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

This rule sets forth the Ohio department of medicaid (ODM) payment for hospice services and care.

(A) ODM will directly pay the designated hospice to care for an individual enrolled in medicaid hospice. Payment to the designated hospice shall cover the array of services listed in rule 5160-56-05 of the Administrative Code, except for:

(1) Services pursuant to paragraph (E) of this rule which are paid directly to the physician; and

(2) Services furnished by a non-hospice provider pursuant to paragraph (I) of this rule for the concurrent care of an individual under the age of twenty-one.

(B) Reimbursement rates paid by ODM to the designated hospice shall be based on the level of care that is appropriate for the individual for each day while receiving hospice care. Based on the methodology set forth in 42 C.F.R. 418.302 (as in effect January 1, 2016), the medicaid payment for hospice care is made at predetermined rates in accordance with paragraph (C) of this rule for levels of care as defined in rule 5160-56-01 of the Administrative Code.

(1) The medicaid payment for hospice covers the cost of services rendered by the hospice either directly or under contractual arrangement.

(2) For designated hospices that are compliant with the hospice quality reporting program in accordance with 42 C.F.R. 418.312 (as in effect January 1, 2016), ODM will reimburse the full medicaid payment rate for hospice services, up to the maximum payment rate prescribed for the county where services were provided.

(3) For designated hospices that fail to comply with the hospice quality reporting program as federally mandated, ODM will reimburse the payment amount minus a two percentage point reduction, as prescribed by CMS for the corresponding federal fiscal year.

(C) The designated hospice shall bill ODM the appropriate code and unit(s) for the appropriate level of care. ODM will allow telehealth services to be provided where in-person visits are mandated:

(1) Hospice providers must use code T2042 for one unit per day to bill for routine home care afforded to an individual in his or her home, who is not receiving continuous home care.

(a) Routine home care days shall be paid using a two-tiered system in accordance with 42 C.F.R 418.302 (as in effect January 1, 2016), where the per diem for the first sixty days of hospice care is paid at a higher rate and days sixty-one and thereafter are paid at a lower rate for the duration of the individual's hospice episode of care. A minimum of a sixty day gap in hospice services is required to reset the counter that determines which per diem to apply.

(b) In accordance with 42 C.F.R 418.302 (as in effect January 1, 2016), routine home care may be eligible for an add-on payment for services provided by a registered nurse (RN) authorized to practice under Chapter 4723. of the Revised Code, and/or a social worker licensed to practice under Chapter 4757. of the Revised Code during the last seven days of an individual's life, when the discharge from hospice care is due to death.

The service intensity add-on (SIA) payment shall be billed using code G0299 for the direct care provided in an in-person visit completed by an RN. The SIA payment shall be billed using code G0155 for the direct care provided during an in-person visit completed by a social worker.

The reimbursement rate for the SIA payment shall be equal to the continuous home care hourly rate converted into fifteen minute increments, up to a maximum of four hours (sixteen units) combined total per day for RN and social worker visits. Visits solely for the pronouncement of death shall not be counted for the service intensity add-on payment.

(2) Hospice providers must use code T2043 for one unit per hour, with a minimum of eight hours per day, to bill for continuous home care.

(3) Hospice providers must use code T2044 for one unit per day to bill for inpatient respite care.

(4) Hospice providers must use code T2045 for one unit per day to bill for general inpatient care.

(5) Hospice providers that deliver any component of services via telehealth will add the GT modifier on those claims, in addition to the appropriate procedure code above.

(6) Services billed with T2044 and T2045 are not eligible to be provided via telehealth.

(D) 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 may be reimbursed for room and board. This additional per diem amount is reimbursable at ninety-five per cent of the rate established for the long-term care facility, as reported to ODM for the individual pursuant to rule 5160-56-06 of the Administrative Code, and only on days where the individual receives routine home care or continuous home care. To receive reimbursement, the hospice:

(1) Must bill for room and bill using code T2046.

(2) Must bill patient liability until consumed to zero dollars.

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

(4) 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.

(5) Hospice providers that deliver any component of services via telehealth will add the GT modifier on those claims, in addition to the procedure code above.

(E) 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.

(F) After receipt of all third-party resources, including private insurance, and taking into account patient liability for room and board, ODM may be billed for the balance owed to the designated hospice, except for services covered by individuals receiving hospice through managed care. For each day the medicaid eligible individual is enrolled in hospice, the total reimbursement for hospice services cannot exceed the medicaid per diem reimbursement rate.

(G) 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.

(H) 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, 2017) there shall be a limitation on reimbursement for inpatient care during the hospice cap period.

(I) For any services related to the terminal illness, non-hospice providers must bill the designated hospice provider directly unless the services were for concurrent care of the terminal illness for individuals under age twenty-one. Providers billing for concurrent care 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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Certification

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