Aetna Better Health® of Florida
1340 Concord Terrace
Sunrise, FL 33323

AETNA BETTER HEALTH® of FLORIDA

Hospice Guidelines Medicaid and LTC Services

Level of Care Revenue Codes & Definitions

Payment for hospice services is made to the designated hospice provider using the CMS annually published Medicaid hospice rates that are effective from October 1 of each year through Sept 30 of the following year. Medicaid reimbursement for hospice care will be made at predetermined rates for each day the patient receives care under one of the following levels of hospice care depending on the type and intensity of the services furnished to the patient for that day.

For continuous home care, the amount of payment is determined based on an hourly rate. For the other categories, the amount of payment is applicable for the category based on a daily rate.

There are four levels of care into which each day of care is classified:

0651 – Routine Home Care (Daily rate) – Hospice services at home, place of residence/home-like setting. Can be a nursing home, assisted living facility, or hospice residential facility.

Routine Home Care is two levels based on the length of time the recipient is in hospice care on a cumulative basis without a 60-day break in stay. If readmission occurs after 60 days, the calculation starts over.

Routine High is 0 to 60 days
Routine Low is 61+ days

0652 – Continuous Home Care (Hourly rate) – Skilled nursing services that are provided in the patient's place of resident to help during a crisis period.

0655 – Respite Care (Daily rate) – Service provided in a facility (hospital, nursing facility, or hospice freestanding inpatient facility) and is designed to give caregivers a rest up to 5 days and nights at a time.

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0656 – Inpatient Care (Daily rate) – Care provided in a facility (hospital, nursing facility, or hospice freestanding inpatient facility) for symptoms or a crisis that cannot be managed in the patient's residence. Inpatient care is provided for a limited period of time, as determined by the physician and the hospice team.

Preauthorization is required for all Hospice services.

Revenue and HCPC Codes:

Locations where the patient is receiving Hospice care and are listed below.

HCPC	Allowed Place of Service HCPC	Routine 0651	CC 0652	Respite 0655	GIP 0656	RB 0658
Q5001	Home	Y	Y	N	N	N
Q5002	Assisted living facility	Y	Y	N	N	N
Q5003	Nursing facility non- skilled	Y	Y	Y	N	Y
Q5004	Nursing facility skilled	Y	N	Y	Y	Y
Q5005	Inpatient hospital	Y	N	N	Y	N
Q5006	Inpatient HOSPICE facility	Y	N	Y	Y	N
Q5007	Long term care hospital	Y	N	Y	Y	N
Q5008	Inpatient psychiatric facility	Y	N	Y	Y	N
Q5009	Place not otherwise specified	Y	Y	Y	Y	N
Q5010	Hospice residential facility	Y	Y	N	N	N

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Other Revenue Codes

Physician Services

0657 – **Physician Services** used per AHCA in combination with HCPCS procedure codes when billing direct care services provided by a physician. The hospice may bill for specified direct care services provided by physicians who are employees of the hospice or other physicians who provide direct care services under arrangement made with the hospice.

Service Intensity Add-on

0551 & 0561 - SIA

The SIA codes below are billed along with Revenue code 0651

Discipline	Rev	HCPCS Code
Skilled Nursing visit	0551	G0299
Medical Social Service visit	0561	0155

Beginning January 1, 2016, an SIA payment may be billed in addition to the per diem rate for routine home care (RHC) level of care, revenue code 0651, but reimbursement is equal to the continuous home care (CHC) hourly rate, revenue code 0652, if the following requirements are met:

- The day is an RHC level of care day.
- The care occurs during the last seven days of an individual's life who is receiving Medicaid-only hospice services and the individual has died.
- The skilled service is provided by a registered nurse (RN) or medical social worker (SW) for at least 15 minutes but no more than four hours per day:
- RN and SW hours are combined and cannot exceed four hours total;
- RN and SW hours provided concurrently count separately;
- RN and SW hours can occur over multiple visits per day;
- The service is provided in person; and
- The skilled service provided is clearly documented.

Room & Board

0658 – Room & Board Services for hospice recipients who are both Medicare and Medicaid eligible, Medicaid reimburses the hospice for the recipient's room and board, and Medicare pays (for the hospice care at the applicable level of care rate) the routine home care rate. Payment for the room and board is made by the Medicaid provider to the hospice, and the hospice pays the nursing facility for room and board.

Once a nursing facility resident elects the Medicaid hospice benefit, the resident is considered a hospice patient and no longer a nursing facility patient for Medicaid reimbursement purposes. Room and board reimbursement does not include the day of discharge or death from hospice. (The hospice will be reimbursed for hospice clinical services provided on the date of death and discharge, but not for room and board).

Medicaid will reimburse the hospice the routine home care rate, plus the established room and board rate for patients who are not dually eligible.

Bed Hold

0185 – Bed Hold (Hospital stay)
0182 – Bed Hold (Therapeutic leave)
Medicaid pays a maximum of 8 days to reserve a bed in a nursing facility for each medically necessary hospital stay and up to 16 days for a therapeutic leave of absence for recipients enrolled in a hospice. The hospice bills using the bed hold room and board revenue code 0185 for hospitalizations and 0812 for therapeutic leaves for facilities which meet the occupancy requirements at set by AHCA.

Patient Responsibility

Patient Responsibility is determined by the Department of Children and Families on a monthly basis.

If the hospice patient has a patient responsibility, value code 31 should be entered in box 39 and the amount. The amount entered should be the gross amount for the entire month even when billing a partial month. The Medicaid Plans will prorate calculation for partial days.
Note: Patient responsibility is being transmitted via the 834 file to the health plans ONLY for recipients that fall into the institutional Care aid categories. Patient responsibility is NOT being transmitted for recipients in any other aid category such as HOSPICE or Waiver. Therefore, the 834 file is not a valid resource for Hospice patient responsibility.

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Hospice Type of Bill Codes and Patient Discharge Status

Type of Bill Code Structure

1st Digit - Type of Facility
8 - Special facility (Hospice)

2nd Digit - Classification (Special Facility Only)
1 - Hospice (Nonhospital based)
2 - Hospice (Hospital based)

3rd Digit Frequency	Definition
1 - Admit Through Discharge Claim	This code is used for a bill encompassing an entire course of hospice treatment for which the provider expects payment from the payer, i.e., no further bills will be submitted for this patient.
2 - Interim – First Claim	This code is used for the first of an expected series of payment bills for a hospice course of treatment.
3 - Interim - Continuing Claim	This code is used when a payment bill for a hospice course of treatment has already been submitted and further bills are expected to be submitted.
4 - Interim - Last Claim	This code is used for a payment bill that is the last of a series for a hospice course of treatment. The “Through” date of this bill is the discharge date, transfer date, or date of death.
5 - Late Charges	Use this code for late charges that need to be billed. Late charges can be submitted only for revenue codes not on the original bill.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct (other than late charges) a previously submitted bill. This is the code used on the corrected or “new” bill.
8 - Void/Cancel of a Prior Claim	This code is used to cancel a previously processed claim.

Based on National Guidelines for completing and submitting a **UB-04** (or the electronic comparative) a provider must assign a Patient Discharge Status code which aligns with the type of bill (TOB) submitted. The Florida requirements, revenue codes and subcategory codes are revised on an ongoing basis by the NUBC. More information is available in the National Uniform Billing Committee (NUBC) Official UB-04 Data Specifications Manual.

Aetna Better Health of Florida requires Patient Discharge Status codes for:

- Hospital Inpatient Claims (TOBs 11X and 12X);
- Skilled Nursing Claims (TOBs 18X, 21X, 22X and 23X);
- Outpatient Hospital Claims (TOBs 13X, 14X, 71X, 73X, 74X, 75X, 76X and 85X); and
- All Hospice Claims (TOBs 81X and 82X).

The appropriate type of bill is determined based on the following guidance from the NUBC:

- The first digit is the type of facility.
- The second digit classifies the type of care being billed.
- The third digit indicates the sequence of the bill for a specific episode of care. The third digit is commonly referred to as the “frequency” code.

The third digit is indicative of the submission frequency, and should align with the Patient Discharge Status reported on the claim. A type of bill with a frequency reflective of an ongoing stay should align with a discharge status indicating that the patient is still receiving care. Additionally, a type of bill reflective of a discharge or final claim should be reported with a Patient Discharge Status that identifies where the patient is at the conclusion of a health care facility encounter, or at the end of a billing cycle (the ‘through' date of a claim).

It is important to select the correct Patient Discharge Status code. In cases in which two or more Patient Discharge Status codes apply, providers should code the highest level of care known.

Aetna Better Health of Florida will deny claims when the Patient Discharge Status is inconsistent with the type of bill reported.

Patient Discharge Status

Code	Description
01	Discharged to home/self-care (routine charge).
02	Discharged/transferred to other short term general hospital for inpatient care.
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care -- (For hospitals with an approved swing bed arrangement, use Code 61 - swing bed. For reporting discharges/transfers to a non-certified SNF, the hospital must use Code 04 - ICF.
04	Discharged/transferred to intermediate care facility (ICF).
05	Discharged/transferred to another type of institution for inpatient care (including distinct parts). NOTE: Effective 1/2005, psychiatric hospital or psychiatric distinct part unit of a hospital will no longer be identified by this code. New code is '65'
06	Discharged/transferred to home care of organized home health service organization.
07	Left against medical advice or discontinued care.
08	Discharged/transferred to home under care of a home IV drug therapy provider. (discontinued effective 10/1/05)
09	Admitted as an inpatient to this hospital (effective 3/1/91). In situations where a patient is admitted before midnight of the third day following the day of an outpatient service, the outpatient services are considered inpatient.
20	Expired (did not recover - Christian Science patient).
21	Discharged/transferred to Court/Law Enforcement
30	Still patient
40	Expired at home (hospice claims only)
41	Expired in a medical facility such as hospital, SNF, ICF, or freestanding hospice. (Hospice claims only)
42	Expired - place unknown (Hospice claims only)
43	Discharged/transferred to a federal hospital (eff. 10/1/03)
50	Hospice - home (eff. 10/96)
51	Hospice - medical facility (eff. 10/96)
61	Discharged/transferred within this institution to a hospital-based Medicare approved swing bed (eff. 9/01)
62	Discharged/transferred to an inpatient rehabilitation facility including distinct parts units of a hospital. (eff. 1/2002)
63	Discharged/transferred to a long term care hospitals. (eff. 1/2002)

64	Discharged/transferred to a nursing facility certified under Medicaid but not under Medicare (eff. 10/2002)
65	Discharged/Transferred to a psychiatric hospital or psychiatric distinct unit of a hospital (these types of hospitals were pulled from patient/discharge status code '05' and given their own code). (eff. 1/2005).
66	Discharged/transferred to a Critical Access Hospital (CAH) (eff. 1/1/06)
69	Discharged/transferred to a designated disaster alternative care site (eff. 10/2013)
70	Discharged/transferred to another type of health care institution not defined elsewhere in code list.
71	Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)
72	Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (eff. 9/01) (discontinued effective 10/1/05)
81	Discharged to home or self-care with a planned acute care hospital readmission (eff. 10/2013)
82	Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission (eff. 10/2013)
83	Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (eff. 10/2013)
84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (eff. 10/2013)
85	Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission (eff. 10/2013)
86	Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission (eff. 10/2013)
87	Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission (eff. 10/2013)
88	Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission (eff. 10/2013)
89	Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission (eff. 10/2013)
90	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission (eff. 10/2013)
91	Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission (eff. 10/2103)

92	Discharged/transferred to nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (eff. 10/2013)
93	Discharged/transferred to a psychiatric hospital/distinct part unit of a hospital with a planned acute care hospital inpatient readmission (eff. 10/2013)
94	Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission (eff. 10/2013)
95	Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission (eff. 10/2013)

Medicaid & Hospice Governing Laws, Rules and Helpful Links

Title XIX of the Social Security Act (SSA) Grants to States for Medical Assistance Programs
Title 42, Code of Federal Regulations (CFR), section 418 – Public Health, Hospice Care
Florida Statues Chapter 409.906 – Social and Economic Assistance
Florida Administrative Code 59G-4.140 - Medicaid
Florida Statutes Chapter 400 Part IV – Hospice Services
Florida Administrative Code 58A-2 - Hospice
CMS Medicaid Hospice Benefits & Reimbursement Rates
Social Security Act §1902(a) (13) (B) – State Plans for Medical Assistance
AHCA Florida Medicaid Hospice Services Coverage Policy
AHCA Hospice Medicaid Billing Codes
AHCA Hospice Level of Care Rates and Room & Board Rates 658
National Uniform Billing Committee (NUBC)

Glossary of Hospice Medicaid Terms and Definitions

Hospice Election – Individuals must elect the hospice benefit by filing an election statement with the hospice. Each hospice designs and prints their own election statement. It must include, signature of the patient or their representative; effective date of election, understanding that other Medicaid services for the cure or treatment of the terminal condition are waived for the duration of their hospice election; and designate and identify the attending physician (may be a Nurse Practitioner), if any. The hospice benefit may be revoked at any time in order to resume Medicaid-covered benefits waived when hospice was elected.

Hospice Benefit Periods – The Medicaid hospice benefit consists of two 90-day benefit periods and an unlimited number of sixty-day benefit periods. For each benefit period, the patient must be certified as terminally ill (prognosis of 6 months or less if the illness runs its normal course). Hospice care is continuous from one benefit period to another, unless the patient revokes the hospice benefit, or the physician discharges the patient, or the patient is not recertified. If/when the patient meets the hospice coverage requirements, they can re-elect the hospice benefit, and will begin with the next benefit period. The two 90-day benefit periods are not renewable – once they are used, the beneficiary has only 60-day benefit periods remaining.

Interdisciplinary group 42 CRF 418.56 (IDG) - The IDG is the team responsible for the holistic care of the hospice patient and is responsible for development and review of the patient's plan of care. The IDG team includes physicians, nurses, home health aides, social workers, counselors, chaplains, therapists and trained volunteers.

Initial Assessment 42 CFR 418.54 - The Hospice RN must complete an initial assessment of the patient's immediate needs within 48 hours after the election of hospice. The hospice completes and files the Notice of Election.

Comprehensive Assessment 42 CFR 418.54 – The Hospice interdisciplinary group, in consultation with the individual's attending physician (if applicable), must complete a comprehensive assessment no later than 5 calendar days after the election of hospice. The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.

Plan of Care 42 CFR 418.56 (POC) –The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions. The POC must be established for provided services, and is continually reviewed and updated, as the condition of the patient requires, but no less than every 15 calendar days.

Hospice Certification 42 CFR 418.22 – In order for a patient to be eligible for the Medicaid hospice benefit, the patient must be certified as being terminally ill. An individual is considered to be terminally ill if, the medical prognosis is a life expectancy of 6 months or less, if the illness runs its normal course. The certification should be based on the clinical judgment of the hospice medical director (or physician member of the interdisciplinary group, and the patient's attending physician including ARNP, if applicable. The certification statement must include the life expectancy statement and a brief narrative, written by the certifying physician, explaining the clinical findings that support the patient's life expectancy of six months or less. All certification must be signed and dated by the physician(s) and must include the benefit period dates to which the certification applies.

Hospice Re-certification – In addition to the initial certification for hospice, the patient must be recertified for each subsequent hospice benefit period. For recertification, only the hospice medical director or the physician member of the IDG is required to sign and date the certification.

Hospice Face to Face – A hospice physician or hospice nurse practitioner must have a face to face encounter with each hospice patient whose total stay across all hospices is anticipated to reach the third
(3rd) benefit period. The face to face encounter must occur prior to, but no more than 30 calendar days prior to, the third (3rd) benefit period recertification, and every benefit period recertification thereafter, to gather findings to support the life expectancy of 6 months or less. When the face to face requirements are not met, the patient is no longer eligible for the Medicaid hospice benefit.