Hospice Care: General Billing Instructions

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This section contains hospice care billing guidelines, including authorization and "from-through" billing requirements.

Special Physician Services

Hospice providers must use revenue code 0657 when billing for pain- and symptom-management services related to a recipient's terminal condition and provided by a physician employed by, or under arrangement made by, the hospice.

Special physician services code 0657 may be billed only for physician services to manage symptoms that cannot be remedied by the recipient's attending physician because of one of the following:

- Immediate need
- Attending physician does not have the required special skills

Claim Completion

Revenue code 0657 should be billed on a separate line for each date of service. Refer to the *UB-04 Completion: Outpatient Services* section of this manual for additional billing information.

Reimbursement

Reimbursement for revenue code 0657 is limited to once per day, per recipient, per provider. The reimbursement rate is outlined in *California Code of Regulations* (CCR), Title 22, Section 51503, 51509 or 51509.1, as applicable. Reimbursement is subject to the hospice cap amount described in CCR, Title 22, Section 51544(d)(2).

Billing Procedures

If the recipient is receiving care for more than one day in a month, use the "from-through" billing method to bill per-diem service and room and board codes, indicated above. If the recipient is receiving care for only one day, bill that day on one line with a single date of service. Do not bill per diem codes on a single line with a quantity greater than one, or the claim will be denied. An explanation of how to bill using the "from-through" method is included in the *UB-04 Special Billing Instructions for Outpatient Services* section of this manual.

Medi-Cal requires that hospices document all coexisting or additional diagnoses related to the recipient's terminal illness on hospice claims. Hospices should not report coexisting or additional diagnoses unrelated to the terminal illness.

Other Health Coverage

If hospice room and board services are covered by a recipient's insurance, first bill the Other Health Coverage prior to billing Medi-Cal.

Medicare/Medi-Cal Recipients

For Medicare/Medi-Cal-eligible recipients, Medicare will be the first payer of hospice care. Medi-Cal covers both coinsurance for drugs and respite care on behalf of Medicare/Medi-Cal recipients, and room and board allowance for recipients residing in Nursing Facility (NF) Level A or B.

If the Medicare-eligible recipient has any other health insurance coverage, a copy of the *Explanation of Benefits* (EOB), *Remittance Advice* (RA) or denial letter must accompany each Medi-Cal claim for services. More information is available in the *Other Health Coverage (OHC) Guidelines for Billing* in the Part 1 manual.

Note: Providers billing hospice care revenue codes 0552, 0650, 0652, 0655, 0656, 0657 or 0659 for Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service, may bill Medi-Cal directly. Medicare denial documentation is not required with these claims.

Revenue code 0657 is not reimbursable when physician services are not related to the treatment of the terminal illness. Such treatment must be billed to Medicare as a Part B covered service, as appropriate.

Medicare/Medi-Cal Billing for Coinsurance

When hard copy billing Medi-Cal for coinsurance amounts, hospices must send the California MMIS Fiscal Intermediary a copy of the Medicare claim with an attached copy of the Medicare RA. This shows that the Medicare payment was made for hospice care during the period covered. Pursuant to state regulation, coinsurance may not be billed for recipients eligible for Medicare or Medi-Cal unless the hospice also bills and collects coinsurance from Medicare-only recipients.

Medicare/Medi-Cal Billing for Room and Board

When billing Medi-Cal for room and board charges, hospices must send the FI a copy of the Medicare claim covering the same dates of service or must enter in the *Remarks* field (Box 80), or attachment to the claim, the date that Medicare was billed, the concurrent dates of hospice care services and the hospice care codes billed.

Treatment Authorization Request: General Inpatient Care (Revenue Code 0656)

General inpatient care (revenue code 0656 billed in conjunction with HCPCS code T2045) requires the submission of a *Treatment Authorization Request* (TAR). General inpatient care during the first 90-day hospice election period may be approved if the TAR is received with all of the required documents listed below:

- Written prescription signed by the recipient's attending physician
- Patient's Hospice Election form
- Initial written plan of care
- Certification of terminal illness by a physician
- A *Hospice General Inpatient Information Sheet (*DHS 6194) and documentation specified in the *Manual of Criteria for Medi-Cal Authorization*, Chapter 11, "Criteria for Hospice Care," Section IV

For providers rendering services during second 90-day or subsequent 60-day periods, a TAR may be approved upon receipt of a document which recertifies the recipient's terminal illness and is signed by a hospice physician.

Fax TAR and Hospice General Inpatient Information Sheet

For concurrent authorization via the fax TAR (form 50-2) process, contact the TAR Processing Center (refer to the *TAR Overview* section in the Part 1 manual). The *Hospice General Inpatient Information Sheet* (DHS 6194) must be attached to fax TARs. For information about the DHS 6194, refer to the *Hospice Care: General Inpatient Information Sheet* section of this manual.

Providers must keep copies of documentation previously sent with the TAR (for example, physician's certification of terminal illness, copy of the plan of care and election statement).

‹‹Hospice Program Election Notice (DHCS 8052) and Patient Notification of Hospice Non-Covered Items, Services, and Drugs (DHCS 8053) Forms

The *Medi-Cal Hospice Program Election Notice* (DHCS 8052) and *Patient Notification of Hospice Non-Covered Items, Services, and Drugs* (DHCS 8053) forms are required for all licensed and certified hospice agencies to use initially when Medi-Cal eligible individuals elect Hospice services. See the *New Hospice Election Notice and Addendum Forms* section of the *Hospice Care* provider manual section for further information and provider instruction.

Additional information and access to the forms may be found at the Hospice Care page of the DHCS website.››

Home and Respite Care: Authorization Not Required

The following hospice services do not require authorization:

- Routine home care
- Continuous home care
- Inpatient respite care
- Physician's services

Claims for services that do not require authorization are billed directly to Medi-Cal.

Continuous and Respite Home Care

When billing for continuous home care (revenue code 0652) or respite care (revenue code 0655), medical justification must be entered in the *Remarks* field of the claim.

If medical justification is not included or is not adequate, reimbursement will be reduced to the rate for 0659 (routine home care, low rate). An appeal may be submitted for reconsideration of payment by including additional documentation of the medical necessity for the increased level of care.

Room and Board Billing Instructions

When billing for room and board codes, the following information is required in the *Remarks* field of the claim, or on an attachment to the claim:

- The recipient resides in a certified NF or Intermediate Care Facility (ICF)
- The name and address of the NF or ICF
- A Minimum Data Set (MDS) on file at the NF verifies that the recipient meets the NF or ICF level of care

Note: A TAR is not required for hospice care room and board provided in an NF or ICF.

Share of Cost (SOC)

Long Term Care Share of Cost (SOC) should be cleared by a hospice provider on the *UB-04* claim by completing the *Value Codes and Amounts* field (Boxes 39 – 41). The value code is "23" and the value amount is what has been paid or obligated by the patient for SOC. Refer to the *Hospice Care Billing Examples* section in this manual for an illustration.

Record Retention Requirements

Medi-Cal hospice providers are required, upon request, to make available to DHCS complete and accurate medical and fiscal records, signed and dated by appropriate staff, to fully substantiate all claims for hospice services submitted to the Fiscal Intermediary (FI), and to permit access to all records and facilities for the purpose of claims audit, program monitoring and utilization review.

Note: Records must be held three years from the last service date.

Periods of Care

Hospice is a covered Medi-Cal benefit with the following periods of care:

- Two 90-day periods beginning on the date of hospice election
- Followed by unlimited 60-day periods

A period of care starts the day the recipient receives hospice care and ends when the 90-day or 60-day period ends.

Remittance Advice Details

The following Remittance Advice Details (RAD) codes and messages appear on the Medi-Cal *Remittance Advice Details* for claims that are denied payment for the reasons listed below.

"From-Through" or Billing for a Quantity Less Than Eight

Claims for hospice continuous home care (revenue code 0652) that are billed using the "from-through" method or billed with a quantity less than "8" are denied with the following denial message.

‹‹RAD Code Denial Message Table››

RAD Code	Denial Message
166	Hospice continuous home care must be billed a minimum of eight hours and cannot be block ("from-through") billed.

Same or Overlapping Dates of Service

Only one level of hospice care is allowed for any hospice recipient for the same day of service. Claims for more than one type of hospice service billed for the same recipient on the same or overlapping dates of service are denied with the following denial message.

‹‹**RAD Code Denial Message Table**››

RAD Code	Denial Message
168	More than one type of hospice care is not payable for any recipient on the same or overlapping dates of service.

Exception: In cases where one hospice discharges a recipient and another hospice admits the same recipient on the same day, each hospice may bill for reimbursement and each will be reimbursed at the appropriate level of care for its respective day of discharge or admission.

Facility Type/Place of Service: Inappropriate

Claims submitted with an inappropriate facility type/Place of Service code are denied with the following denial message.

‹‹**RAD Code Denial Message Table**››

RAD Code	Denial Message
9591	Revenue code 658 must be billed with facility type codes “25,” “26,” “28,” “65,” “81” or “86” on the *UB-04* claim.

Billing Tip: Computer Media Claims (CMC) providers – Revenue code 658 should be entered on the claim line as a five-digit number with two leading zeros (00658).

‹‹Legend››

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.