codes are not reported together the claim will be returned to the provider.

HOSPICE SERVICES PROVIDED DURING THE COVID-19 PUBLIC HEALTH EMERGENCY (PHE)

Hospice providers may render telehealth services through audio/visual services with two-way communication or through audio-only during the COVID-19 PHE for routine home care if appropriate.

Face-to-face services for recertification purposes may be performed via real time audio/visual telehealth with two-way communication.

Service intensity add-on payments will not be made for telehealth hospice services during the COVID-19 PHE.

NURSING FACILITIES

Reimbursement will not be provided to nursing facilities for a bed hold in the event of Medical Leave of Absence (MLOA). Reimbursement will only be provided for a bed hold during the 10-day period of Non-Medical Leave of Absence (NMLOA).

DURABLE MEDICAL EQUIPMENT (DME)

Requests for DME **should not** be sent to the DME Medicare Administrative Contractors (MACs).

CCA assumes responsibility for all unrelated care, services, and items, including DME. CCA may conduct pre-payment development or post-payment review to validate that the services unrelated to the terminal illness and related conditions (billed with the appropriate modifier or condition code) are not related to the terminal illness and related conditions.

In the event that the claim exceeds the number of allowable modifiers, suppliers are instructed to use modifier 99 on the line to indicate additional modifiers are reported in the remarks field. The supplier must include the GW modifier in the claim remarks. Claims that do not contain the GW modifier shall be denied.

BILLING AND CODING GUIDELINES:

The Health Insurance Portability & Accountability Act (HIPAA) Transaction and Code Set Rule requires providers to use the code(s) that are valid at the time the service is provided. Providers must only use industry standard code sets and must use specific HCPCS and CPT codes when available.

Revenue Code	Description

651	Routine Home Care
652	Continuous Home Care
655	Inpatient Respite Care
656	General Inpatient Care
657	Physician Services

Code	Hospice Service Description
Q5001	Hospice or home health care provided in patient's home/residence
Q5002	Hospice or home health care provided in assisted living facility
Q5003	Hospice care provided in nursing long-term care facility (LTC) or nonskilled nursing facility (NF)
Q5004	Hospice care provided in skilled nursing facility (SNF)
Q5005	Hospice care provided in inpatient hospital
Q5006	Hospice care provided in inpatient hospice facility
Q5007	Hospice care provided in long-term care facility
Q5008	Hospice care provided in inpatient psychiatric facility
Q5009	Hospice or home health care provided in place not otherwise specified (NOS)
Q5010	Hospice home care provided in a hospice facility

The following services may also be submitted on the claim; however, no additional payment will be issued by CCA as the services are considered bundled with the level of care on the claim.

Revenue Code	Description	HCPCS Code	Required Detail
250	Non-injectable Prescription Drugs	No HCPCS Required	Report a monthly charge total for all drugs (i.e., report a total charge amount for the period covered by the claim) using revenue code 0250.
29X	Infusion Pumps	N/A	Report a monthly charge total for infusion DME (i.e., report a total charge amount for the period covered by the claim), including DME infusion drugs, using revenue center 029X for the infusion pumps and 0294 for DME infusion drugs
42X	Physical Therapy	G0151	Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on

			the claim are the multiplier for the total time of the visit defined in the HCPCS description.
43X	Occupational Therapy	G0152	Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
44X	Speech Therapy –Language Pathology	G0153	Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
55X	Skilled Nursing	G0299 or G0300	Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
56X	Medical Social Services	G0155	Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
569	Other Medical Social Services	G0155	Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
57X	Aide	G0156	Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
636	Injectable Drugs	N/A	After 10/01/2018 revenue code 636 is not required.

Professional services of attending physicians, who may be nurse practitioners or physician assistants, furnished to hospice beneficiaries are coded with modifier GV when performed by an Attending physician not employed or paid under arrangement by the patient's hospice provider.

RELATED SERVICE POLICIES:

Skilled Nursing Facilities

DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable and adherence to plan policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES:

Medicare Claims Processing Manual 100-04 Chapter 11

Hospice Flexibilities to Fight COVID-19 https://www.cms.gov/files/document/covid-hospices.pdf

Federal Register FY2020 Hospice Wage Index https://www.federalregister.gov/documents/2019/08/06/2019-16583/medicare-program-fy-2020-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting

POLICY TIMELINE DETAILS

1. Drafted September 2020