TO BE RESCINDED

5160-56-06 **Hospice services: reimbursement.**

The Ohio department of medicaid (ODM) shall reimburse only the hospice provider directly for the costs of all covered services related to the treatment of the individual's terminal illness with the exception of reimbursement for physician services that are for direct patient care and, if the individual is under age twenty-one, with the exception of reimbursement for concurrent curative treatment for the individual'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 (October 1, 2014), 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 individual 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 ODM 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 individual on that day.

(1) Routine home care is covered in accordance with 42 C.F.R. 418.302 (October 1, 2014). 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 (October 1, 2014). 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 (October 1, 2014). 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 (October 1, 2014). Hospice providers must use code T2045 for one unit per day to bill for general inpatient care.

(C) When the individual is a resident of a nursing facility (NF) or an intermediate care facility for individuals with intellectual disabilities (ICF-IID), 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 ODM the amount equal to ninety-five per cent of the medicaid NF or the ICF-IID per diem rate as obtained from the NF or the ICF-IID.

(2) Must bill only for days that the individual is in the NF or ICF-IID overnight and is medicaid eligible.

(3) Must bill for individuals who are medicare and medicaid eligible, medicare for services provided under the medicare hospice benefit and medicaid for the individual's room and board.

(D) Separate payment may be made to a physician for services involving direct patient care. The physician may be an employee of the hospice, a practitioner under contractual arrangement with the hospice, or an attending practitioner who is not an employee of the hospice but is an eligible medicaid provider. Separate payment cannot be made, however, for the following services:

(1) A physician service furnished on a volunteer basis or on an administrative basis;.

(2) A procedure classified as a technical service; or

(3) Laboratory or radiography services performed in connection with the physician service.

(E) After receipt of a third-party resource, ODM may be billed for the balance. For each day the medicaid eligible individual 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-IIDs 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 5160-3-16.4 of the Administrative Code. It is the hospice's responsibility to contract with and pay the ICF-IID in accordance with rule 5123:2-7-08 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) (as in effect January 1, 2015) 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 individuals 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 5160-1 of the Administrative Code.

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CERTIFIED ELECTRONICALLY

Certification

09/21/2017

Date

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