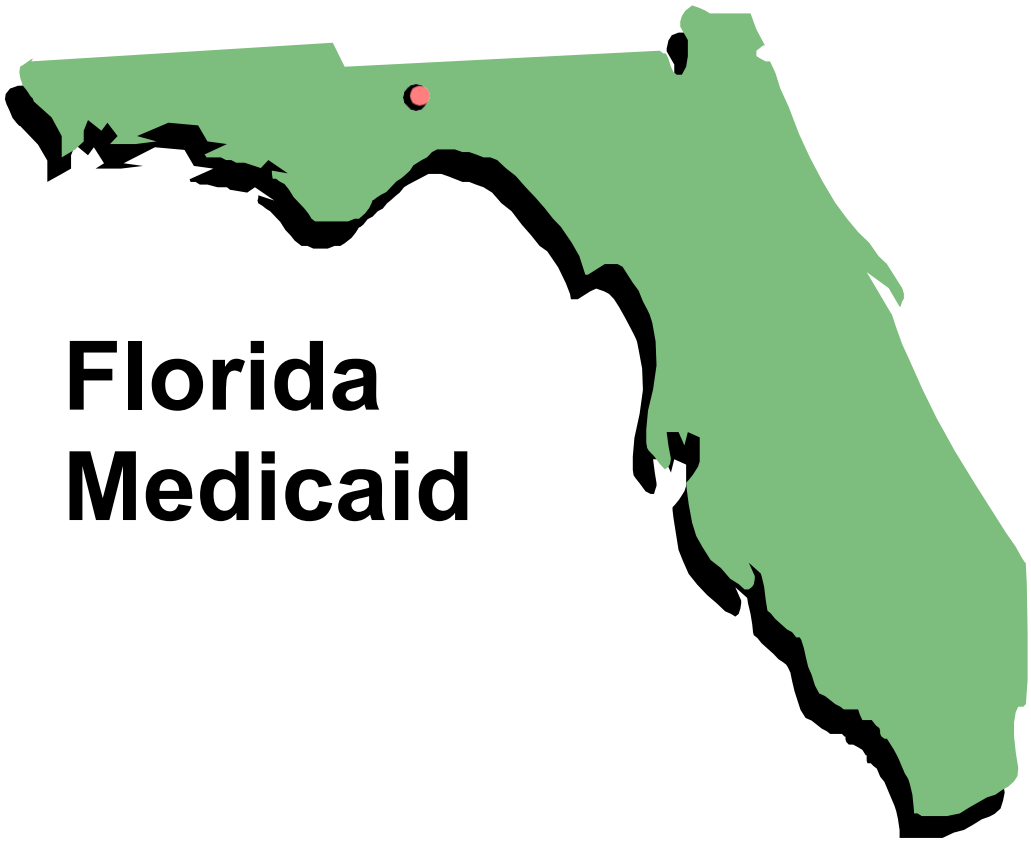

# Florida Medicaid

## Hospice Services Coverage Policy

**Agency for Health Care Administration**

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# 1.0 Introduction

## 1.1 Description

Florida Medicaid hospice services provide palliative care to terminally ill recipients.

### 1.1.1 Florida Medicaid Policies

This policy is intended for use by hospice providers that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

### 1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum service requirements for all providers of hospice services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in AHCA's contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

## 1.2 Legal Authority

Hospice services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), section 418
- Section 409.906, Florida Statutes (F.S.)

## 1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

### 1.3.1 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

### 1.3.2 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

### 1.3.3 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

### 1.3.4 Leave Days

When a recipient leaves the facility overnight for hospitalization or therapeutic leave.

### 1.3.5 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

### 1.3.6 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

#### 1.3.7 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

## 2.0 Eligible Recipient

### 2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

### 2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary hospice services who meet the following:

- Certified as terminally ill in accordance with 42 CFR 418.22, except as provided in paragraph (a)(4).
  - No face-to-face examination is required for the third hospice benefit period, nor any benefit period certification thereafter.
- Elected hospice in accordance with 42 CFR 418.24
  - Recipients under the age of 21 years are not required to forego curative treatment as a result of their hospice election and may continue to receive medically necessary covered services under the Florida Medicaid program.

Some services may be subject to additional coverage criteria as specified in section 4.0.

### 2.3 Coinsurance, Copayment, or Deductible
There is no coinsurance, copayment, or deductible for this service.

## 3.0 Eligible Provider

### 3.1 General Criteria
Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Enrolled directly with Florida Medicaid if providing services through a fee-for-service delivery system
- Enrolled directly or registered with Florida Medicaid if providing services through a managed care plan

### 3.2 Who Can Provide
Hospice providers licensed in accordance with Chapter 400, Part IV, F.S., and Rule Chapter 58A-2, F.A.C.

## 4.0 Coverage Information

### 4.1 General Criteria
Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

### 4.2 Specific Criteria
Florida Medicaid reimburses for 365/6 days of hospice services per year, per recipient, when the following criteria are met:

- The provider conducts an initial assessment in accordance with 42 CFR 418.54
- The provider develops and maintains a plan of care in accordance with section 400.6095, F.S.

- Services are rendered in accordance with 42 CFR 418.202 and 42 CFR 418.302

Providers must provide or arrange for the provision of necessary care and services to manage a recipient's terminal illness or related condition including:

#### 4.2.1 Core Services

The following services, included in the per diem payment, must be provided in accordance with 42 CFR 418.64:

- Counseling services
- Medical social services
- Nursing services
- Physician services

#### 4.2.2 Non-Core Services

The following services, included in the per diem payment, must be provided when specified in the recipient's plan of care and in accordance with 42 CFR 418.70-78 and 42 CFR 418.106-108:

- Hospice aide services
- Medical supplies and durable medical equipment
- Pharmacy services
- Therapy services
- Volunteer services
- Any other item or service specified in the plan of care as reasonable and necessary for the palliation and management of the recipient's terminal illness or related condition in accordance with 42 CFR 418.202

#### 4.2.3 Hospice Services in a Nursing or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

Florida Medicaid reimburses providers for nursing facility and ICF/IID room and board in addition to the per diem payment when a resident recipient elects hospice.

##### 4.2.3.1 Leave Days for Facility Residents

Florida Medicaid reimburses for leave days in accordance with the Florida Medicaid nursing facility and ICF/IID services coverage policies.

#### 4.2.4 Physician Services

Florida Medicaid reimburses for the following separately, in addition to the per diem payment, in accordance with the applicable Florida Medicaid fee schedule(s) when rendered by a practitioner licensed within the scope of their practice:

- Consultations provided by a physician whose opinion or advice regarding the evaluation or management of a specific problem is requested by another physician or the hospice
- Hospital services for the evaluation and management of initial hospital admission, subsequent care, and discharge services
- Nurse practitioner services in accordance with 42 CFR 418.304(2)
- Office and home visits

### 4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's authorization requirements policy.

## 5.0 Exclusion

### 5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

### 5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- Curative treatment for recipients ages 21 years and older who have elected hospice
- Room and board for a recipient residing in a nursing facility on the date of death or discharge from hospice
- Services for recipients who have elected hospice and are enrolled in the following:
  - Program of All-Inclusive Care for the Elderly (PACE)
  - Program of All-Inclusive Care for Children (PACC)

## 6.0 Documentation

### 6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's recordkeeping and documentation policy.

### 6.2 Specific Criteria

Providers must maintain a fully executed, age-appropriate, election statement in the recipient's file in accordance with the specifications in 42 CFR 418.24.

## 7.0 Authorization

The authorization information described below is applicable to the fee-for-service delivery system, unless otherwise specified. For more information on general authorization requirements, please refer to Florida Medicaid's authorization requirements policy.

### 7.2 Specific Criteria

There are no specific authorization criteria for this service.

## 8.0 Reimbursement

### 8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system, unless otherwise specified.

### 8.2 Claim Type

Institutional (837I/UB-04)

### 8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

### 8.4 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

## 8.5 Rate

For a schedule of rates, as incorporated by reference in Rule 59G-4.002, F.A.C., visit the AHCA Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml,

For the hospice room and board and level of care rates, visit AHCA's Web site at: http://ahca.myflorida.com/medicaid/cost_reim/hospice_rates.shtml.

### 8.5.1 Nursing and Intermediate Care Facility Rates

Florida Medicaid reimburses providers at 95% of the Medicaid rate on file for the facility where the recipient resides. Providers are responsible for the room and board payment to the nursing facility or ICF/IID.

### 8.5.2 Routine Home Care

Florida Medicaid reimburses for routine home care at a higher rate during the first 60 days of hospice admission.

- Providers cannot restart the day count of recipients discharged from hospice prior to the completion of 60 days unless a 60-day period has elapsed between discharge and readmission.

### 8.5.3 Service Intensity Add-on Payments

Florida Medicaid reimburses service intensity add-on (SIA) payments for routine home care during a recipient's final seven days of life.

- Provider must indicate on the claim that the recipient was discharged as deceased.