Hospice Services

Policy

Mass General Brigham Health Plan reimburses contracted hospice providers for hospice care provided to terminally ill members. Recipient has a medical prognosis that his/her life expectancy is 6 months or less if the illness runs its normal course.

Definitions

Hospice: A program or facility that provides special care for people who are near the end of life and for their families.

- **Hospice Care**: Care designed to give supportive care to people in the final phase of a terminal illness and focus on comfort and quality of life, rather than cure. The goal is to enable patients to be comfortable and free of pain, so that they live each day as fully as possible. Aggressive methods of pain control may be used. Hospice programs generally are home-based, but they sometimes provide services away from home - in freestanding facilities, in nursing homes, or within hospitals. The philosophy of hospice is to provide support for the patient's emotional, social, and spiritual needs as well as medical symptoms as part of treating the whole person.

- **Hospice Inpatient Facility:** A palliative-care facility that cares solely for hospice members requiring short-term, general inpatient, or respite care and is owned and operated directly by a licensed hospice hospital licensed per MGL CH. 111 §51.

- **Respite Care:** Care provided to the patient to temporarily relieve the patient's family or other primary caregiver from the daily demands of caring for the patient. Respite care may be provided in the patient's home or in an inpatient facility.

- **Terminally Ill:** Recipient has a medical prognosis that his/her life expectancy is 6 months or less if the illness runs its normal course.

Reimbursement

Providers are reimbursed according to the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan Payment Policy and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include but are not limited to: copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to General Coding and Billing for more information. All claims are subject to audit services and medical records may be requested from the provider. Mass General Brigham Health Plan reimbursement is based on the line of business.

All subcontracted services must be billed by the hospice agency and must not be billed by a subcontractor. All services billed as a result of a subcontract arrangement will be paid as a component of the hospice per diem and not reimbursed separately. Bill for hospice services on an Institutional UB-04 Form using the appropriate revenue code(s), per your contractual agreement with Mass General Brigham Health Plan. Please refer to your contract with Mass General Brigham Health Plan for information regarding specific coding requirements.

It is the level of care, and not the place of service that determines reimbursement. Bill other services on a CMS-1500 FORM. Submit only one revenue code per date of service. Submit an individual date on each service line. If submitting date ranges on a one-line-only claim, the count must match the number of days in the date range.

Mass General Brigham Health Plan Reimburses

- Home care when less than 8 hours of primary nursing care, which may be intermittent, are
- required in a 24-hour period.

- Continuous home care for the relief of acute medical symptoms, when at least a total of 8 hours of primary skilled care, which may be intermittent, is required in a 24-hour period.
- Inpatient respite care that is short term (i.e., up to 14 days per calendar year) and provided as part of the overall treatment plan, for the safety and supervision of a hospice patient to relieve the primary caregiver at home.
- Inpatient hospice care when the intensity or scope of care needed is not feasible in the home setting will be short term, and when the individual treatment plan is specifically directed at acute symptom management and/or pain control.
- A physician separately for services rendered during a hospice episode when such care is **unrelated** to the terminal illness.
- Radiation services outside the hospice contracted per diem to contracted providers.
- Services provided as a result of a subcontract arrangement with the hospice will be reimbursed to the hospice directly and paid as a component of the hospice per diem.

Mass General Brigham Health Plan Does *Not* Reimburse

- Hospice services for individuals no longer considered terminally ill.
- Services, supplies, or procedures that are directed at curing the terminal condition or deemed to be life-prolonging (e.g., life sustaining) unless said services are part of the palliative plan of care.
- Services to solely aid in the performance of activities of daily living (ADLs).
- Nutritional supplements, vitamins, and drugs not covered by the pharmacy benefit.
- Medical supplies unrelated to the palliative care to be provided.
- Services outside of the hospice benefit.
- Inpatient care other than the services described above.
- Subcontracted hospice services which must be billed directly to the hospice provider
- Respite care is not reimbursed in addition to routine hospice home care.

Revenue Codes

Note: This list of codes may not be all-inclusive.

Rev Code	Descriptor	Comment
0651	Hospice Service-Routine Home Care	For billing less than 8 hours of care. Enter number of hours in UB- 04 Form Locator 46. Submit the appropriate code to indicate rendering location.

Rev Code	Descriptor	Comment
0652	Hospice Service-Continuous Home Care	Enter the number of hours in UB-04 Form Locator 46 Submit the appropriate code to indicate rendering location.
0655	Hospice Service-Inpatient Respite Care	Enter the number of days in UB-04 Form Locator 46 Submit the appropriate code to indicate rendering location.
0656	Hospice Service-Inpatient General Care (non-respite)	Enter the number of days in UB-04 Form Locator 46 Submit the appropriate code to indicate rendering location.
0657	Hospice-Physician Services	Provide CPT/HCPCS Level II code detail Submit the appropriate code to indicate rendering location.
0658	Hospice- Room and Board-Nursing Facility	Enter the number of days, in addition to Rev Code 0651 or 0652. Submit the appropriate code to indicate rendering location.
0659	Hospice-Other	Enter the number of hours in UB-04 form Locator 46 Submit the appropriate code to indicate rendering location.

Procedure Codes

HCPCS Code	Descriptor
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes
G0337	Hospice evaluation and counseling services, pre-election
G9473	Services performed by chaplain in the hospice setting, each 15 minutes
G9474	Services performed by dietary counselor in the hospice setting, each 15 minutes
G9475	Services performed by other counselor in the hospice setting, each 15 minutes
G9476	Services performed by volunteer in the hospice setting, each 15 minutes
G9477	Services performed by care coordinator in the hospice setting, each 15 minutes
G9478	Services performed by other qualified therapist in the hospice setting, each 15 minutes
G9479	Services performed by qualified pharmacist in the hospice setting, each 15 minutes
Q5001	Hospice care provided in patient's home/residence
Q5002	Hospice care provided in assisted living facility
Q5003	Hospice care provided in nursing long term care facility or non-skilled nursing facility

HCPCS Code	Descriptor
Q5004	Hospice care provided in skilled nursing facility
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 care provided in place not otherwise specified
Q5010	Hospice home care provided in a hospice facility
S9125	Respite care in the home, per diem
S9126	Hospice care in the home, per diem (routine hospice care)
T2042	Hospice routine home care; per diem
T2043	Hospice continuous home care; per hour
T2044	Hospice inpatient respite care; per diem
T2045	Hospice general inpatient care; per diem
T2046	Hospice long-term care, room and board only; per diem

Related Mass General Brigham Health Plan Payment Guidelines

General Coding and Billing
MassHealth Hospice
Home Health Care Agency

References

American Medical Association, *CPT current year, Professional Edition*
American Medical Association, *HCPCS Level II, current year, Professional Edition*
CMS Medicare Benefit Policy Manual, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance, Sections 40.1.9; 40.3; 40.4.1
Division of Medical Assistance 130 CMR; 437:000 Hospice Services Mass.
Division of HCFA, 114.3 CMR 343.00 Hospice Services
MassHealth Transmittal Letter HOS-14, March 2010
MassHealth Transmittal Letter HOS-15, March 2011

Publication History

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