Ohio | Anthem Blue Cross and Blue Shield Medicaid | Ohio Medicaid Managed Care

Hospice

Anthem

Agenda

- About hospice
- Hospice eligibility
- Hospice levels of care
- Palliative care vs. hospice
- Ohio Department of Medicaid (ODM) ventilator program
- Hospice billing guidelines
- Waiver codes
- Provider revalidations
- Staying connected
- Questions

What is hospice?

What is hospice?

Hospice:

- Hospice is a program that gives special care to members who are near the end of life.
- Hospice offers physical, emotional, social, and spiritual support to members and their families.
- Hospice's main goal is to control pain and symptoms of the illness or disease.
- Hospice is given at home or where the member resides and calls home.

Who is eligible for hospice?

Who is eligible for hospice?

Hospice eligibility:

- Individuals with a life expectancy of less than six months qualify for hospice services.
- The patient must also be diagnosed as terminally ill by a community physician and a hospice medical director.

Hospice levels of care

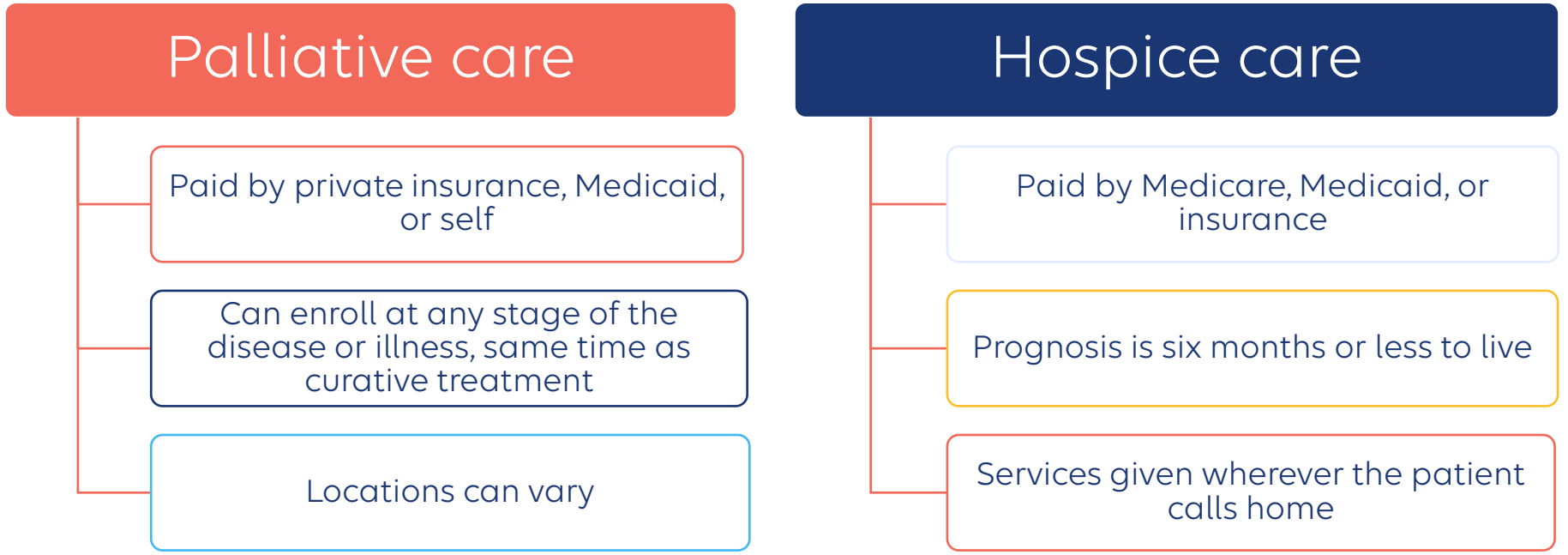
Hospice levels of care

Four levels of care:

1. Routine home care — This is the most common level of care. It is provided to patients in hospice care and is available wherever the patient calls home.
2. Continuous care (intensive comfort care) — This level is related to the development of acute medical symptoms in a patient who wishes to stay at home but requires more extensive care than that provided in routine home care. Must be provided a minimum of eight hours/day in a 24-hour period. This is primarily nursing care.
3. General inpatient care — This level is for pain and other symptoms that cannot be managed at home. All hospice providers must have the availability of inpatient care.
4. Institutionalized respite care — This level has service limits to five consecutive days in each benefit period. This provides a break for the home care patient's primary caregiver by admitting the hospice patient to a facility.

Palliative care versus hospice care

Palliative care versus hospice care



What do palliative care and hospice have in common?

- Both provide comfort care and reduce stress for caregivers, families, and most of all the patient.
- Both offer complex symptom relief related to serious illness as well as physical and psychosocial relief.

ODM ventilator program

Ventilator program

- This program is for ventilator dependent individuals in a nursing facility.
- Hospice providers can bill for services pertaining to ventilators.
- The nursing facility must participate in the ventilator program.
- There are eligibility requirements for this program for both the patients and the nursing facility.
- OAC Rule for nursing facility ventilator program: codes.ohio.gov/ohio-administrative-code/rule-5160-3-18
- A nursing facility can request to participate in the program by emailing NFPolicy@medicaid.ohio.gov.
- ODM ventilator program fact sheet: Ventilator program fact sheet

Hospice billing guidelines

Hospice billing guidelines

Hospice requirement for claims:

- All Medicare-certified hospice providers must comply with hospice quality reporting requirements.
- *Value Codes* and *County Codes* are required in box 39 and the amount box when billed on a *UB-04*. If these codes are missing or not correct per billing and ODM, the claim may not be processed.
- County codes can be found on ODM Fee Schedule and Rates (ohio.gov):
  - Note: These codes are different from Medicare county codes.
- *OAC Rule 5160-56-06* | Hospice services: reimbursement (ohio.gov)
- Our provider manual

Hospice billing guidelines (cont.)

Valid institutional bill types

- 081x — special facility hospice (non-hospital based)
- 082x — special facility hospice (hospital based)

Valid value codes

- 61 — location where service is furnished (HHA and Hospice)
- G8 — facility where inpatient hospice service is delivered

Please note: When value code G8 is billed, the NPI of the **Facility,** along with their **Name,** must be billed in box 80 **Remarks** on UB.

Provider communication on hospice billing: providernews.anthem.com/ohio/articles/filing-hospice-claims-17671-17671

Hospice billing guidelines (cont.)

Listed here are the billing guidelines based on CPT® codes.

Physician services are billed and paid when the physician is employed by the hospice provider.

Note: Hospice providers can deliver hospice services via telehealth by adding the GT modifier. Codes T2044 and T2045 are **not** eligible for telehealth.

Service	Claim form	Billing guidelines	Payment
Hospice RandB T2046	HCFA — professional	Must bill nursing facilities NPI in box 32a and the Name of the nursing facility in which the services were delivered in box 32.	95% Published Skilled Nursing Facility Rate
Routine home care per day (days 1 to 60 and 61+) Rev 0651/T2042	UB — institutional	Bill Type - 081x Value code - 61 and ODM specified SSA/State County Code 1 line per DOS	100% Compliant and Noncompliant CBSA rates
Continuous home care per hour Rev 0652/T2043	UB — institutional	Bill Type - 081x Value code - 61 and ODM specified SSA/State County Code 1 line per DOS	100% Compliant and Noncompliant CBSA rates
Inpatient respite care per day Rev 0655/T2044	UB — institutional	Bill Type - 082x Value code - G8 and ODM specified SSA/State County Code	Bill Type - 082x Value code - G8 and ODM specified SSA/State County Code
General inpatient care per day Rev 0656/T2045	UB — institutional	Bill Type - 082x Value code - G8 and ODM specified SSA/State County Code	Bill Type - 082x Value code - G8 and ODM specified SSA/State County Code

Hospice billing for private room

Hospice billing for private room

The current listing of facilities with Medicaid IDs can be found on the Ohio Department of Medicaid website https://medicaid.ohio.gov/resources-for-providers/enrollment-and-support/provider-types/nursing-facilities/nursing-facilities under *Nursing Facility Rates.* This information allows claims to be properly priced avoiding backend work and delay.

Hospice billing for nursing facility room and board (HCPCS T2046) and ventilator/ventilator weaning services:

- HCFA form (*CMS-1500*) for hospice nursing facility room and board (NF RandB)
- *UB-04* form for ventilator and ventilator weaning:
  - Must include diagnosis code Z99.11 for ventilator and ventilator weaning services

Hospice billing for private room (cont.)

Hospice providers billing for nursing facility room and board must bill using the HCFA (*CMS-1500*) form. The name of the nursing facility in which the services were delivered must be placed in Box 32, and the NPI related to the nursing facility must be placed in 32a.

Hospice billing for private room (cont.)

Private room add-on payment (effective for DOS on or after December 18, 2024)

If a hospice provider is billing for room and board for a SNF, and the member was placed in a private room where the SNF is approved by ODM as a Category 1 or Category 2 Private Room Service provider, hospice providers are eligible for 95% of the Category 1 add-on payment of $30 and the Category 2 add-on payment of $20 (as applicable).

Hospice providers should bill using the following code/modifier combinations to receive this add-on payment. Category 1 and Category 2 should be billed on individual claim lines (in other words, do not bill both modifiers on the same claim line).

Private Room	Bill Code	Modifier	95% of SNF Add-On
Category 1	T2046	XP	$28.50
Category 2	T2046	XU	$19.00

Updated billing guidance for hospice billing for nursing facility room and board (HCPC T2046) and ventilator/ventilator-weaning services - Provider News

Ventilator billing for private room

Ventilator dependent and ventilator weaning (0410, 0419) claims must be billed using the *UB-04* Institutional form.

Type of bill — 81X/081X: If the claim is billed with the incorrect type of bill, reimbursement will be delayed due to incorrect billing.

When billing ventilator dependent and weaning claims, the hospice provider is required to include the name and NPI of the nursing facility in which the services were delivered in Box 80 (*Remark code*). In addition, when billing for ventilator and/or ventilator weaning services, the diagnosis code **Z99.11** must be included.

Any claims for nursing facility room and board or ventilator/ventilator weaning that do not meet the instructions in this guidance may be delayed and may require the submission of an adjusted claim. Nursing facility hospice (T2046) and vent/vent weaning services are not billable on the same date of service.

Provider revalidations

Provider revalidations

Letters are mailed and emailed (from OHPNM@maximus.com) 120 days, 90 days, 60 days, and 30 days prior to their revalidation date. Providers who do not submit their revalidation may experience termination at the state level, which would cascade to the managed care entities (MCEs) and may cause claim reimbursement issues.

Revalidation notices are posted in the provider network management (PNM) module and can be accessed in the correspondence folder. Providers will also see a *Begin Revalidation* option in the PNM Enrollment Action Selection 120 days prior to the Medicaid Agreement end date. Providers can locate this under the *Manage Application,* then the *Enrollment Actions* option within the provider file. Select the **Revalidation/Reenrollment Quick Reference Guide** for step-by-step instructions.

Providers who need technical assistance can contact ODM's Integrated Help Desk at **800-686-1516** and follow the prompts for *Provider Enrollment* or email IHD@medicaid.ohio.gov.

Additional information

Provider Advisory Council

We invite providers to participate in our Provider Advisory Council. The meetings intent is to collaborate with our provider community to gather input, discuss trends, identify challenges, and remove barriers ultimately improving the healthcare delivery system.

If you are interested in participating, please sign up by selecting this link.

Stay in touch

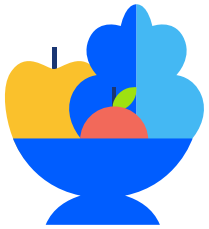
Register to stay in touch and receive all provider communications and our monthly provider newsletter, *Provider News*, via email. Register now by going to providers.anthem.com/oh.

Note: *Provider News* emails will come from providercommunications@email.anthem.com.

Key takeaways

Key takeaways

- A member must meet eligibility criteria for hospice.
- Hospice will coordinate all the member's services pertaining to the hospice illness or disease.
- All hospice care is palliative care, but not all palliative care is hospice care.
- All hospice services are billed on a *UB-04* except hospice room and board, which is on a *CMS-1500*.
- Value codes and county codes are required (*UB-04*).
- Hospice providers can bill for the private room add-on code if the nursing facility is approved by ODM.
- Hospice services can be billed as telehealth except T2044 and T2045.
- Provider revalidations have resumed.
- One more thing: Managed care organizations can have their own billing guidelines.



Questions?

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