# Hospice Services Payment Policy

Applies to the following Tufts Health Public Plans products:

☒ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)

☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)

☒ Tufts Health RITogether (a Rhode Island Medicaid Plan)

☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

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The following payment policy applies to Tufts Health Plan contracting providers who render hospice services for Tufts Health Public Plans products. For Commercial products, click here. For Senior Products, 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 medically necessary hospice services for members who have been diagnosed as terminally ill, in accordance with the member's benefits, CMS, MassHealth, and/or Rhode Island (RI) EOHHS guidelines, as applicable.

The following levels of care may be provided when clinical coverage criteria outlined in the hospice services medical necessity guidelines for Tufts Health Direct, Tufts Health Together and Tufts Health RITogether are met:

- Routine hospice care provided in the member's home/residence
- Continuous home hospice care (provided in lieu of routine hospice care)
- Short-term inpatient care provided in a hospice inpatient unit, general inpatient hospital or skilled nursing facility

**Note:** The hospice provider is responsible for providing any and all services indicated in the plan of care as necessary for the palliation and management of the terminal illness and related conditions.

## 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 Tufts Health Public Plans Provider Services.

**Note:** There is no member responsibility for covered services for Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

## 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.

**Note:** If services are requested after hours, verification and authorization must be obtained on the next business day.

### Initial Assessment/Evaluation

The initial hospice assessment/evaluation visit (G0337) requires a provider order.

### Post-Evaluation Care

Prior authorization is required for post-evaluation care and continuation of hospice services. Requests for continued hospice services are the responsibility of the hospice provider. If services are requested after hours, verification and authorization must be obtained on the next business day.

To request prior authorization for hospice care after the initial evaluation, the provider must fax a completed Universal Health Plan Home Assessment (UHHA) Form to the Precertification Operations Department at 617.972.9409 **within two business days** of the initial evaluation and include a copy of the written interdisciplinary plan of care.

**Subsequent/Ongoing Visits**
For ongoing requests beyond the initial coverage period, the provider must fax the completed UHHA form at least **two business days** prior to the coverage period end date (or before the last visit, whichever is sooner) to prevent a gap in coverage. Documentation must include the most current clinical notes, interdisciplinary plan of care, and the level of hospice care being requested.

**Note:** UHHA forms that are not filled out completely (e.g., omission of defined medical goals and plan of care) will be rejected for lack of information. In rare circumstances, providers may be asked to provide the information in a shorter timeframe than those specified above. Tufts Health Plan reserves the right to deny provider requests when the provider fails to submit the required clinical information.

For more information on coverage criteria, refer to the hospice services medical necessity guidelines for Tufts Health Direct and Tufts Health Together and Tufts Health RITogether.

## 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 Health Direct**
Refer to the Hospice Services Medical Necessity Guidelines for a list of codes that may be billed for hospice services.

**Tufts Health Together and Tufts Health RITogether**
- Submit claims for hospice services to Tufts Health Plan.
- Append modifier TN on claims for hospice services if the hospice facility is located outside the member's county.

Refer to the Hospice Services for Tufts Health Together, Tufts Health RITogether and Tufts Health Unify Medical Necessity Guidelines for a list of codes that may be billed for hospice services.

**Tufts Health Unify**
- 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.

**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 N.P.) 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

Refer to the Hospice Services for Tufts Health Together, Tufts Health RITogether and Tufts Health Unify Medical Necessity Guidelines for a list of codes that may be billed for hospice services.

## COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable network contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For additional 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 Health Together and Tufts Health RITogether

Tufts Health Plan remains the primary payer upon hospice election and will compensate hospice services in accordance with applicable MassHealth and/or RI EOHHS requirements.

### Tufts Health Unify

Upon hospice election, Medicare becomes the primary payer for Medicare-covered hospice services, hospice drugs and all other Medicare services. 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 Health Plan remains the primary payer for all plan-covered services not covered under Medicare Parts A or B, certain nonhospice covered Part D drugs, and Medicaid-only covered services.

Tufts Health Plan is responsible for payment of services unrelated to the terminal illness if the services are not covered by Medicare but are covered by Tufts Health Plan as a supplemental benefit, as well as any applicable cost sharing. Medicaid-only covered services continue to be covered by Tufts Health Plan, per MassHealth regulation.

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.

## ADDITIONAL RESOURCES

- Home Health Care Services Payment Policy

## DOCUMENT HISTORY

- December 2020: Policy reviewed by committee; clarified billing requirements and compensation/reimbursement information
- July 2018: Policy created

## 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℠ 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.