TUFTS Health Plan

Hospice Services Payment Policy

Applies to the following Tufts Health Plan products:

☐ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]

☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]

☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

The following payment policy applies to Tufts Health Plan contracting providers who render hospice services and pre-hospice election professional services in an outpatient or office setting. For Commercial products, click here. For Tufts Health Public Plans, click here.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers member cost sharing and supplemental benefits of claims unrelated to the terminal illness for members who have elected hospice, in accordance with the member's benefits, CMS, and/or MassHealth guidelines, as applicable.

Tufts Health Plan SCO coverage and plans include:

- **Tufts Health Plan SCO (HMO-SNP)** for members who are dual-eligible for Medicare and MassHealth Standard (Medicaid); covers cost sharing and supplemental benefits of claims unrelated to the terminal illness, as well as Medicaid-only benefit claims.
- **Tufts Health Plan SCO (Medicaid-only)** for members eligible for MassHealth Standard; covers hospice and nonhospice services.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting Senior Products Provider Relations.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO members.

Hospice Benefit Information

Pre-Election Hospice Evaluation and Counseling Services

G0337 (hospice evaluation and counseling services, pre-election) furnished by a contracting provider, medical director or employee of a hospice agency is a one-time covered visit for members who have been determined to be terminally ill and have not yet elected the hospice benefit. The visit may include evaluation of the need for pain and symptom management, counseling with respect to hospice care and other care options and advising the member regarding advanced care planning.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization and Notification Policy.

Prior authorization is not required for hospice services. Contact Provider Relations to determine the appropriate care manager to inform Tufts Health Plan of hospice election and revocation.

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink[SM] when Tufts Health Plan is the primary administrator.

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

- G0337 (pre-election hospice evaluation) should be submitted to Tufts Health Plan.
- Claims submitted for services during hospice election must be submitted separately from claims submitted when the member is not on hospice..

Tufts Medicare Preferred HMO and Tufts Health Plan SCO (HMO-SNP) members

- Claims for Medicare-covered services **related** to the terminal illness should be sent to the hospice agency
- Claims for Medicare-covered services **unrelated** to the terminal illness should be sent to the appropriate MAC
- Providers must submit the explanation of benefits (EOB) from the primary payer with the claim when Tufts Health Plan is the secondary payer.
- Refer to the Medicare Claims Processing Manual for procedure codes covered under the member's Medicare Benefits.
- Refer to Subchapter 6 of the MassHealth Hospice Manual for a list of procedure codes covered under Tufts Health Plan SCO member's MassHealth benefits

Submitting the cost-sharing portion of claims unrelated to the terminal illness

In most cases, providers must first bill the MAC for payment of the claim and then submit an EOB to Tufts Health Plan with the claim and the appropriate modifier. Claims missing the required information will deny.

Modifier and Condition Codes

Hospice services provided by an attending provider not employed or paid under arrangement by the member's hospice provider should be billed to the MAC. Services may or may not be related to the terminal condition and should be billed with the appropriate modifier and/or condition code for consideration of payment.

- GV modifier – Attending provider (M.D, D.O. or NP) not employed or paid under arrangement by the member's hospice provider
- GW modifier – Service not related to the hospice member's terminal condition
- 07 condition code – Service unrelated to the treatment of the member's terminal illness

Tufts Health Plan SCO (Medicaid-only)

- Tufts Health Plan SCO Medicaid-only members who elect hospice are covered for hospice and nonhospice covered services.
- Claims for services **related** to the terminal illness should be sent to the hospice agency, and the hospice agency should submit hospice claims to Tufts Health Plan SCO.
- Claims for services **unrelated** to the terminal illness should continue to be sent to Tufts Health Plan SCO.
- Append modifier TN on claims for hospice services if the hospice facility is located outside the member's county.
- Append modifier UD when billing for members on and after 61 days of hospice care
- Refer to Subchapter 6 of the MassHealth Hospice Manual for a list of procedure codes that may be billed for hospice services.

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For more information, refer to the Professional Services and Facilities Payment Policy.

Payment responsibility is based on hospice election/revocation information available electronically from CMS at the time of claims adjudication. As information is updated, claims may be subject to readjudication.

Tufts Medicare Preferred HMO
Once hospice is elected, the Medicare fee-for-service Medicare Administrative Contractor (MAC) pays the hospice directly for hospice services as well as any Medicare-covered services unrelated to the terminal illness. If a member revokes their hospice election, Medicare-covered services will continue to be paid by the MAC until the last day of the month in which hospice was revoked. For more information on hospice Medicare coverage guidelines, refer to CMS.

Tufts Medicare Preferred HMO becomes the secondary payer and pays for services unrelated to the terminal illness if the services are not covered by Medicare but are covered by Tufts Medicare Preferred HMO as a supplemental benefit (minus applicable member cost-sharing).

Tufts Health Plan SCO (HMO-SNP)
Upon hospice election, Medicare becomes the primary payer and the MAC pays the hospice directly for hospice services as well as any Medicare-covered services unrelated to the terminal illness. If a member revokes their hospice election, Medicare-covered services will continue to be paid by the MAC until the last day of the month in which hospice was revoked.

Tufts Health Plan SCO becomes the secondary payer and pays for services unrelated to the terminal illness if the services are not covered by Medicare but are covered by Tufts Health Plan SCO as a supplemental benefit, as well as any applicable member cost-sharing.

Medicaid-only covered services continue to be covered by Tufts Health Plan SCO, in accordance with MassHealth requirements.

Tufts Health Plan SCO (Medicaid-only)
Tufts Health Plan SCO remains the primary payer upon hospice election and will compensate both hospice and nonhospice services, in accordance with MassHealth requirements.

Tufts Health Plan will compensate the facility directly for room and board when routine or continuous hospice services are provided in a long-term care setting for Tufts Health Plan SCO members.

ADDITIONAL RESOURCES

- Medicare Claims Processing Manual 100-04, Chapter 11: Processing Hospice Claims
- MassHealth Hospice Manual

DOCUMENT HISTORY

- November 2020: Policy reviewed by committee; clarified billing requirements and compensation information for Tufts Health Plan SCO members
- June 2018: Template updates
- March 2018: Template updates
- September 2017: Policy reviewed by committee; clarified authorization and billing language
- January 2017: Template updates
- September 2015: Template conversion
- June 2015: Policy reviewed; added Tufts Health Plan SCO; formatting changes; template updates

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink[SM] for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.