

5101:3-56-06

Hospice services: reimbursement.

ODJFS shall reimburse only the hospice provider directly for the costs of all covered services related to the treatment of the consumer's terminal illness with the exception of reimbursement for physician services that are for direct patient care and, if the consumer is under age twenty-one, with the exception of reimbursement for concurrent curative treatment for the consumer's terminal illness. Physician services for direct patient care will be reimbursed according to paragraph (D) of this rule. Providers billing for concurrent curative treatment will be reimbursed according to paragraph (H) of this rule.

- (A) Based on the methodology set forth in 42 C.F.R. 418.302 (~~August 31, 2007~~)(August 6, 2009), the medicaid payment for hospice services is made at one of four predetermined rates. Each rate is based on the level of care that is appropriate for the consumer for each day while under the care of the hospice.

Each rate covers all services rendered by the hospice (either directly or under contractual arrangement), the administrative services, the technical services, and the general supervisory activities performed by physicians, and travel expenses and supervision provided by other hospice staff.

The medicaid maximum payment rate for each hospice is set forth in the hospice's provider charge file that is specifically assigned to each participating hospice.

- (B) The hospice shall bill ODJFS the appropriate code and unit(s) for the appropriate level of care. The rate paid for the date of service depends on the level of care furnished to the consumer on that day.

(1) Routine home care is covered in accordance with 42 C.F.R. 418.302 (~~August 31, 2007~~)(August 6, 2009). Hospice providers must use code T2042 for one unit per day to bill for routine home care.

(2) Continuous care is covered in accordance with 42 C.F.R. 418.302 (~~August 31, 2007~~)(August 6, 2009). Hospice providers must use code T2043 for one unit per hour, minimum of eight hours per day to bill for continuous home care.

(3) Inpatient respite care is covered in accordance with 42 C.F.R. 418.302 (~~August 31, 2007~~)(August 6, 2009). Hospice providers must use code T2044 for one unit per day to bill for inpatient respite care.

(4) General inpatient care is covered in accordance with 42 C.F.R. 418.302 (~~August 31, 2007~~)(August 6, 2009). Hospice providers must use code T2045 for one unit per day to bill for general inpatient care.

- (C) When the consumer is a resident of a NF or an ICF-MR, the hospice shall be

reimbursed for room and board. This additional per diem amount is reimbursable for routine home care and continuous home care days. Hospice providers shall use code T2046 to bill for room and board. To receive reimbursement, the hospice:

- (1) Must bill ODJFS the amount equal to ninety-five per cent of the medicaid NF or the ICF-MR per diem rate as obtained from the NF or the ICF-MR.
 - (2) Must bill only for days that the consumer is in the NF or ICF-MR overnight and is medicaid eligible.
 - (3) Can bill for consumers who have elected the hospice benefit under medicare but are medicaid eligible and reside in a medicaid-reimbursed NF or ICF-MR for the room and board.
- (D) ODJFS will reimburse separately for physician services involving direct patient care, as follows:
- (1) Reimbursement for services provided by physicians who are hospice employees or who are under contractual arrangements with the hospice, unless furnished on a volunteer basis, an administrative basis or a technical service, will not be included in any of the predetermined rates, but will be paid to the hospice separately in accordance with Chapter 5101:3-4 of the Administrative Code.
 - (2) If the consumer designates an attending physician who is not an employee of the hospice, medicaid will pay the physician directly, if the physician has a valid medicaid provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code. Costs for services such as lab or x-rays are not to be included on the attending physician's bill, but are covered in the predetermined rate paid the hospice. Payment for attending physician services is based on current medicaid rules and regulations for physician services as found in Chapter 5101:3-4 of the Administrative Code.
- (E) After receipt of the third-party resource, ODJFS may be billed for the balance. For each day the medicaid eligible consumer is enrolled in hospice, the total reimbursement for hospice services cannot exceed the per diem rate for the appropriate code specifying the appropriate level of care.
- (F) Medicaid eligible residents of NFs or ICF-MRs who are enrolled in a medicare or medicaid hospice program are not entitled to medicaid-covered bed-hold days. It is the hospice's responsibility to contract with and pay the NF in accordance with rule 5101:3-3-16.4 of the Administrative Code. It is the hospice's responsibility to contract with and pay the ICF-MR in accordance with rule 5101:3-3-16.8 of the

Administrative Code.

- (G) Pursuant to Section 1861(dd)(2)(A)(iii) of the Social Security Act, 42 U.S.C. 1395x(dd)(2)(A)(iii) (March 30, 2010) there shall be a limitation on reimbursement for inpatient care during the hospice cap period.
- (H) For any services related to the terminal illness, providers must bill the hospice provider directly unless the services were for concurrent curative treatment of the terminal illness for consumers under age twenty-one. Providers billing for concurrent curative treatment must comply with, and will only be reimbursed according to, all the requirements for medicaid providers in Chapter 5101:3-1 of the Administrative Code.

Effective: 02/01/2011

R.C. 119.032 review dates: 03/01/2013

CERTIFIED ELECTRONICALLY

Certification

01/03/2011

Date

Promulgated Under: 119.03
Statutory Authority: 5111.02
Rule Amplifies: 5111.01, 5111.02
Prior Effective Dates: 5/1/90, 5/15/90, 5/16/90, 12/1/91, 4/1/94, 9/26/02,
1/1/04, 4/1/05, 3/2/08