

SMSO Policy Manual

HOSPICE SERVICES – MEDICARE

Executive Sponsor: Stephen Adamson, Chief Operations Officer

Issuing Department: Claims

Gate Keeper: Melissa Rusk, Director Claims

COMPLIANCE STATEMENT:

Enforcement: All members of the workforce are responsible for compliance with this policy. Failure to abide by the requirements of this policy may result in corrective action, up to and including termination. Workforce members are responsible for reporting any observed violations of this policy.

Review Schedule: This policy will be reviewed and updated as necessary and no less than every two years.

Monitoring and Auditing: The Issuing/Collaborating Department(s) is responsible for monitoring compliance with this policy.

Documentation: Documentation related to this policy must be maintained for a minimum of 10 years.

Applies to:

☒ SummaCare ☐ Apex
☐ Summa Health Management Company ☒ Summa Insurance Company

Line of Business:

☐ Commercial Groups ☒ Medicare
☐ Medicare Supplemental ☐ On-Exchange
☐ Off-Exchange ☐ Self-Funded

1.0 Purpose:

- 1.1 To provide a consistent process for the administration of the Hospice benefit which are compliant with CMS guidelines.

2.0 Policy:

- 2.1 This policy describes the administration of hospice service benefits for Medicare members.

3.0 Procedure:

- 3.1 When a member signs a Hospice Election Statement (provided by Medicare Hospice Providers), the member must select and use a Medicare certified hospice provider(s) for care related to the terminal illness.
 - 3.1.1 As of the first of the month after the member elects hospice, the capitation from CMS to the client is reduced to an administrative management fee per member per month. CMS places the member in an administrative suspension status.
 - 3.1.2 Care provided on or after the date of the hospice election, by the hospice provider as it relates to the terminal diagnosis is paid directly by CMS.
 - 3.1.3 CMS is billed by non-hospice providers for care unrelated to the terminal illness, (with the exception of the supplemental plan benefits, e.g., eyeglasses, dental, prescription etc., which will continue to be directed, provided and paid for by the plan.)
 - 3.1.4 When billing CMS, providers should follow CMS guidelines, using the appropriate modifiers.
 - 3.1.5 Members can revoke hospice elections at any time to resume curative care. If so revoked, the client will resume coverage for the member according to his/her benefit plan, **the first** of the following month. The client will then begin receiving normal capitation payments from CMS. Prior to the first of the month and after revocation of the hospice benefit, member reverts to Original Medicare.
- 3.2 The client is only responsible for the following in relation to members seeking or receiving hospice care and services:
 - 3.2.1 Education for the member regarding availability of hospice care
 - 3.2.2 Referral to a Medicare hospice provider
 - 3.2.3 Pre-Hospice consultation/evaluation by either the medical director or employee of a hospice provider for members who has not yet elected hospice benefit (effective January 1, 2005) for complete criteria see: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf>

- 3.2.4 Covered care and services for conditions that are **unrelated to the member's terminal illness**
 - 3.2.4.1 Plan providers must bill Medicare Carriers and Intermediaries for the member's basic benefits, using fee-for-service mechanisms for those services (applicable copayments also apply). When billing CMS, providers should follow CMS guidelines, using the appropriate modifiers.
 - 3.2.4.2 To ensure members are receiving their full benefit for non-hospice related services, basic benefits will be coordinated with CMS not to exceed what the plan would have paid if they had been the only payer. Appropriate co-pays and coinsurance will apply.
 - 3.2.4.3 The plan is responsible for covering the member's supplemental benefits (e.g., eyeglasses, prescription drugs), if any, as long as the member uses a plan provider and remains enrolled with the plan.

3.3 Melissa Rusk, Director, Claims & BPO Operations has the authority and responsibility for the activities in this policy or procedure.

3.4 The Issuing Dept. is responsible for monitoring/enforcing the compliance with this policy.

4.0 References:

4.1 Source of the policy (regulatory citation, accreditation standard, internal standard)

4.1.1 MMCM

4.2 Are there any references to other documents, regulations, or intranet locations?

4.2.1 For Medicare coverage guidelines for Hospice Services, refer to the Medicare Benefit Policy Manual (Pub.100-2), Chapter 9 - Coverage of Hospice Services under Hospital Insurance at: <http://www.cms.hhs.gov/manuals/Downloads/bp102c09.pdf>.

4.2.2 Also see the Medicare Claims Processing Manual (Pub. 100-4), Chapter 11 - Processing Hospice Claims at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf>

4.3 Are there other policies that work in conjunction with this policy?

4.3.1 None

4.4 Replaces (if applicable):

4.4.1 None

5.0 Definitions:

5.1 Hospice Benefit Period

- 5.1.1 Two (2) 90 day initial periods followed by an unlimited number of 60-day periods. Each benefit period requires the physician to certify that the member is terminally ill and has a life expectancy of 6 months or less. An election to receive hospice care will continue through the consecutive period if the member remains in hospice and does not revoke the election.

5.2 Hospice Care

- 5.2.1 A method for caring for terminally ill members as defined by having a life expectancy of 6 months or less. Hospice care emphasizes supportive services, such as in-home care and pain control, rather than cure-oriented.

6.0 Key Words or Aliases (Optional):

6.1 Hospice, Medicare

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