SUNCOAST
HOSPICE

empath™ health

Insight into Hospice and PACE

Defining Hospice Care

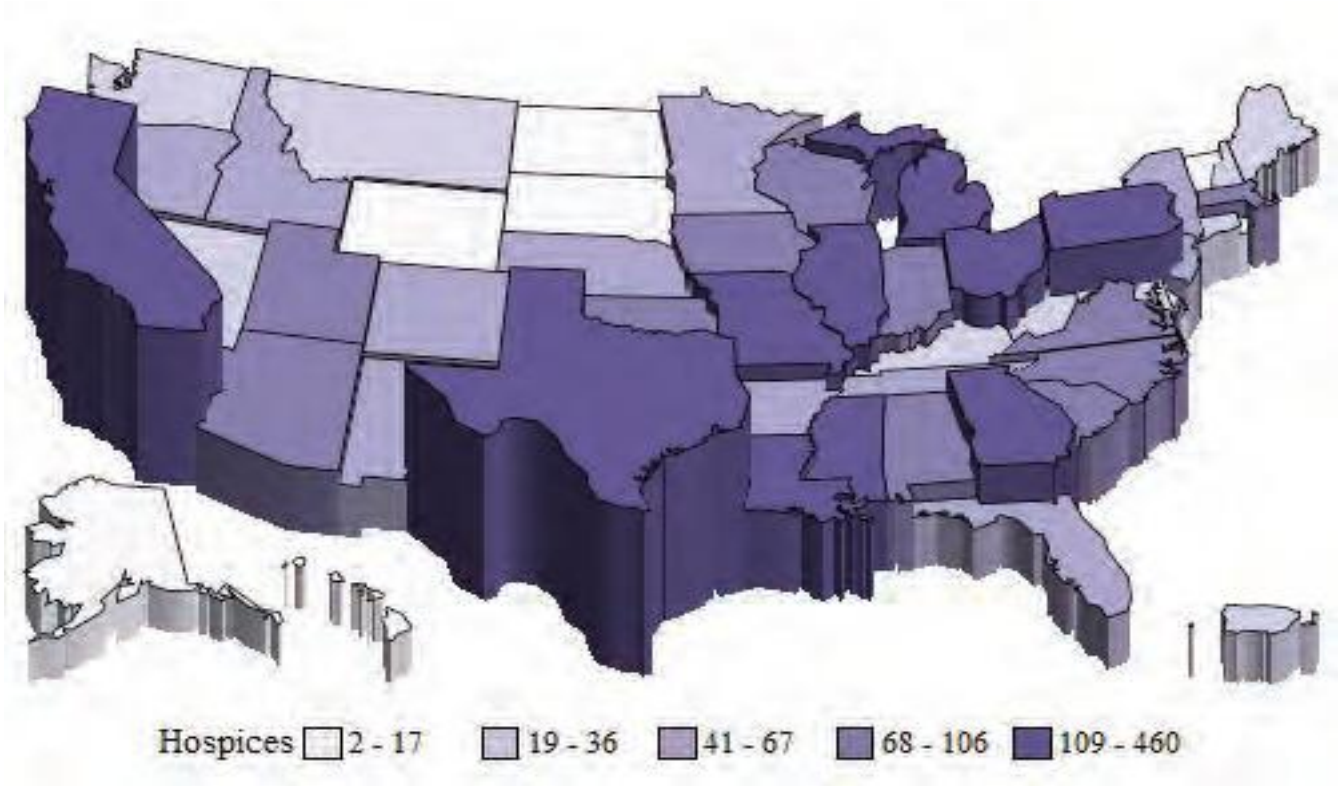
- A form of palliative care designed to provide medical, spiritual and psychological care to individuals facing a life limiting illness.
- Focuses on caring, not curing.
- Includes support for the family
- Services provided by physicians, nurses, home health aides, social workers, spiritual care and volunteers

Interdisciplinary Team

"You matter because you are you, and you matter to the end of your life. We will do all we can not only to help you die peacefully, but also to live until you die."

— Dame Cicely Saunders, nurse, physician and writer, and founder of hospice movement (1918 - 2005).

Medicare Certified Hospices



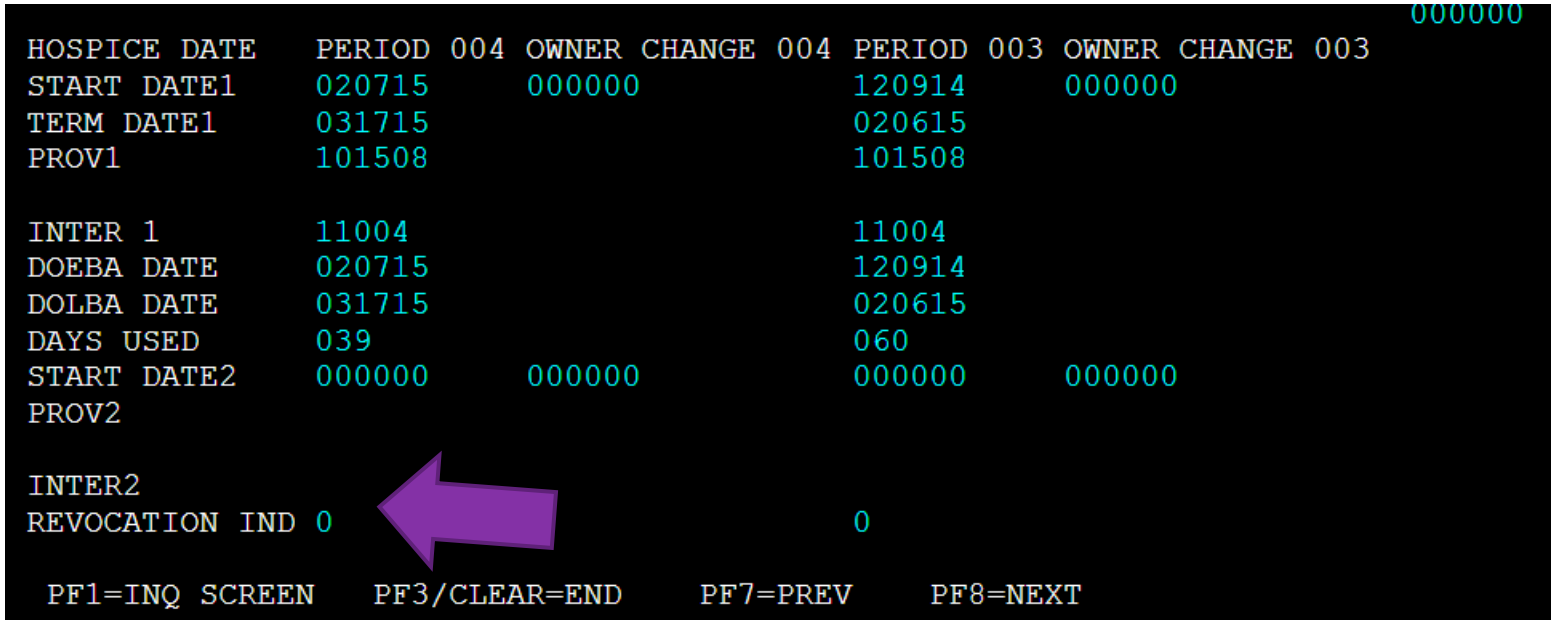
Medicare Hospice Benefit

- Terminal prognosis of 6 months or less
- DNR not necessary
- Not seeking aggressive treatment. (Exception for patients 18 and under who may seek concurrent treatment)
- Initial Certification of terminal illness by Attending Physician and Hospice Medical Director; Recertification by Medical Director only
- If greater than 3rd benefit period requires Face-to-Face certification by ARNP or physician

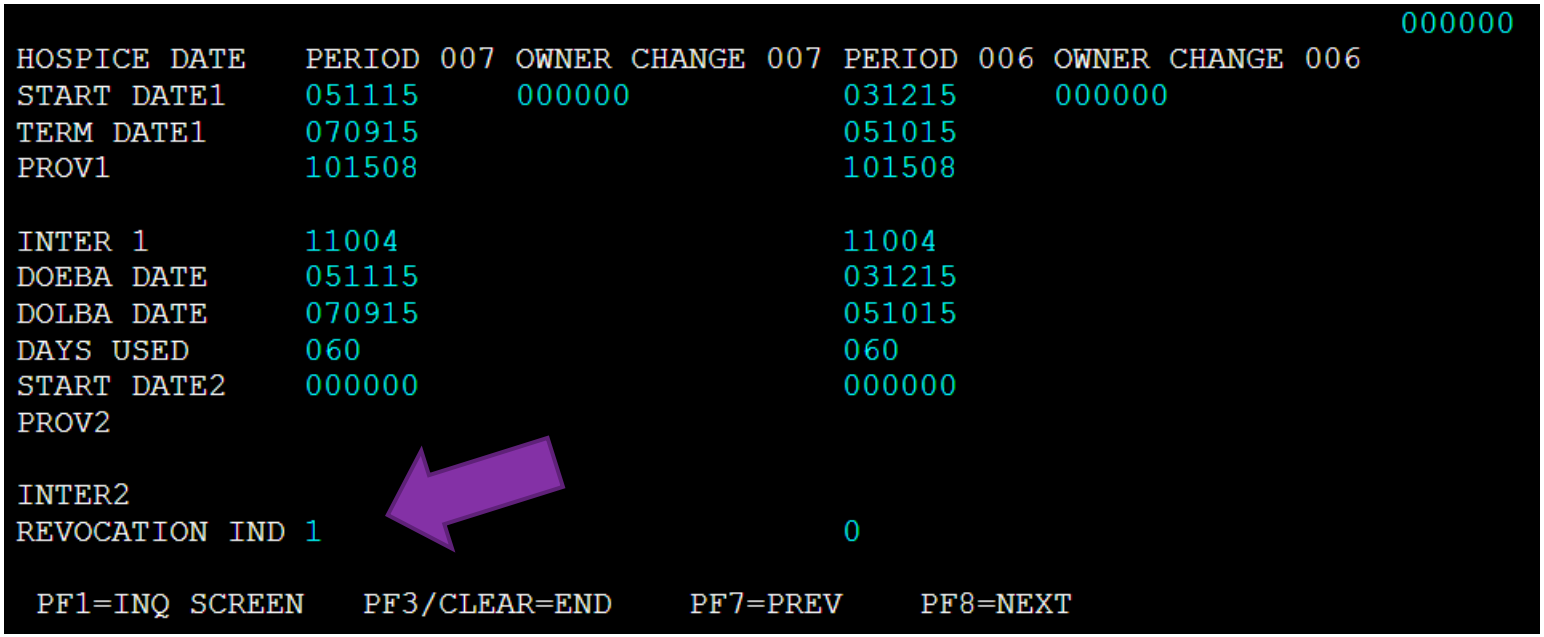
Medicare Notice of Election

- MM8877 - Must file Hospice NOEs within 5 calendar days after the effective date of hospice election. A timely-filed NOE is a NOE that is submitted to the Medicare contractor and accepted by the MAC within 5 calendar days after the hospice admission date. If you do not file the NOE within this 5 calendar day period, Medicare will not cover and pay for the days of hospice care from the effective date of election to the date of NOE filing.
- If a hospice beneficiary is discharged alive or if a hospice beneficiary revokes the election of hospice care, you must file a NOTR within 5 calendar days after the effective date of a beneficiary's discharge or revocation, unless you have already filed a final claim.

Medicare DDE of Patient Deceased



Medicare Patient Discharged Alive



Hospice Reimbursement

- 4 Levels of Care
  - Routine $159.34
  - Continuous Care $929.31
  - General Inpatient $708.77
  - Respite $164.81
  - Physician services fee schedule
  - Room & Board

Location Codes

- Created to show where patients are receiving services
  - Q5001 – home
  - Q5002 – ALF
  - Q5003 – nursing facility (nonskilled)
  - Q5004 – Skilled nursing facility
  - Q5005 – Inpatient hospital
  - Q5006 – Inpatient hospice facility
  - Q5007 – Long term care facility
  - Q5008 – Psychiatric facility
  - Q5010 – Routine, CC at hospice facility

Other UB04 Requirements

- Visit detail for nurses, home health aides, social workers
- Phone calls by social workers
- Infusion pumps
- Injectable and non-injectable medications dispensed to patients regardless of where services are received including NDC and HCPCs

These items are reported but not reimbursed

Hospice Diagnosis

Diagnosis…Who gets the bill?

Related vs Unrelated

- Only hospice IDT/medical director can make determination
- Identify principal terminal diagnosis
- Is this service diagnosis caused or exacerbated by Principal terminal diagnosis?
- Are there additional diagnoses or symptoms that contribute to terminal prognosis?
- Are there additional diagnoses, conditions or symptoms caused or exacerbated by treatment of related conditions?
- Is the treatment/procedure/test in the hospice plan of care?

YES?

Bill hospice

No?

- Service is deemed unrelated and physician/facility will bill Medicare/Medicaid or other payer directly
- Unrelated hospital stay billed with Condition code 07
- Physicians use modifier GW on 1500 form
- Service not in the hospice plan of care, *even if related*, cannot be billed to Medicare/Medicaid but must be patient responsibility only

Ask hospice provider for statement of coverage in writing

Hospice and Managed Care

§ 417.585 Special rules: Hospice care.

(a) No payment is made to an HMO or CMP on behalf of a Medicare enrollee who has elected hospice care under § 418.24 of this chapter except for the portion of the payment applicable to the additional benefits described in § 417.592. This no-payment rule is effective from the first day of the month following the month of election to receive hospice care, until the first day of the month following the month in which the enrollee resumes normal Medicare coverage.

Medicare Benefit Policy Manual

20.4 – Election by Managed Care Enrollees

- Once a managed care enrollee has elected hospice, all his or her Medicare benefits revert to fee-for-service, though the enrollee still remains on managed care for any additional benefits provided by his or her managed care plan, such as dental or vision coverage. The Medicare hospice benefit, through fee-for-service Medicare, covers all hospice care from the effective date of election to the date of discharge or revocation. During the election, fee-for-service Medicare also covers attending physician services and all care unrelated to the terminal illness.

PACE

Program for All Inclusive Care of the Elderly

Who is eligible?

Individuals who are age 55 or older, certified by their state to need nursing home care and able to live safely in the community at the time of enrollment

Identifying PACE Recipient

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HIQACRO     CWF   PART A   INQUIRY REPLY                          PAGE 01 OF 15

PER 4 PLAN-TYP HMO                    CURR  ID H3430 OPT C ENR 110114 TERM
PRIOR PLAN-TYP HMO                    PRIOR ID H1036 OPT C ENR 010103 TERM 103114
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PACE Reimbursement

- Medicare – Risk based capitation program
- Medicare D – Bid system which represents an estimation of the drug costs
- Medicaid – Capitation (same amount for each recipient)

PACE Responsibilities

- PACE is regulated under Medicare Advantage rules (therefore is similar to the recipient's HMO
- PACE physician becomes recipient's Primary Care physician
- PACE covers all recipient's health needs including medical, dental, eye care, psychological, nursing home, hospice etc.

- Adult day care and transportation services
- Pre-authorization required for all outside services ie. Labs, consulting physicians with exception of emergency services
- Non-authorized services cannot be billed to Medicare/Medicaid or the recipient

QUESTIONS?

Thank you!!

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