

# Hospice Workshop Handouts

September 2006



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## GENERAL COVERAGE GUIDELINES



Hospice care integrated services and supplies designed to provide palliative and supportive care to terminally ill patients in their home or an inpatient hospice setting.

### Hospice Care for Standard Contracts

When the member elects hospice services which are covered under their Home Care Rider, the hospice becomes responsible for all the patient's care except for physician's charges or charges from a hospital for inpatient care.

If the hospice patient is admitted to the hospital, the hospital will assume the care of the patient and bill their services to Blue Cross. If the patient is receiving outpatient hospital services in addition to hospice services, this care must be coordinated by the hospice. The following services are included in routine hospice coverage.

- 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
- Radiation therapy

### FEP Hospice Benefits

The Federal Employee Program provides home hospice coverage for members with a life expectancy of six months or less when prior approval is obtained. Home hospice coverage includes:

- Physician visits
- Nursing care
- Medical social services
- Physical therapy

- Services of home health aides
- Durable medical equipment
- Prescription drugs
- Medical supplies

Inpatient hospice is available to members that are currently receiving home hospice care benefits. Coverage is available for up to five consecutive days in a hospice inpatient facility. Each inpatient hospice stay must be separated by at least 21 days. These covered inpatient hospice benefits are available only when inpatient services are necessary to:

- Control pain and manage the patient's symptoms
- Provide an interval of relief (respite) to the family

### **State of Kansas Employee Group Hospice Benefits**

Covered hospice services include the following when provided for routine home care according to the hospice care plan and provide by the hospice for the terminal illness:

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

Professional Services of a Physician

## Hospice Election Form

BCBSKS must receive a copy of the hospice election form from the Contracting Provider or patient prior to claim adjudication. BCBSKS must receive, prior to approval, written certification from the patient's physician that the hospice patient has a life expectancy of six months or less.

Reviews will be conducted by BCBSKS on all services billed for the terminal patient from the hospice and other providers of care to ensure that routine hospice services are not otherwise reimbursed and that only palliative care is provided. Hospice benefits will cease if BCBSKS determines that palliative care is no longer provided or the patient revokes the hospice election.



Palliative Care is treatment directed at controlling pain, relieving other physical and emotional symptoms and focusing on the special needs of the hospice patient and the hospice patient's family, as they experience the dying process rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.



A hospice care plan means a coordinated plan of care which provides Palliative Care for the hospice patient. This plan will be designed to provide care to meet the special needs during the final stages of a terminal illness.

## Prior Authorization

Contracting Providers who provide home health or hospice services must obtain prior authorization before services are provided to a BCBSKS member. Approval or denial of the medical necessity review will be communicated to the provider by telephone if requested, and a follow-up confirmation letter of the decision will always be sent to the Contracting Provider.

Even if a self-insured group does not require it in their member policy, it is a provision of the provider's contract that prior authorization applies to all services provided to Blue Cross and Blue Shield of Kansas (BCBSKS) members receiving hospice services.

If prior authorization is not obtained, BCBSKS has the right to request medical records to review and determine whether services are eligible under the members contract. Services are not automatically denied due to lack of prior

authorization. All services not prior authorized will be reviewed for medical necessity.

If upon review the service is deemed medically necessary but no prior authorization was done, the services are paid at a 25% penalty up to \$250 per episode.



A treatment episode is defined as the treatment period for that diagnosis and that plan of care. It begins when the physician orders hospice care and the hospice agency agrees to care for the patient. The treatment episode ends when the patient stops receiving hospice services. This could be because the patient revokes their hospice election or if the patient is admitted for inpatient care.

If a treatment episode ends and the patient later needs additional services, this starts a new treatment episode and the services must be prior authorized. If not, a payment reduction will be assessed. The authorization process continues when additional or continuing services are ordered by the physician.

At times you may need to provide services to a patient after business hours or on the weekend. In these situations, you will need to call BCBSKS and leave a message with us describing the patient's condition and the services in which you are requesting prior authorization. Then contact us the next business day to complete the prior authorization process.

## Example #1: Prior Authorization Letter for Hospice

Date

PreCert #: AC

Hospice Name/Address

RE: Patient Name

Group #:

Physician:

Facility:

Facility Admission Date:

Dear:

On March 12<sup>th</sup>, 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.

## Example #2: Prior Authorization Letter for Hospice

Date

PreCert #: AC

Hospice Name/Address

RE: Patient Name

Identification #:

Group #:

Physician:

Facility:

Facility Admission Date:

Dear:

On August 14<sup>th</sup>, 2005 we received a request for precertification of **hospice services** for the above patient. It has been determined that medical necessity has been supported and the following benefits will be provided **from AUGUST 14, 2005 TO AUGUST 28, 2005** according to the provisions of their Premier Blue contract. However, this benefit determination is contingent upon **authorization by the primary care physician, XXXXX, MD.**

### **approved hospice care for two weeks**

All services will be subject to the **Hospice maximum** of this member's contract. Any services provided above this benefit maximum will be non-covered and the member's responsibility.

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 approved 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 necessity determination, please call 1-800-xxx-xxxx, extension xxxx. Any questions related to the benefits of this member's contract should be directed to Customer Service at 1-800-xxx-xxxx or 785-xxx-xxxx.

The claim should be coded to reflect the services that were prior authorized in the letter.

**Letter #1**

Rev	Description	Date of Service	Units	Total Charge	Allowed	Paid Amount
651	Hospice Home Visit	3/12/06	18	\$2,700.00	*\$2,268.00	*\$2,268.00

\*this example reflects a charge of \$150.00 and a hospice per diem of \$126.00

**Letter #2**

Rev	Description	Date of Service	Units	Total Charge	Allowed	Paid Amount
651	Hospice Home Visit	8/14/06	14	\$2,100.00	*\$1,764.00	*\$1,764.00

\*this example reflects a charge of \$150.00 and a hospice per diem of \$126.00

**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.

**Out of State Members**

When you provide services to a patient that is covered by a Blue Plan other than BCBSKS, you must prior authorize services through the patient's home plan. You will also need to call that other Plan to verify member benefits for home health services.

You will know if the member has an out of state plan by viewing their Blue Cross identification card.

## BILLING AND PAYMENT

### Type of Bill

The bill types that should be reported for hospice claims submitted on the UB-92 are:

#### Type of Bill (Non-hospital based)

- 811 Admit through Discharge Claim
- 812\* Interim – First Claim
- 813\* Interim – Continuing Claim
- 814\* Interim – Last Claim
- 817 Replacement Claim
- 818 Cancelled Claim

#### Type of Bill (hospital-based)

- 821 Admit Through Discharge Claim
- 822\* Interim – First Claim
- 823\* Interim – Continuing Claim
- 824\* Interim – Last Claim
- 827 Replacement Claim
- 828 Cancelled Claim

\*Interim billing is accepted, but not required.

### Revenue and CPT Codes

Revenue Code	CPT Code	Description
651		Routine Home Care
656		*General Inpatient Care (Non-respite)
551		**Skilled Nursing Visit

\* Billed by providers whose inpatient program has been approved by Blue Cross

\*\*Used to bill the initial evaluation

### Units

Units represent the number of days approved under the hospice per diem when the patient has a hospice benefit. If services are being allowed under the Private Duty Nursing or Home Health benefit in lieu of a Hospice benefit, units represent the number of approved visits being billed on the claim.

**Line Item Date of Service**

Line item date of service is not required on hospice claims when the member has a hospice benefit and the hospice per diem has been approved. If the member does not have a hospice benefit and has been approved to receive skilled services under a Private Duty Nursing (PDN) benefit or the Home Health (HH) benefit, line item date of service is required.

**Hospice Benefit / Hospice Per Diem**

Rev	Description	Date of Service	Units	Total Charge	Allowed	Paid Amount
651	Home Hospice	8/1/06	15	*\$1,350.00	*\$1,350.00	\$1,350.00

\*assuming a charge and hospice per diem of \$90.00

**Skilled Services / PDN or HH**

Rev	Description	Date of Service	Units	Total Charge	Allowed	Paid Amount
551	Skilled Visit	8/1/06	1	*\$90.00	*\$90.00	\$90.00
551	Skilled Visit	8/3/06	1	*\$90.00	*\$90.00	\$90.00
551	Skilled Visit	8/7/06	1	*\$90.00	*\$90.00	\$90.00
551	Skilled Visit	8/11/06	1	*\$90.00	*\$90.00	\$90.00
551	Skilled Visit	8/15/06	1	*\$90.00	*\$90.00	\$90.00

\*assuming a charge and hospice per diem of \$90.00

**Per Diem Rate**

Blue Cross and Blue Shield of Kansas approves the Medicare home hospice rate as the home per diem rate for Blue Cross patients. When the per diem rate is approved, claims are reimbursed at the rate on file when the claim is submitted. For this reason, hospice providers must provide written notification to BCBSKS when their Medicare per diem rates are updated each October. This MAP includes all home services, prescription drugs, and home medical equipment related to the terminal illness.

For facilities that have an approved inpatient hospice program, the reimbursement is 110% of the Medicare General Inpatient Rate.

This rate will be applied to all prior approved inpatient hospice admissions submitted on behalf of BCBSKS members. This rate also applies to plans administered or serviced by BCBSKS or other entities when services are received within the company service area and BCBSKS is involved in the processing of the claim and payment is issued either by BCBSKS, other Blue Cross and Blue Shield companies/plans or other entities such as insurers or

administrators of welfare benefit plans. Facilities that bill for inpatient hospice whose program has not been submitted to Blue Cross and approved for inpatient reimbursement will receive reimbursement at the home hospice rate.

Continuous or Respite care is not recognized under Blue Cross contracts with the exception of the Federal Employee Program (FEP).

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

- 1) A skilled nursing visit one time per week
- 2) Home health aide visits three times per week
- 3) A social worker visit one time per month
- 4) Medical equipment in the home and pharmacy

**OR;**

- 1) Multiple skilled nursing visits per week
- 2) Social worker visits two times per month
- 3) Medical equipment in the home and pharmacy

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

### **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 the hospice per diem rate.

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

- 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 indicating a skilled nursing visit was provided. No HCPCS code is required.

- The claim will be billed with the hospice provider number.
- Contracting Providers will be reimbursed at their home hospice rate for the initial evaluation visit to determine the level of hospice care.

Rev	HCPCS/CPT	Date of Service	Total Charge	Allowed	Paid Amount
551		8/1/06	\$130.00	\$126.00	\$126.00

### Claim Examples

**Example 1:** The patient does not have a hospice benefit so services are being allowed as skilled visits under the member's Private Duty Nursing benefit. Three letters were sent as outlined below. Will all of the billed services be allowed?

Letter 1      Approve 3 skilled visits from 7/31/06 – 8/11/06  
 Letter 2      Approve 3 skilled visits from 8/14/06 – 8/25/06  
 Letter 3      Approve 1 skilled visit from 8/28/06 – 9/1/06

Rev	Description	Date of Service	Total Charge	Allowed	Paid Amount
551	Skilled Visit	8/1/06	\$100.00	\$	\$
551	Skilled Visit	8/3/06	\$100.00	\$	\$
551	Skilled Visit	8/8/06	\$100.00	\$	\$
551	Skilled Visit	8/14/06	\$100.00	\$	\$
551	Skilled Visit	8/23/06	\$100.00	\$	\$
551	Skilled Visit	8/29/06	\$100.00	\$	\$
551	Skilled Visit	8/30/06	\$100.00	\$	\$

**Example 2:** The hospice has been approved to perform an initial evaluation visit. What revenue code will the hospice use to bill this service?

Rev	Description	Date of Service	Total Charge	Allowed	Paid Amount
	Initial Evaluation	8/1/06	\$100.00	\$100.00	\$100.00

### Example 3:

Patient 'A' does not have a hospice benefit so skilled services are being allowed under the private duty nursing benefit. Ten visits were approved from 8/1/06 – 8/30/06 and 10 visits were made.

Patient 'B' has a hospice benefit and hospice services were approved. Ten visits were made from 8/1/06 through 8/30/06.

Will payment be the same in both of these scenarios?