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

~~ODJFS~~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 ~~consumer's~~ individual's terminal illness with the exception of reimbursement for physician services that are for direct patient care and, if the ~~consumer~~individual is under age twenty-one, with the exception of reimbursement for concurrent curative treatment for the ~~consumer's~~ 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 ~~(August 6, 2009)~~(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 ~~consumer~~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 ~~ODJFS~~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 ~~consumer~~individual on that day.

(1) Routine home care is covered in accordance with 42 C.F.R. 418.302 ~~(August 6, 2009)~~(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 ~~(August 6, 2009)~~(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 ~~(August 6, 2009)~~(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 ~~(August 6, 2009)~~(October 1, 2014). Hospice providers must use code T2045 for one unit per day to bill for general inpatient care.

(C) When the ~~consumer~~individual is a resident of a ~~NF~~nursing facility (NF) or an ~~ICF-MR~~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 ~~ODJFS~~ODM the amount equal to ninety-five per cent of the medicaid NF or the ~~ICF-MR~~ICF-IID per diem rate as obtained from the NF or the ~~ICF-MR~~ICF-IID.

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

(3) ~~Can~~Must bill for ~~consumers~~ individuals who ~~have~~ are ~~elected the hospice benefit under~~ medicare ~~but are~~and medicaid eligible, medicare for services provided under the medicare hospice benefit and medicaid for the individual's ~~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~~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) ~~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~~ A physician service furnished on a volunteer basis or on an administrative basis;.

(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.~~ A procedure

classified as a technical service; or

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

(E) After receipt of ~~the~~a third-party resource, ~~ODJFS~~ODM may be billed for the balance. For each day the medicaid eligible ~~consumer~~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-MRs~~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 ~~5101:3-3-16.4~~5160-3-16.4 of the Administrative Code. It is the hospice's responsibility to contract with and pay the ~~ICF-MR~~ICF-IID in accordance with rule ~~5101:3-3-16.8~~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) (~~March 30, 2010~~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 ~~consumers~~ 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 ~~5101:3-1~~5160-1 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates: 12/19/2014

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Certification

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Date

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