

HOSPICE

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I. Overview

Blue Cross and Blue Shield of Kansas offer a wide range of contracts to meet the needs of the groups we service.

Some contracts, such as the Federal Employee Program, cover a group's employees nation-wide. These types of programs are commonly referred to as national accounts.

Other contract types, such as Blue Choice, etc., are underwritten locally and marketed to Kansas groups. You'll hear these referred to as local groups.

Whether it's a national account or local group, some contracts include hospice benefits and others do not.

When a local account includes hospice benefits, it's usually done by adding coverage referred to as Home Care Benefits.

II. General Guidelines

A. Agency will not charge the member for services prior to them being provided except for deductible and coinsurance amounts or non-covered services.

- Up front collection of these amounts is the provider's decision. BCBSKS does not have a policy that requires providers to collect up front.
- If the member has already satisfied part of their deductible, coinsurance or share payment, providers can only bill up front for the balance.
- Member responsibility must be calculated based on the BCBSKS MAP or allowance and not on the total charge.
- If the up front collection results in an overpayment that is due the patient, a refund must be made to them timely.

B. Agency will not bill the member for services that are medically unnecessary or experimental/investigational unless the member was notified prior to the services being provided. Refer to section titled PRIOR AUTHORIZATION/PRECERTIFICATION of ADMISSIONS/SERVICES for complete details about the Notice of Personal Financial Obligation.

C. Claims will be submitted within 15 months from the date of outpatient service. Some groups may impose alternate timely filing and claim assessment requirements. Failure to meet those requirements will result in claim denial.

If BCBSKS requests additional information or clarification about a claim before it can be processed, the provider will submit this information within 15 months of the date of service or discharge.

Corrected claims or adjustment requests must also be filed within 15 months of the date of service or discharge.

D. The following services are included in routine hospice coverage:

- a. Nursing care
- b. Home health aide services
- c. Social worker services
- d. Pastoral services
- e. Volunteer support
- f. Bereavement services
- g. Counseling services
- h. Dietary and nutritional counseling services
- i. All drugs, medical supplies, and equipment related to the terminal illness
- j. Speech therapy
- k. Occupational therapy
- l. Physical therapy
- m. Radiation therapy

E. Hospice providers that have a qualified inpatient hospice facility approved by BCBSKS may receive when applicable an inpatient payment (110% of the Medicare inpatient hospice rate) for each day of approved inpatient hospice service.

F. Agency will provide written notice to BCBSKS when the Medicare per diem rates are updated.

G. When requested, complete medical record information will be provided in a format that can be utilized by BCBSKS.

The member's contract allows BCBSKS to request and receive medical record information without the need for additional authorization.

III. Case Management

Case management is a process that identifies and coordinates alternative treatment plans to enhance care through effective administration of available health care resources in the most cost efficient manner.

The process is accomplished through the development of a treatment plan by the patient or legal representative, the physician, other health care providers, and the BCBSKS case manager.

The services may include both covered services and non-covered services with the exception of specifically stated exclusions. Total benefits paid for such services shall not exceed the total benefits to which the member would otherwise be entitled under the terms of their contract.

Participation in case management is voluntary. The member may withdraw at any time and return to the stated benefits of their contract.

If a member's care is being handled through the case management process, our medical staff may negotiate reimbursement rates different than the established hospice maximum allowable payment.

IV. Home Care Benefits

Home Care Benefits can be purchased by local Blue Cross and Blue Shield groups and adds home health and hospice benefits to the group's basic health insurance plan.

Maximum Benefit Limit The group decides what maximum benefit limit they want for their members. The limit can be either a maximum dollar amount (i.e. \$5,000 per lifetime, \$10,000 per lifetime, etc.) or a visit limit (i.e. 50 visits per calendar year, etc.)

***Allowed Charge** Equivalent to your Medicare hospice per diem rate.

This rate includes all services provided by the Medicare certified hospice or other facility or professional providers under the direction of the hospice and not charging for services separately from the charges made by the hospice.

Hospice Services (Palliative Care) Services to control pain and relieve other physical and emotional symptoms related to the member's terminal illness and to focus on the special needs of the patient and their family as they experience

the dying process rather than treatment aimed at investigation and intervention for the purpose of cure or prolonging life. Services must be provided by a Medicare certified hospice.

Election of Hospice Benefits

When a member elects hospice benefits, the Medicare certified hospice must make available to BCBSKS a copy of the Hospice Election Form. It can be faxed to the pre-certification department at the time the services are prior authorized or it can be sent with the claim.

Covered Hospice Services

Nursing Care
Home Health Aide Services
Social Work Services
Pastoral Services
Volunteer Support
Bereavement Services
Counseling Services
Dietary and Nutritional Counseling/Services
All Drugs, Medical Supplies, and Equipment related to the Terminal Illness
Speech Therapy
Occupational Therapy
Physical Therapy
Lab Fees
Home Medical Equipment
Educational Services
Other Services and Supplies provided through the d Hospice (excluding inpatient hospital care and inpatient or outpatient physician's visits) recommended by a Doctor

Home Hospice
Minimum Service Level

For member contracts that have a home hospice benefit, the hospice per diem applies when a minimum level of medically necessary services are provided to a member which includes:

1) skilled nursing visit, 1 x week, home health aide visits, 3 x week, social worker visit, 1 x month, medical equipment in the home and pharmacy services.

OR;

2) Multiple skilled nursing visits per week, social worker visit, 2 x month, medical equipment in the home and pharmacy services

Any exceptions to the above minimum requirements would be based on individual consideration.

Inpatient Hospice

Inpatient hospice programs must receive prior approval from BCBSKS.

The allowance for approved inpatient hospice services will be 110% of your Medicare inpatient hospice rate.

Inpatient hospice services must be prior authorized.

V. Prior Authorization

The BCBSKS medical and utilization review staff is not involved in the decision making process when a member elects hospice care. This decision is between the patient, the doctor, family members and the hospice. Once this decision is made, our staff and hospice personnel must communicate in order to insure that the coverage criteria for both home or inpatient hospice care as outlined in the member's contract is met.

The medical and utilization review department can be contacted by calling 1-800-782-4437

At the time of initial contact, hospice personnel must be prepared to provide or discuss:

* Hospice Election Form must either be faxed to the pre-certification department at the time the services are prior authorized or it can be sent with the claim.

* Services to be provided, including but not limited to:

- | | |
|--|-------------------------|
| -nursing care | -lab fees |
| -home health aide | -volunteer support |
| -physical therapy | -home medical equipment |
| -occupational therapy | -medical supplies |
| -medications (including route and frequency) | -social work services |
| -any other services | |

AT ANYTIME THEREAFTER, IF THE PLAN OF CARE CHANGES, BCBSKS MUST BE CONTACTED IMMEDIATELY.

A. Hospice Initial Evaluation

Through our case management efforts, BCBSKS has identified the need to provide payment for initial patient evaluations. The evaluations are used to determine if the care

the patient requires meets BCBSKS hospice coverage criteria and is subject to a maximum allowable payment.

To be eligible for reimbursement, initial evaluations will be handled as follows:

- Initial evaluations must take place in the member's home and not during a hospital stay.
- The hospice agency will notify BCBSKS prior to conducting an initial evaluation
- Following the initial evaluation, the hospice agency will contact BCBSKS to prior authorize any additional services.
- The 25% payment penalty applies to all services (including initial evaluations) that are not prior authorized.
- The hospice agency will bill the initial evaluation with revenue code 0551 – Skilled Nursing Visit. No HCPCS code is required.
- The claim will be billed with the hospice provider number.

B. Skilled Nursing Visits

- The skilled nursing visit medical necessity guidelines to include homebound status will be applied when approving hospice on a per visit basis.
- The nursing visits must be billed using revenue code 551 when services have been approved on a per visit basis.
- Reimbursement for each skilled visit will be the hospice per diem rate per visit when daily hospice has not been approved.
- A copy of the Hospice Election Form along with the Informed Consent Form must be sent to Blue Cross and Blue Shield of Kansas when a patient has elected hospice.

C. Payment Reduction When Prior Authorization Is Not Obtained

The Policies and Procedures Payment Attachment for hospice agencies, allows Blue Cross and Blue Shield of Kansas (BCBSKS) to assess a payment reduction when an agency fails to prior authorize services. The contract language reads:

Failure to preauthorize will result in a 25 percent reduction in payment with a maximum penalty of \$250 per treatment episode.

The payment reduction:

- Applies to medically necessary hospice services that are not prior authorized,
- Will be applied to services that are initiated outside of normal business hours. The provider can however avoid the penalty on these cases by notifying BCBSKS by the end of the first business day following the service(s).
- Is applied per treatment episode,
- Can only be assessed once per treatment episode, and

- Is a provider write-off.

A treatment episode:

- Is defined as the treatment period for that diagnosis and that plan of care,
- Begins when the physician orders hospice care and the hospice agency agrees to care for the patient,
- Ends when the patient stops receiving hospice services. This could be because the patient is admitted for inpatient care or because the patient or the family chooses not to continue. (This is not an all-inclusive list.)

If a treatment episode ends and the patient later receives additional services, this starts a new treatment episode and the services must be prior authorized. If they're not, a payment reduction will be assessed.

D. Sample Prior Authorization Letter for Hospice

Upon completion of the prior authorization the provider will receive a letter showing approval of the authorized visits. This letter must accompany the claim when submitted.

Date

PreCert #: AC

Hospice Name/Address

RE: Patient Name

Group #:

Physician:

Facility:

Facility Admission Date:

Dear:

On March 12th, 2006 we received a request for precertification of hospice services for the above patient. Based on the information available, criteria for hospice benefits has been met. **Benefits will be provided from March 12, 2006 through March 30, 2006, up to the hospice contract maximum.**

All services received by the patient after March 12, 2006 related to terminal illness, except medically necessary inpatient hospital care and physician services, **MUST BE COORDINATED AND BILLED THROUGH YOUR AGENCY.** Coverage is only available under this Hospice Care provision for terminal illness care. If Blue Cross and Blue Shield of Kansas determines the care provided is not for a terminal illness, benefits from the hospice care provision will not be available. Covered services will be allowed subject to the terms of the member's contract.

Should the hospice contract maximum be met, further specific benefits may be available for medically necessary services under other portions of the member's contract.

The above decision was based on the information available to us today and is subject to the terms of the contract in force on the date the services were actually provided. Actual payment is subject to any deductible, coinsurance specified dollar maximums, or benefit period limitations of this member's contract. Any additional services exceeding those above, should be prior authorized for medical necessity to be eligible for reimbursement.

ALL CLAIMS SHOULD BE SUBMITTED WITH A COPY OF THIS LETTER ATTACHED IN ORDER THAT BENEFITS WILL BE PAID AS APPROVED ABOVE.

If you have questions, regarding this medical determination, please call xxx-xxx-xxxx, extension xxxx. Any questions related to the benefits of this member's contract should be directed to Customer Services at xxx-xxx-xxxx.

VI. Appeals

Refer to Section 7: Compliance and Appeals.

VII. Reimbursement

- Reimbursement is the Medicare home hospice rate for services:
 - Provided in the home
 - Provided in the nursing facility when the nursing facility is deemed the patient's home
 - Provided in the skilled nursing facility for inpatient hospice care and the provider does not have an approved inpatient hospice program with Blue Cross and Blue Shield of Kansas. In these situations, room and board may be billed to the patient.
 - Provided during an initial hospice evaluation when the evaluation takes place in the member's home

- Reimbursement is 110% of the Medicare General Inpatient hospice rate for inpatient programs that have been submitted to and approved by Blue Cross and Blue Shield of Kansas. This reimbursement applies when:
 - Services are provided in the skilled nursing facility, hospital or other inpatient facility approved under the hospice inpatient program. Members can not be billed separately for room and board. If the member has an inpatient skilled nursing facility benefit in addition to their hospice benefit, only the hospice benefit will be payable when the member has elected hospice coverage.

VIII. Frequently Asked Questions

In answering the following questions, we've assumed the patient's contract included hospice benefits.

Q1. If a patient resides in a personal care nursing home, can hospice be provided?

A1. Yes.

Q2. Will the hospice be paid the per diem for each day of the week regardless of whether or not services were provided each day?

A2. Yes, with one exception (see question 3).

Q3. What if the patient is admitted to a hospital?

A3. Hospice benefits are not paid while the patient is an inpatient. The hospice per diem would be paid for the day of the actual hospital inpatient admission and for the day of discharge but not for any days in between.

Q4. Does BCBSKS need to be notified of hospital admissions?

A4. Yes. At that time a complete evaluation of the patient's plan of care must occur. It would need to be determined if other than palliative care was being provided.

Q5. Under certain circumstances, outpatient services occurring prior to an inpatient hospital admission must be included as part of the hospital's inpatient claim. What is this rule, and does it apply to outpatient hospice services occurring prior to a hospital admission?

A5. The rule is:

If a patient is treated as an outpatient and then admitted as an inpatient to the same hospital (where the outpatient services were provided) before midnight of the day following the outpatient services, then, charges for the outpatient services must be included on the hospital's inpatient claim.

i.e.: The patient received outpatient care on 01/22/05 at 10:00 a.m. At 11:00 p.m. on 01/23/05 the patient was admitted to that same hospital as an inpatient. By applying the rule above, the charges for outpatient services must be included on the hospital's inpatient claim.

Hospitals apply this rule to all BCBSKS members, including hospice patients.

Remember, this rule applies only if the outpatient services and the inpatient admission are at the same hospital.

Q6. If an inpatient hospital admission occurs, should the hospice split their billing so the dates of services do not overlap the inpatient claims?

A6. Yes.

Q7. Some hospices cannot provide the intense psychiatric services that some patients require. If this occurs, can the services be provided by an independent provider and reimbursed under the psychiatric portion of the member's contract?

A7. Assuming that the patient has benefits for the service and also assuming that the service is provided by an eligible provider, the answer is yes.

Q8. Sometimes palliative care includes chemotherapy, blood transfusions or radiation therapy. Is this part of the hospice per diem?

- A8. Yes. We understand that these situations are rare. With the exception of physician services and inpatient hospital services, reimbursement for all services related to the terminal illness are included in the per diem.
- Q9. What if radiation therapy is provided by a free-standing (meaning not part of a hospital) radiologist?
- A9. These charges would be considered physician charges and not included in the per diem.
- Q10. Is TPN and drugs for HIV patients part of the per diem too?
- A10. TPN, which is related to the terminal condition, is a portion of the per diem. TPN, which is for a chronic condition unrelated to the terminal condition and considered palliative, will be reviewed for coverage on an individual consideration basis, subject to the member's coverage. If TPN is not considered palliative, we assume that the hospice will discharge the patient so that non-hospice benefits under the member's contract will resume.

Drugs for HIV patients are also considered part of the per diem. If not considered palliative, we again assume that the hospice will discharge the patient so that non-hospice benefits under the member's contract will resume.

IX. UB-04/837I Claim Form

Hospice agencies submit claims for authorized services using the UB-04/837I HCFA 1450 claim billing format.

Coding requirements specific for hospice agencies are outlined in this manual section. Refer to the UB-04/837I section of this manual for a complete description of the UB-04/837I form locators.

A. Type of Bill

UB-04/837I Form Locator 4

The bill type is a code indicating the specific type of bill (outpatient, adjustment). This is a four-position field and is mandatory for all outpatient bills submitted to BCBSKS.

The bill types that should be reported for hospice claims submitted on the UB-04/837I are:

081X	Special Facility-Hospice (non-hospital based)
082X	Special Facility-Hospice (hospital-based)

The fourth digit defines the frequency.

XXX1	Admit through Discharge Claim
XXX2*	Interim – First Claim
XXX3*	Interim – Continuing Claim
XXX4*	Interim – Last Claim
XXX7	Replacement Claim
XXX8	Cancelled Claim

*Interim billing is accepted, but not required.

If you are a hospice agency your type of bill and provider number/NPI must reflect hospice regardless of the benefit in the member's contract that is used to pay for the services. Edits have been implemented to return the claim to the provider when the type of bill does not match the provider number/NPI on the claim.

B. Reporting of Revenue Codes, HCPCS/CPT and UNITS

Revenue Code- UB-04/837I Form Locator 42

This is a general category code used to report the service.

0551	Skilled Nursing Visit (includes initial evaluations)
	Used to report skilled nursing visits including initial evaluations.
0651	Home hospice services
0656	Inpatient hospice services

HCPCS/CPT- UB-04/837I Form Locator 44

Not required for hospice claims

Units UB-04/837I Form locator 46

The number of days being billed on this claim

C. Line Item Date of Service

UB-04/837I Form Locator 45

Not required for hospice claims