

Hospice Payment Policy

Policy

Updates related to coronavirus disease 2019 (COVID-19) for MassHealth ACO and NaviCare SCO¹:

Effective March 12th, 2020, in response to the State of Emergency in Massachusetts due to 2019 novel coronavirus (COVID-19), hospice agencies are permitted to provide services via telehealth in accordance with [MassHealth LTSS guidance](#) for MassHealth ACO and NaviCare SCO members. Unless otherwise stated, information provided in the LTSS guidance is effective for the duration of the State of Emergency declared by Governor Baker. The State of Emergency ended on June 15, 2021.* Those services are limited to:

- A Hospice Agency Provider may conduct required in-person activities as described at 130 CMR 437.423 via telehealth (including telephone and live video) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/doc/all-provider-bulletin-289-masshealth-coverage-and-reimbursement-policy-for-services-related-to/download>), and as determined necessary by the Hospice Agency Provider.
- The performance of these functions shall be billed per usual protocols and the performance and delivery via telehealth must be clearly documented in the Member's record. Providers should bill the same procedure codes for services delivered via telehealth as appropriate for services delivered face-to-face.
- Please refer to the Fallon Health Telemedicine Payment Policy for coding and billing information respective to telehealth.

* Through All Provider Bulletin 314, MassHealth announced that it would maintain the agency's telehealth policy through the date that is 90 days after the termination of the State of Emergency in the Commonwealth due to the Coronavirus disease 2019 (COVID-19) outbreak. Managed Care Entity Bulletin 60 requires managed care plans to maintain telehealth policy consistent with All Provider Bulletin 314. Through All Provider Bulletin 324, which supersedes All Provider Bulletin 314, MassHealth maintains and extends the telehealth policy set forth in All Provider Bulletin 314 and extends that policy through October 15, 2021. Managed Care Entity Bulletin 68 requires managed care plans to maintain telehealth policy consistent with All Provider Bulletin 324. Through All Provider Bulletin 327, which supersedes All Provider Bulletin 324, MassHealth sets forth MassHealth's updated telehealth policy effective for dates of service on or after October 16, 2021. MassHealth anticipates this policy to remain in place through at least December 31, 2022. Managed Care Entity Bulletin 74 requires managed care plans to maintain telehealth policy consistent with All Provider Bulletin 327.

Effective for dates of service on or after October 16, 2021 and through at least December 31, 2022, hospice providers may deliver clinically appropriate, medically necessary MassHealth-covered hospice services to MassHealth ACO and NaviCare SCO members via telehealth (including telephone and live video), in accordance with MassHealth Managed Care Entity Bulletin 74 and notwithstanding any regulation to the contrary.

Consistent with MassHealth Hospice Bulletin 19, hospice telehealth visits may be used for routine home care hospice services that

- a. the member has consented to receive via telehealth; and
- b. do not require any hands-on care.

¹ These provisions do not apply to NaviCare HMO SNP members as all hospice services described below are paid by Medicare Administrative contractors and are not the responsibility of Fallon Health.

Live video telehealth may be used to conduct an initial or comprehensive assessment for members receiving routine home care during the initial and comprehensive assessment timeframe if they have concerns due to COVID-19, with the member's consent. In most, but not all, situations the initial and comprehensive assessments be conducted in person.

Hospice telehealth visits may not be used for

- a. any routine home care service that the member has not consented to receive via telehealth;
- b. any routine home care service that requires hands-on care; or
- c. any hospice service provided to a member not receiving routine home care.

Telehealth may not be used to conduct initial or comprehensive assessments for members not receiving routine home care during the initial and comprehensive assessment timeframe.

Providers must obtain verbal consent from a member and the member's caregiver/legal guardian if applicable, prior to the initiation of hospice services via telehealth. Providers must also document the consent in the member's record.

All documentation requirements of 130 CMR 437.000 apply when hospice services are delivered via telehealth and the documentation must also include the following:

- a. Indication in the visit note that the service was provided via telehealth; and
- b. Description in the visit note of the rationale for providing the service via telehealth.

Hospice agencies should bill the same procedure codes for services delivered via telehealth as appropriate for services delivered face-to-face.

Hospice agencies must include modifier "GT" when submitting claims for services delivered via telehealth.

Additionally, the following administrative requirements will be waived or amended during the State of Emergency in accordance with the LTSS guidance. The State of Emergency ended on June 15, 2021. The following flexibilities are no longer in effect.

- In accordance with a CMS waiver of this requirement under Medicare, Fallon Health is temporarily suspending the requirement for hospice agencies to directly provide certain non-core hospice services as described under 42 CFR 418.70, including physical therapy, occupational therapy, and speech-language pathology, and homemaker services, as long as a hospice provider's suspension of directly providing non-core hospice services does not inhibit the hospice provider's ability to effectively provide palliation of the member's terminal illness.
- If a Member's physician is unable to complete and submit to the Hospice Agency Provider written certification of terminal illness for a Member's initial 90-day certification period, or any subsequent recertification periods, the Hospice Agency Provider may acquire an oral certification within 2 calendar days and the written certification before the Hospice Agency Provider submits a claim for payment in accordance with CFR 418.22(3).
- Hospice Agencies may provide hospice aide supervisory visits conducted by a nurse via Telehealth (including telephone and/or live video) in accordance with the standards set forth in the All Provider Bulletin 289 located on the MassHealth website (<https://www.mass.gov/doc/all-provider-bulletin-289-masshealth-coverage-and-reimbursement-policy-for-services-related-to/download>). Additionally, hospice aide supervisory visits shall be conducted no less than every 30 days. This is an expansion of the requirements established under 42 CFR 418.76(h), which require a supervisory visit no less than every 14 days.
- Per 42 CFR 418.64, a Hospice Agency Provider may use contracted staff for core services only under extraordinary circumstances (i.e., to supplement hospice employees in order to meet patients' needs during periods of peak patient load.) If contracting is used, the hospice

must continue to maintain professional, financial, and administrative responsibility for the services in accordance with current regulations and policy.

Commercial

The Plan reimburses hospice services provided to commercial plan members, subject to the terms and conditions of the plan member's Member Handbook/Evidence of Coverage.

MassHealth ACO

The Plan reimburses hospice services provided to MassHealth ACO members in accordance with 130 CMR 437.00 which governs the provision of hospice services under MassHealth.

Fallon Medicare Plus

When a Fallon Medicare Plus member elects hospice, Original Medicare is responsible for coverage of all Medicare-covered Part A and Part B services – this includes services related to the terminal condition and services not related to the terminal condition. Fallon Medicare Plus members may receive hospice services from any Medicare-certified hospice agency. While a hospice election is in effect for a Fallon Medicare Plus member:

1. All Medicare-covered Part A and B services are reimbursed by Medicare Administrative Contractors (A/B or HH&H MACs), subject to the usual Medicare payment rules. This includes the following services regardless of whether the provider is contracted or is not contracted with Fallon Medicare Plus:
 - Hospice services provided by a Medicare-certified hospice.
 - Services provided by the member's designated attending provider, if the provider is not employed by or under contract with the hospice.
 - Services not related to the terminal condition while the hospice election is in effect.
 - Services provided to the Plan member after revocation or expiration of a hospice election until the first day of the month following the month during which the hospice election was revoked.
2. The Plan will reimburse the following services, subject to the terms and conditions of the Plan member's Member Handbook/Evidence of Coverage:
 - Mandatory supplemental services (i.e., those services provided by Fallon Medicare Plus in addition to Medicare-covered Part A and B services), such as routine eye exams.
 - Part D prescription drugs not covered by Medicare under the hospice benefit (to the extent that the drugs are included on the Fallon Medicare Plus prescription drug formulary).

A Fallon Medicare Plus member may revoke a hospice election at any time. When a Fallon Medicare Plus member revokes a hospice election, Fallon Medicare Plus member will begin reimbursing for all covered services on the first day of the month following the month during which the hospice election was revoked, as long as the member remains enrolled in and continues to pay the monthly premium for Fallon Medicare Plus.

NaviCare HMO SNP (Dual Eligible)

When a NaviCare HMO SNP member elects hospice, Original Medicare is responsible for coverage of all Medicare-covered Part A and Part B services – this includes services related to the terminal condition and services not related to the terminal condition. NaviCare dual-eligible members may receive hospice services from any Medicare-certified hospice program. While a hospice election is in effect for a NaviCare dual-eligible member:

1. All Medicare-covered Part A and B services are reimbursed by Medicare Administrative Contractors (A/B MACs), intermediaries, and/or carriers, subject to the usual Medicare payment rules. This includes the following services regardless of whether the provider is contracted or is not contracted with the Plan:
 - Hospice services provided by a Medicare-certified hospice.
 - Services provided by the member's designated attending provider, if the provider is not employed by or under contract with the hospice.

- Services not related to the terminal condition while the hospice election is in effect.
 - Services provided to the Plan member after revocation or expiration of a hospice election until the first day of the month following the month during which the hospice election was revoked.
2. The Plan will reimburse the following services, subject to the terms and conditions of the Plan member's Member Handbook/Evidence of Coverage:
- Services provided by the Plan in addition to Medicare-covered Part A and B services, such as but not limited to routine eye exams, dental services, and non-emergent transportation.
 - Part D prescription drugs not covered by Medicare under the hospice benefit (to the extent that the drugs are included on the NaviCare prescription drug formulary).

A NaviCare dual eligible member may revoke a hospice election at any time. When a NaviCare dual eligible member revokes a hospice election, the Plan will begin reimbursing for all covered services on the first day of the month following the month during which the hospice election was revoked, as long as the member remains enrolled in and continues to pay the monthly premium for the Plan.

The Plan will continue reimbursing for Medicaid covered services in addition to those covered by Medicare Part A or B regardless of the revocation date.

Navicare SCO (Non-Dual Eligible)

The Plan reimburses hospice services provided to NaviCare non-dual eligible members in accordance with 130 CMR 437.00 which governs the provision of hospice services under MassHealth.

Reimbursement

Commercial, MassHealth ACO and NaviCare SCO (non-dual eligible)

For each day that a commercial, MassHealth ACO or NaviCare non-dual eligible plan member is receiving authorized hospice care, the hospice will be paid a daily rate depending on the level of care provided on that day. The Plan reimburses one level of hospice care per date of service.

There are four levels of care:

- Routine home care
- Continuous home care
- Respite care (in-home and inpatient)
- Short-term general inpatient care

The number of units for each level of care is measured in days for routine home care, respite care, and short-term general inpatient care. Continuous home care is reimbursed based on the number of hours of skilled nursing care, reported in 15-minute increments (units), that is provided to the Plan member on that day. Payment is based upon the number of 15-minute units that are billed for 32 or more units (i.e., 8 or more hours). Units should be rounded to the nearest 15-minute increment. Rounding to the next whole hour is not allowed.

Routine home care (revenue code 0651)

The routine home care per diem rate is paid for each day the Plan member is at home under the care of a hospice and not receiving continuous home care, respite care, or short-term general inpatient care. The Plan does not pay the routine home care rate for the day of discharge; the Plan will pay the routine home care rate for day of death.

Continuous home care (revenue code 0652)

Continuous home care is not reimbursed in addition to routine home care. Continuous home care is covered only during a period of crisis and only as necessary to maintain the terminally ill Plan member at home. The continuous home care rate is paid by the hour. The hospice payment on a continuous care day varies depending on the number of hours of continuous services provided.

The number of hours of continuous care provided during a continuous home care day is multiplied by the hourly rate to yield the continuous home care payment for that day. A minimum of 8 hours of care must be furnished on a particular day to qualify for the continuous home care rate.

Respite care

Reimbursement for any unauthorized respite days will be made at the routine home hospice per diem rate. Respite care is not reimbursed in addition to routine home care.

- In-home respite care (revenue code 0659) - The goal of in-home respite care is to provide temporary relief to the primary caregiver maintaining the Plan member at home. This service is not covered for MassHealth ACO or NaviCare non-dual eligible members.
- Inpatient respite care (revenue code 0655) - The hospice agency will provide or arrange for inpatient respite care to be provided in a hospital licensed pursuant to MGL Chapter 111 § 51 or in a long-term care facility licensed pursuant to MGL Chapter 111 § 71 with whom the hospice has entered into a written agreement, or in a hospice inpatient facility directly owned and operated by the hospice agency. The hospice agency is paid the inpatient respite care rate for each day the member is receiving authorized inpatient respite care. (The hospice agency will reimburse the inpatient facility.)
 - For commercial plan members, the Plan will cover respite care for a maximum of seven consecutive days, including the date of admission but not the date of discharge. The Plan will pay the inpatient respite care rate for the day of death.
 - For MassHealth ACO and NaviCare non-dual eligible plan members, inpatient respite care is limited to five (5) consecutive days including the date of admission but not including the date of discharge. The Plan will pay the inpatient respite care rate for the day of death.

Short-term general inpatient care (revenue code 0656)

The hospice agency will provide or arrange for short-term inpatient care in hospitals licensed pursuant to MGL Chapter 111 § 51 or in long-term care facilities licensed pursuant to MGL Chapter 111 § 71 with whom the hospice has entered into a written agreement, or in hospice inpatient facilities directly owned and operated by the hospice agency. The Plan pays the hospice inpatient care rate for the date of admission and all subsequent inpatient days. The Plan does not pay the general inpatient care rate for the day of discharge; the appropriate level of home care is reimbursed. The Plan will pay the general inpatient care rate for the day of death. (Short-term general inpatient care is not reimbursed in addition to any other level of hospice care).

Provider's services

Each commercial, MassHealth ACO and NaviCare non-dual eligible member who elects hospice must designate an Attending Provider* who maintains primary responsibility for the Plan member's medical care. This provider may be the plan member's PCP or another plan provider (including the hospice medical director or another provider who is employed by or under contract with the hospice) who has primary responsibility for the plan member's medical care.

Reimbursement for the Attending Provider's services provided in conjunction with the hospice benefit is based on the type of service provided:

- Provider's administrative and supervisory services, as defined in 105 CMR 141.204 (C), are included in the hospice per diem payment.
- Patient care services provided by the Plan member's attending provider that are medically necessary for the treatment or management of a Plan member's terminal illness are separately reimbursed.

Reimbursement for direct patient care services provided by the Attending Provider will be made as follows:

1. When the attending provider is the Plan member's PCP (or another plan provider who has primary responsibility for the Plan member's medical care), and the attending provider is contracted with the Plan, the provider may submit claims for patient care services to the Plan for reimbursement. Attach the GV modifier (attending provider not employed or paid under agreement by the patient's hospice provider). Reimbursement for covered services will be made to the provider according to the terms of the provider's contract with the Plan.
2. When the Attending Provider is the medical director of the hospice (or employed by or under contract with the hospice), and the attending provider is contracted with the Plan, the attending provider may submit claims for direct patient care services to the Plan for reimbursement. Attach the GV modifier (Attending Provider not employed or paid under agreement by the patient's hospice provider). Reimbursement for covered services will be made to the provider according to the terms of the provider's contract with the Plan.

** Definition:*

Attending provider – When hospice coverage is elected, a Plan member may designate an attending provider (who may be the Plan member's PCP) who will have the most significant role in the determination and delivery of the Plan member's medical care, in addition to receiving care from hospice-affiliated providers.

Room and board (revenue code 0658) for commercial plan members

The hospice agency will provide or arrange for room and board to be provided in a hospital licensed pursuant to MGL Chapter 111 § 51 or in a long-term care facility licensed pursuant to MGL Chapter 111 § 71 with whom the hospice has entered into a written agreement, or in a hospice inpatient facility directly owned and operated by the hospice agency. The hospice agency will be paid the room and board rate for each day room and board is authorized in addition to either the routine home care rate or the continuous home care rate. (The hospice agency will reimburse the inpatient facility.)

Commercial plan members with Medicare as their primary insurance and a Plan Commercial product as secondary insurance are eligible for Plan-covered services that are not covered under the Medicare hospice benefit, such as room and board.

Room and board (revenue code 0658) for MassHealth ACO and NaviCare non-dual eligible members

Hospice services in a nursing facility:

A resident of a nursing facility may elect hospice services and continue to reside in the facility, if the facility is serviced by a hospice provider. When a member elects hospice in accordance with 130 CMR 437.000, the Plan will not pay for nursing facility services and will not pay the nursing facility for medical leaves of absence while the election is in effect. The Plan will pay the hospice for room and board and medical leave of absence while the election is in effect and the member remains in the nursing facility. The Plan may recoup any payment made by the Plan to the facility for services to the member while a hospice election is in effect.

The hospice and the nursing facility must enter into a written agreement under which the hospice takes full responsibility for the professional management of the member's hospice services and the nursing facility agrees to provide room and board to the member. Room and board includes performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of the member's room, and supervision and assistance in the use of durable medical equipment and prescribed therapies.

The Plan pays the hospice a room and board per diem amount for a member residing in a nursing facility in accordance with DHCFP regulations and in addition to either the routine home care rate or the continuous home care rate. However, Medicare remains primary for any hospice related services.

The hospice agency is responsible for submitting the room and board claim with the applicable Patient Paid Amount (PPA) as it is determined by MassHealth. The hospice agency is responsible for coordinating with the nursing facility regarding this information and ensuring its accuracy.

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- If the hospice election is revoked during the month, room and board charges are payable to the hospice agency through the date of revocation. Following that date, the nursing facility may begin billing room and board charges in accordance with their contract with Fallon.
- Room and Board charges not covered by Medicare Parts A or B and are therefore payable by the plan during this timeframe and should not be denied prior to the first day of the month following the revocation.

The Plan does not pay a hospice the room and board per diem amount, and does not pay for medical-leave-of-absence days, for any day that a member receives inpatient respite from the hospice.

If a member receiving hospice services in a nursing facility is hospitalized, the Plan will pay for the medical leave of absence in accordance with 130 CMR 456.000, provided that the conditions for medical leave of absence are met in accordance with 130 CMR 456.000. The Plan does not pay for room and board on the member's day of discharge from hospice, unless the member remains in the nursing facility after discharge from the hospice, or on the member's date of death.

Fallon Medicare Plus

When a Fallon Medicare Plus member elects hospice, Original Medicare is responsible for coverage of all Medicare-covered Part A and Part B services – this includes services related to the terminal condition and services not related to the terminal condition.

Hospice services provided by the hospice agency

When a Fallon Medicare Plus member elects hospice, for each day that the member is under the care of the hospice, Medicare reimburses the hospice agency for the services furnished to the member for that day.

Fallon Medicare Plus members may receive hospice care from any Medicare-certified hospice program.

Room and board is not covered by Medicare or the Plan for Fallon Medicare Plus members. A Fallon Medicare Plus member whose place of residence is a long-term care facility may elect hospice as long as the room and board continues to be paid for by (or arrangement for payment is made by) the plan member.

A hospice agency may charge a hospice beneficiary coinsurance for Part B outpatient drugs and biologicals and inpatient respite care. No other cost-sharing may be imposed by the hospice agency for services furnished to a hospice beneficiary during the period of hospice election regardless of the setting of the services.

Attending provider services

When hospice is elected, a hospice beneficiary may designate an attending provider (who may be a nurse practitioner) who is not employed by nor receives compensation from the hospice, in addition to receiving care from hospice-affiliated providers. The attending provider may provide direct patient care services related to the hospice Plan member's terminal illness. Attending

provider services are not considered hospice services. These services are billed by the attending provider to the A/B MACs.

If another provider covers for a hospice plan member's designated attending provider, the services of the covering provider are billed by the designated attending provider under the reciprocal or locum tenens billing instructions to the A/B MACs.

When the service is considered a hospice service (i.e., related to the terminal illness and furnished by someone other than the attending provider), the provider must look to the hospice for compensation. Services related to the Plan member's terminal illness furnished by someone other than the designated attending provider (or a provider covering for the designated attending provider) are not reimbursed by Medicare or the Plan.

Services unrelated to the terminal condition

Reimbursement for Medicare-covered Part A/B services unrelated to the terminal condition (for Fallon Medicare Plus members who have elected hospice) are made by Medicare as if the member were an Original Medicare beneficiary until the first day of the month following the month in which hospice is revoked (regardless of whether the provider is contracted or not contracted with Fallon Medicare Plus).

When providers bill A/B MACs for Medicare-covered services unrelated to the terminal illness during a hospice election period, the provider will be reimbursed according to Original Medicare fee-for-service rules. As long as the member remains enrolled in and continues to pay the monthly premium for Fallon Medicare Plus, the Plan will reimburse providers for coinsurance that is Plan member responsibility under the standard rules of the Medicare program less any cost-sharing that would be member responsibility under Fallon Medicare Plus. Claims for reimbursement for Plan member coinsurance for Medicare-covered services should be submitted to the Plan with a GW modifier (for services not related to the terminal condition) along with a copy of the Medicare RAS.

Services furnished to a Fallon Medicare Plus member after revocation of the Plan member's hospice election until the full monthly capitation payments resume

Federal regulations require that Medicare maintains financial responsibility for Fallon Medicare Plus members who elect hospice. By regulation, the duration of payment responsibility extends from the date of hospice election until the first day of the month following the month in which hospice is revoked by the hospice beneficiary.

When providers bill A/B MACs for services furnished to Fallon Medicare Plus members after a hospice election has been revoked but prior to when Fallon Medicare Plus Plan's full monthly capitation payments from Medicare begin, the provider will be reimbursed according to Original Medicare fee-for-service rules. As long as the member remains enrolled in and continues to pay the monthly premium for Fallon Medicare Plus, the Plan will reimburse providers for coinsurance that is Plan member responsibility under the standard rules of the Medicare program less any cost-sharing that would be member responsibility under Fallon Medicare Plus. Claims for reimbursement for Plan member coinsurance for Medicare-covered services should be submitted to the Plan with a GW modifier (for services not related to the terminal condition) along with a copy of the Medicare RAS.

NaviCare HMO SNP (dual eligible)

When a NaviCare dual eligible member elects hospice, Original Medicare is responsible for coverage of all Medicare-covered Part A and Part B services – this includes services related to the terminal condition and services not related to the terminal condition.

Hospice services provided by the hospice agency

When a NaviCare dual eligible member elects hospice, for each day that the member is under the care of the hospice, Medicare reimburses the hospice agency for the services furnished to the plan member for that day.

NaviCare dual eligible members may receive hospice care from any Medicare-certified hospice program.

Hospice services in a nursing facility

A resident of a nursing facility may elect hospice services and continue to reside in the facility, if the facility is serviced by a hospice provider. When a member elects hospice in accordance with 130 CMR 437.000, the Plan will not pay for nursing facility services and will not pay the nursing facility for medical leaves of absence while the election is in effect. The Plan will pay the hospice for room and board and medical leave of absence while the election is in effect and the member remains in the nursing facility. The Plan may recoup any payment made by the Plan to the facility for services to the member while a hospice election is in effect.

The hospice and the nursing facility must enter into a written agreement under which the hospice takes full responsibility for the professional management of the member's hospice services and the nursing facility agrees to provide room and board to the member. Room and board includes performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of the member's room, and supervision and assistance in the use of durable medical equipment and prescribed therapies.

The Plan pays the hospice a room and board per diem amount for a member residing in a nursing facility in accordance with DHCFP regulations and in addition to either the routine home care rate or the continuous home care rate. However, Medicare remains primary for any hospice related services.

The hospice agency is responsible for submitting the room and board claim with the applicable Patient Paid Amount (PPA) as it is determined by MassHealth. The hospice agency is responsible for coordinating with the nursing facility regarding this information and ensuring its accuracy.

The hospice agency is responsible for submitting the room and board claim with the applicable Patient Paid Amount (PPA) as it is determined by MassHealth. The hospice agency is responsible for coordinating with the nursing facility regarding this information and ensuring its accuracy.

- If the hospice election is revoked during the month, room and board charges are payable to the hospice agency through the date of revocation. Following that date, the nursing facility may begin billing room and board charges in accordance with their contract with Fallon.
- Room and Board charges not covered by Medicare Parts A or B and are therefore payable by the plan during this timeframe and should not be denied prior to the first day of the month following the revocation.

The Plan does not pay a hospice the room and board per diem amount, and does not pay for medical-leave-of-absence days, for any day that a member receives inpatient respite from the hospice.

If a member receiving hospice services in a nursing facility is hospitalized, the Plan will pay for the medical leave of absence in accordance with 130 CMR 456.000, provided that the conditions for medical leave of absence are met in accordance with 130 CMR 456.000. The Plan does not pay for room and board on the member's day of discharge from hospice, unless the member remains in the nursing facility after discharge from the hospice, or on the member's date of death.

Attending provider services

When hospice is elected, a hospice beneficiary may designate an attending provider (who may be a nurse practitioner) who is not employed by nor receives compensation from the hospice, in addition to receiving care from hospice-affiliated providers. The attending provider may provide direct patient care services related to the hospice Plan member's terminal illness. Attending provider services are not considered hospice services. These services are billed by the attending provider to the A/B MACs.

If another provider covers for a hospice member's designated attending provider, the services of the covering provider are billed by the designated attending provider under the reciprocal or locum tenens billing instructions.

When the service is considered a hospice service (i.e., related to the terminal illness and furnished by someone other than the attending provider), the provider must look to the hospice for compensation. Services related to the Plan member's terminal illness furnished by someone other than the designated attending provider (or a provider covering for the designated attending provider) are not reimbursed by Medicare or the Plan.

Services unrelated to the terminal condition

Reimbursement for Medicare covered Part A and B services unrelated to the terminal condition (for NaviCare members who have elected hospice) is made by Medicare as if the member were an Original Medicare beneficiary until the first day of the month following the month in which hospice is revoked (regardless of whether the provider is contracted or not contracted with the Plan).

When providers bill the A and B MACs for Medicare-covered services unrelated to the terminal illness during a hospice election period, the provider will be reimbursed according to Original Medicare fee-for-service rules. As long as the member remains enrolled in the Plan, the Plan will reimburse providers for any cost associated with the Part B services that is Plan member responsibility under the standard rules of the Medicare program.

Services furnished to a NaviCare member after revocation of the Plan member's hospice election until the full monthly capitation payments resume

Federal regulations require that Medicare maintains financial responsibility for Medicare members who elect hospice. By regulation, the duration of payment responsibility extends from the date of hospice election until the first day of the month following the month in which hospice is revoked by the hospice beneficiary. Claims for dual-eligible member's Medicare-covered services should be submitted to Medicare with a GW modifier (for services not related to the terminal condition).

When providers bill the A and B MACs for services furnished to NaviCare members after a hospice election has been revoked but prior to when the Plan's full monthly capitation payments from Medicare begin, the provider will be reimbursed according to Original Medicare fee-for-service rules. As long as the member remains enrolled in the NaviCare Plan, the Plan will reimburse providers for any associated cost-sharing that is Plan member responsibility under the standard rules of the Medicare program. Claims for reimbursement for Plan member cost-sharing for Medicare-covered services should be submitted to the Plan with a GW modifier (for services not related to the terminal condition) along with a copy of the Medicare RAS.

Medicaid-covered only services are reimbursable by the plan during hospice election. Examples of Medicaid-covered only services include but aren't limited to Adult Day Health, Home Delivered Meals, Personal Care Attendant Services, and Vision Care Services.

Referral/notification/prior authorization requirements

Commercial and MassHealth ACO

Prior authorization is required for hospice service for commercial and MassHealth ACO plan members.

When a commercial or MassHealth ACO plan member elects hospice, the hospice agency will mail or fax a copy of the Hospice Notice of Election Form to the Plan Prior Authorization Department, fax number 508-368-9700, prior to beginning hospice care and within 5 business days of election.

To obtain initial authorization for hospice care, the Hospice Agency must send the Universal Health Plan/Home Health Authorization Form to the Plan Prior Authorization Department, fax number 508-368-9700, within 5 business days of the start of care. The period of time authorized will be indicated on the Notification of Prior Authorization Decision form.

To obtain prior authorization for continued hospice services, the Hospice Agency must send the Universal Health Plan/Home Health Authorization Form to the Plan Prior Authorization Department, fax number 508-368-9700, prior to the existing authorization's end date. The Hospice Agency must indicate which revenue code is being requested on the authorization form. The period of time authorized will be indicated on the Notification of Prior Authorization Decision form.

All changes in hospice level of care must be prior authorized. For example, a change from routine hospice care to continuous hospice care, or a change from routine hospice care to inpatient respite care requires prior authorization. Changes must be indicated on a new Universal Health Plan/Home Health Authorization Form.

In addition, prior authorization is required for room and board (revenue code 0658). The Hospice Agency must send an additional Universal Health Plan/Home Health Authorization Form to the Plan Prior Authorization Department, fax number 508-368-9700, prior to beginning room and board.

When a commercial, MassHealth ACO or NaviCare non-dual eligible plan member revokes hospice (or is discharged or decertified), the hospice agency will mail or fax a copy of the revocation form, discharge summary, or decertification form to the Plan Prior Authorization Department, fax number 508-368-9700, within 5 days.

The Plan requires an updated clinical status every 6 months for continued coverage. Failure to submit this or the lack of continued clinical need will result in denial of continued services.

Fallon Medicare Plus and Navicare HMO SNP (dual eligible)

Fallon Medicare Plus members may receive hospice services from any Medicare-certified hospice agency. No referral or prior authorization is required.

When a Fallon Medicare Plus member elects hospice, the hospice agency will mail or fax a copy of the Hospice Notice of Election Form to the Plan Prior Authorization Department, fax number 508-368-9700, within 5 business days of election.

In addition, the revocation form, discharge summary, or decertification form should be mailed or faxed to the Plan Prior Authorization Department, fax number 508-368-9700, within 5 days.

Note: Summit ElderCare manages end of life care services for enrolled participants. Please contact Summit ElderCare for more information.

NaviCare SCO (non-dual eligible)

When hospice services are ordered by a provider for a NaviCare non-dual eligible member, prior authorization is required.

When a NaviCare non-dual eligible member elects hospice, the hospice agency will mail or fax a copy of the Hospice Notice of Election Form to the Plan Prior Authorization Department, fax number 508-368-9700, prior to beginning hospice care and within 5 business days of election.

To obtain initial authorization for hospice care, the Hospice Agency must send the Universal Health Plan/Home Health Authorization Form to the Plan Prior Authorization Department, fax number 508-368-9700, within 5 business days of the start of care. The period of time authorized will be indicated on the Notification of Prior Authorization Decision form.

To obtain prior authorization for continued hospice services, the Hospice Agency must send the Universal Health Plan/Home Health Authorization Form to the Plan Prior Authorization Department, fax number 508-368-9700, prior to the existing authorization's end date. The Hospice Agency must indicate which revenue code is being requested on the authorization form. The period of time authorized will be indicated on the Notification of Prior Authorization Decision form.

All changes in hospice level of care must be prior authorized. For example, a change from routine hospice care to continuous hospice care, or a change from routine hospice care to inpatient respite care requires prior authorization. Changes must be indicated on a new Universal Health Plan/Home Health Authorization Form.

In addition, prior authorization is required for room and board (revenue code 0658). The Hospice Agency must send an additional Universal Health Plan/Home Health Authorization Form to the Plan Prior Authorization Department, fax number 508-368-9700, prior to beginning room and board.

When a NaviCare non-dual eligible member revokes hospice (or is discharged or decertified) the hospice agency will mail or fax a copy of the revocation form, discharge summary, or decertification form to the Plan Prior Authorization Department, fax number 508-368-9700, within 5 days.

When a NaviCare non-dual eligible member elects hospice in accordance with 130 CMR 437.000, the Plan will not pay for nursing facility services and will not pay the nursing facility for medical leaves of absence while the election is in effect. The Plan will pay the hospice for room and board and medical leave of absence while the election is in effect and the member remains in the nursing facility. The Plan may recoup any payment made by the Plan to the facility for services to the member while a hospice election is in effect.

The hospice and the nursing facility must enter into a written agreement under which the hospice takes full responsibility for the professional management of the member's hospice services and the nursing facility agrees to provide room and board to the member. Room and board includes performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of the member's room, and supervision and assistance in the use of durable medical equipment and prescribed therapies.

The Plan requires an updated clinical status every 6 months for continued coverage. Failure to submit this or the lack of continued clinical need will result in denial of continued services.

Billing/coding guidelines

Hospices use the UB-04 (CMS-1450) or electronic equivalent per industry standard to bill for covered hospice services. Claims for all other services should be submitted on a CMS-1500 claims form or HIPAA standard electronic equivalent per industry standard guidelines.

Hospices should use the appropriate hospice revenue code (0651-0659) to bill for hospice care.

Please note: Although Original Medicare requires the Q codes (Q5001-Q5010) on hospice claims, these codes are NOT required on hospice claims submitted to Fallon Health.

For routine hospice care, continuous hospice care, and in-home respite care, place of residence can be an inpatient facility if the Plan member uses that facility as a place of residence. It is the level of care that is provided and not the location where the hospice services are provided that determines payment.

In line with CMS requirements, all diagnoses that are identified in the initial and comprehensive assessments should be reported on hospice claims, whether related or unrelated to the terminal prognosis of the individual.

While a hospice election is in effect for a Fallon Medicare Plus or NaviCare dual eligible plan member, providers should bill the A and B MAC or HH&H MAC and not the Plan for the following services:

- Hospice services provided by a Medicare-certified hospice.
- Services provided by the member's designated attending provider, if the provider is not employed by or under contract with the hospice.
- Services not related to the terminal condition while the hospice election is in effect.
- Services provided to the Plan member after revocation or expiration of a hospice election until the first day of the month following the month during which the hospice election was revoked.

The MAC will process these claims in accordance with regular claims processing rules.

Fallon Medicare Plus or NaviCare dual eligible plan member that have elected hospice may revoke a hospice election at any time, claims will continue to be paid by A and B or HH&H MACs as if the plan member were a fee-for-service beneficiary until the first day of the month following the month in which hospice was revoked.

Providers may refer to the Medicare Claims Processing Manual, Chapter 11 for billing and coding information.

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	1/01/2009
Previous revision date(s):	11/01/2009 - Updated Referral/notification/ preauthorization requirements; added note that room and board is not covered for Commonwealth Care members. 11/01/2010 - Updated language in the Reimbursement section to remove references to criteria that are outlined in the FCHP Medical Policy for Hospice Services, to identify services that are limited or not covered for Commonwealth Care and FCHP MassHealth members, and to more clearly identify differences between Commercial and Senior Plan. 09/01/2015 - Moved to new Plan template and added code Q5010 to the billing/coding section. 07/01/2016 - Added the requirement to report all diagnoses identified in the initial and comprehensive assessments on hospice claims. 03/01/2017 - Added guidelines for NaviCare members.
Connection date & details:	July 2017 - Added guidelines for members enrolled through MassHealth.

October 2018 – Clarified Medicaid services are reimbursable for NaviCare during hospice election.
January 2019 – Clarified NaviCare reimbursement section.
Clarified prior authorization renewals.
January 2020 – Updated Medicare Advantage branding.
June 1, 2020 – Updates for MassHealth ACO and NaviCare SCO members in accordance with MassHealth LTSS guidance.
July 2022 – Updated Policy section related to coverage for services delivered via telehealth for MassHealth ACO and NaviCare SCO members; clarified that Q5001-Q5010 are not required on hospice claims submitted to Fallon Health.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.