ADMINISTRATIVE POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Hospice Services OH-MCD-AD-1065	12/01/2022-01/31/2024
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Hospice Services

B. Background

Hospice services are provided to individuals who are terminally ill and at the end of life. These services are intended to provide comfort or palliative care. Hospice care is a type of care that focuses on the palliation of a terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs. Hospice care has a palliative focus without curative intent. Usually, it is used for patients with no further options for curing disease or who have decided not to pursue further options that are arduous, likely to cause more symptoms, and unlikely to succeed.

C. Definitions

- **Hospice Care Program** - A coordinated program of home, outpatient, and inpatient care and services operated by a person or public agency that provides the following care and services to hospice patients and to hospice patients' families through a medically-directed interdisciplinary team:
  - Nursing care by or under the supervision of a registered nurse
  - Physical, occupational, or speech or language therapy, unless waived by the department of health
  - Medical social services by a social worker under the direction of a physician
  - Services of a home health aide
  - Medical supplies, including drugs and biologicals, and the use of medical appliances
  - Physician services
  - Short-term inpatient care, including both palliative and respite care, and procedures
  - Counseling for hospice patients and families
  - Services of volunteers under the direction of the provider of the hospice care program
  - Bereavement services for hospice patients' families.

  These services are provided under interdisciplinary plans of care established pursuant to section 3712.06 of the Revised Code to meet the physical, psychological, social, spiritual, emotional, and other special needs experienced during the final stages of illness, dying, and bereavement.
- **Hospice Patient** - A patient, other than a pediatric respite care patient, who has been diagnosed with a terminal illness, has a life expectancy of six months or less, and has voluntarily requested and is receiving care from a person or public agency licensed under Ohio law to provide a hospice care program.
- **Palliative Care**- Specialized care for a patient of any age who has been diagnosed with a serious or life-threatening illness that is provided at any stage of the illness by an interdisciplinary team working in consultation with other health care professionals, including those who may be seeking to cure the illness aims to do all of the following:
  - Relieve the symptoms, stress, and suffering resulting from the illness
  - Improve the quality of life of the patient and the patient's family

- Address the patient's physical, emotional, social, and spiritual needs
- Facilitate patient autonomy, access to information, and medical decision making.

- **Pediatric Hospice Care** - A program operated by a person or public agency that provides inpatient respite care and related services to pediatric respite care patients and the patients' families to meet the physical, psychological, social, spiritual, and other special needs experienced during or leading up to the final stages of illness, dying, and bereavement.
- **Terminal Illness** - A qualifying condition for which a prospective patient has received a diagnosis for a life expectancy of six months or less if the illness runs its normal course.

D. Policy

I. CareSource considers hospice services a covered service with the following requirements:

A. Election of hospice benefits form must be signed by the CareSource member and submitted.
B. Provider must produce and submit a Certificate of Terminal Illness form.
C. CareSource may request documentation to support medical necessity. Appropriate and complete documentation must be presented upon CareSource request to validate medical necessity.
D. Criteria for determination of terminal illness:
1. Hospice care is provided for two ninety-day periods followed by increments of sixty-day periods, as recertifications occur.
2. Patient must have a qualifying condition with a diagnosis of a life expectancy of six months or less if the illness runs its normal course.
3. At the start of the first ninety-day benefit period, the patient must be certified as terminally ill.
4. The patient must be recertified as terminally ill at the start of each benefit period following the first ninety-day period by the hospice physician.
E. Short-term inpatient care may be provided in hospital, hospice inpatient unit, or a participating Skilled Nursing Facility or Nursing Facility on an intermittent, non-routine basis:
1. For relief of the individual's caregivers, and/or
2. General inpatient care for the purpose of respite, pain control and acute or chronic symptom management that cannot feasibly be provided in other settings.
F. When an individual younger than age 21 elects to receive hospice care, it does not constitute a waiver of any rights of the individual to receive curative services related to the treatment of a terminal condition.
G. When an adult over the age of 21 elects to receive hospice care, he or she agrees to waive Medicaid services provided to him or her for the cure and treatment of the terminal condition.
H. Ohio law considers people who are 18 years of age or older capable of giving valid, legally enforceable consent to receive hospice services.

II. Hospice care for under age 18 years requires the consent of a parent or guardian unless certain exceptions exist as noted under Ohio law.

III. When the reason for discharge from hospice care is death, routine home care provided in an in-home visit by a registered nurse and/or a social worker during the last seven days of a patient's life requires documentation of medical necessity.

IV. Billing for Hospice Services
   A. Professional claims must be billed on a CMS 1500 (HCFA) form with the following documentation:
      1. The name of the nursing facility where the services were delivered and
      2. The National Provider Identifier (NPI) of the service facility.
      3. Consistent with the current process set forth by the OAC, providers must submit claims as a single line with date of service span and units billed to match.
   B. Institutional claims must be billed on a UB04 form with the following documentation:
      1. The name of the nursing facility where the services were delivered.
      2. If the hospice services are billed in a Health Care Isolation Center (HCIC) Room and Board, the claims must be billed using the HCIC revenue codes as provided in the Ohio Department of Medicaid guidance.
   C. Hospice providers that deliver any component of services via telehealth must add the GT modifier on those claims, in addition to the appropriate procedure code.

V. For the administration of Hospice Services, CareSource follows the rules sets forth in Chapter 5160-56, Medicaid Hospice Program in the Ohio Administrative Code (OAC) and Chapter 3712, Hospice Care in the Ohio Revised Code (ORC).

E. Conditions of Coverage
N/A

F. Related Policies/Rules
N/A

G. Review/Revision History

DATES		ACTION
Date Issued	07/21/2021	New Policy
Date Revised	08/17/2022	Updated references; no changes
Date Effective	12/01/2022	
Date Archived	01/31/2024	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. OAC - 5160-1-18. Telehealth (2020, November 150). Retrieved August 2, 2022 from www.codes.ohio.gov.
2. OAC - 5160-56-01 Hospice services; definitions. Retrieved August 2, 2022 from www.codes.ohio.gov.
3. OAC - 5160-56-02 Hospice services; eligibility and election requirements. Retrieved August 2, 2022 from www.codes.ohio.gov.
4. OAC - 5160-56-03 Hospice services; discharge requirements. Retrieved August 2, 2022 from www.codes.ohio.gov.
5. OAC - 5160-56-04 Hospice services; provider requirements, Retrieved August 2, 2022 from www.codes.ohio.gov.
6. OAC - 5160-56-05 Hospice services; covered services. Retrieved August 2, 2022 from www.codes.ohio.gov.
7. OAC - 5160-56-06 Hospice services; reimbursement. Retrieved August 2, 2022 from www.codes.ohio.gov.
8. ODM. Telehealth Billing Guidelines for Dates of Service on or after 11/15/2020. Retrieved August 2, 2022 from www.medicaid.ohio.gov
9. ORC - 2317.54 Informed consent to surgical or medical procedure or course of procedures. Retrieved August 2, 2022 from www.codes.ohio.gov.
10. ORC 2907.29 Hospital emergency services for victims of sexual offenses. Retrieved August 2, 2022 from www.codes.ohio.gov.
11. ORC 2919.121 Unlawful abortion upon minor. Retrieved August 2, 2022 from www.codes.ohio.gov.
12. ORC 3709.241 Minor may give consent for diagnosis or treatment of venereal disease. Retrieved August 2, 2022 from www.codes.ohio.gov.
13. ORC - Chapter 3712 Hospice Care. Retrieved August 2, 2022 from www.codes.ohio.gov.
14. ORC - 3719.012 Minor may give consent to diagnosis or treatment of condition caused by drug or alcohol abuse. Retrieved August 2, 2022 from www.codes.ohio.gov.
15. ORC - 5122.04 Outpatient services for minors without knowledge or consent of parent or guardian. Retrieved August 2, 2022 from www.codes.ohio.gov.