Hospice Care

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Hospice care is a medical multidisciplinary care designed to meet the unique needs of terminally ill Medi-Cal members.

Hospice care is used to alleviate pain and suffering and treat symptoms rather than to cure the illness. Items and services are directed toward the physical, psychological, social, and spiritual needs of the Medi-Cal member and their family unit. Medical and nursing services are designed to maximize the Medi-Cal member's comfort, alertness, and independence so that the Medi-Cal member can reside in the home as long as possible.

Providers must enroll as a Medi-Cal Hospice provider. All claims are submitted using the *UB-04* claim. For additional hospice billing procedures and claim form instructions, refer to the appropriate Part 2 outpatient services manual.

Eligible Providers

Hospice providers may include the following:

- Hospitals
- Skilled nursing facilities
- Intermediate care facilities
- Home health agencies
- Any licensed health provider who has been certified by Medicare to provide hospice care and is enrolled as a Medi-Cal hospice provider

‹‹All services must be rendered in accordance with Centers for Medicare & Medicaid Services (CMS) requirements for the federal Medicare program.››

‹‹Eligible Medi-Cal Members

Any Medi-Cal eligible member certified by a physician as having a life expectancy of six months or less may elect to receive hospice care in lieu of normal Medi-Cal coverage for services related to the terminal condition. Election of hospice care occurs when the Medi-Cal member (or their authorized representative) voluntarily files a *Medi-Cal Hospice Program Election Notice* (DHCS 8052) with the hospice provider, which acknowledges that the Medi-Cal member understands that the hospice care relating to the illness is intended to alleviate pain and suffering rather than to cure, and that certain Medi-Cal benefits are waived by this election. The hospice provider is responsible for the coordination of hospice services and is responsible for completion of the DHCS 8052.

A signed copy of DHCS 8052, completed by the Medi-Cal member or their authorized representative, must be submitted by the hospice provider as follows:

- For Medi-Cal members who are in managed care and receive hospice care through a Medi-Cal managed care plan (MCP), the hospice provider must submit the DHCS 8052 directly to the Medi-Cal MCP as outlined in All Plan Letter #25-008. The MCP will maintain the DHCS 8052 in their records and make it available to the Benefits Division (BD) within the Department of Health Care Services (DHCS) upon request. Hospice providers are not required to submit the DHCS 8052 directly to BD/DHCS. If the Department of Health Care Services (DHCS) receives a Notice of Election for a the Medi-Cal member enrolled in an MCP, the document will be securely destroyed in accordance with DHCS' policies for handling personally identifiable information (PII) and protected health information (PHI), as well as its official records retention policy.››

- ‹‹For Medi-Cal eligible members who are in Medi-Cal fee-for-service and receive hospice care through a Medi-Cal fee-for-service hospice provider, the hospice provider must submit the DHCS 8052 directly to the hospice clerk in BD/DHCS within five (5) days of election, as follows:
  - (Preferred method) Electronically (e-mail) to:
    - *MCHospiceClerk@dhcs.ca.gov*
    - For emails, send all information via a secure, encrypted format to maintain Medi-Cal member confidentiality and ensure compliance with all applicable state and federal privacy requirements related to PII and PHI.
  - Mail to:

    Department of Health Care Services
    Benefits Division
    Attn: Hospice Clerk
    1501 Capitol Avenue, MS 4601
    Sacramento, CA 95899››

Medi-Cal Members Younger Than Age 21

In accordance with section 2302 of the Patient Protection and Affordable Care Act, any Medi-Cal member younger than 21 years of age and certified by a physician as having a life expectancy of six months or less may elect to concurrently receive hospice care in addition to curative treatment of the hospice-related diagnosis. Non-hospice providers will be able to bill Medi-Cal for medically necessary, curative treatments that are provided within their scope of practice and that are considered a benefit under the Medi-Cal program. ‹‹All services are subject to current Medi-Cal policies, which includes any appliable authorization and utilization review mechanisms.

A copy of the DHCS 8052 signed by the Medi-Cal member (or their authorized representative) must be submitted as described in more detail above.››

‹‹Required Documentation

The (DHCS 8052) and *Patient Notification of Hospice Non-Covered Items, Services, and Drugs* (DHCS 8053) are required for all licensed and certified hospice agencies to use initially when Medi-Cal eligible members elect hospice services. Hospice providers must complete the forms and submit as described in more detail above.››

Instructions:

1. Download the DHCS 8052 and DHCS 8053 PDF form(s), which are available on the DHCS website.
2. Enter the information digitally or print the PDF form(s) to fill out for manual completion.
3. ‹‹Manually and/or digitally sign the form(s) as needed, if submitting electronically (via email). If mailing, enclose the original, signed form(s).
4. Submit as described in more detail above.

If the DHCS 8052 and DHCS 8053 are rejected, the hospice provider must correct the forms, then resubmit the corrected form(s) within five business days of the notification of the error(s). The form(s) must not be back dated.››

Resources:

- *Medi-Cal Hospice Election Notice* (DHCS 8052)
- *Patient Notification of Hospice Non-Covered Items, Services, and Drugs* (DHCS 8053)
- DHCS' Hospice Care website
- Frequently Asked Questions for the Hospice Election Form and Addendum
- Medi-Cal Hospice Care Manual

For questions, email MCHospiceClerk@DHCS.ca.gov.

Periods of Care

Hospice is a covered Medi-Cal benefit with the following periods of care:

- Two 90-day periods, beginning on the date of hospice election.
- Followed by unlimited 60-day periods.

A period of care starts the day the Medi-Cal member receives hospice care and ends when the 90-day or 60-day period ends.

‹‹Medi-Cal Member Certification/Recertification Required››

The attending physician (if one exists) and the medical director or physician member of the hospice interdisciplinary team must have certified in writing at the beginning of the first 90-day period that the Medi-Cal member was terminally ill. For all subsequent recertification periods, only a hospice provider, which can include a physician or the hospice medical director, may certify that the Medi-Cal member is terminally ill with six months to live.

At the start of the first 90-day period of care, the Hospice provider must maintain an initial certification that the Medi-Cal member is terminally ill in the Medi-Cal member's medical record. At the start of each subsequent period of care, the hospice provider must maintain a recertification that the Medi-Cal member is terminally ill in Medi-Cal member's medical record.

Example:

A Medi-Cal member has an end-stage liver disease, and her attending physician told her she has six months to live. ‹‹The Medi-Cal member elects hospice in lieu of curative treatment and completes the required election forms and her attending physician and the hospice medical director certifies she is terminally ill. The Medi-Cal member elects hospice on September 1, 2009, and begins receiving hospice care.››

- Initial certification: September 1, 2009, through November 29, 2009 (first 90-day period). The Medi-Cal member remains alive, and the hospice medical director certifies her again as terminally ill. The Hospice provider must maintain the certification that the Medi-Cal member is terminally ill in the Medi-Cal member's medical record.
- Recertification: November 30, 2009, through February 27, 2010 (second 90-day period). The Medi-Cal member continues to live, and the hospice medical director certifies her again as terminally ill. The Hospice provider must maintain the recertification that the Medi-Cal member is terminally ill in the Medi-Cal member's medical record.
- Recertification: February 28, 2010, and again April 29, 2010, etc. (60-day periods, unlimited. Every 60 days the hospice medical director must certify that the Medi-Cal member is terminally ill. The Hospice provider must maintain the certification that the Medi-Cal member is terminally ill in the Medi-Cal member's medical record.

Face-To-Face Encounter

A hospice physician or nurse practitioner (NP) is required to have a face-to-face encounter with every hospice Medi-Cal member to determine the continued eligibility of that Medi-Cal member. The face-to-face encounter requirement is satisfied when the following criteria are met:

- Timeframe of the encounter: The encounter must occur no more than 30 calendar days prior to the start of the third benefit period, and no more than 30 calendar days prior to every subsequent benefit period thereafter (refer to item four below for an exception to this timeframe).
- Attestation requirements: A hospice physician or NP who performs the encounter must attest in writing that he or she had a face-to-face encounter with Medi-Cal member, including the date of the encounter. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. Where an NP performed the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician for use in determining whether the Medi-Cal member continues to have a life expectancy of six months or less, should the illness run its normal course.
- Practitioners who can perform the encounter: A hospice physician or a hospice NP can perform the encounter. A hospice physician is a physician who is employed by the hospice or working under contract with the hospice. A hospice NP must be employed by the hospice. A hospice employee is one who receives a W-2 from the hospice or who volunteers for the hospice.
- Timeframe exceptional circumstances for new hospice admissions in the third or later benefit period: In cases where a hospice newly admits a Medi-Cal member in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period. For example, if the Medi-Cal member is an emergency weekend admission, it may be impossible for a hospice physician or NP to see the Medi-Cal member until the following Monday. Or, if CMS data systems are unavailable, the hospice provider may be unaware that the Medi-Cal member is in the third benefit period. In such documented cases, a face-to-face encounter that occurs within two days after admission will be considered timely. Additionally, for such documented exceptional cases, if the Medi-Cal member dies within two days of admission without a face-to-face encounter, a face-to-face encounter can be deemed complete.

- Timeframe requirements when a Medi-Cal member transfers from one hospice to another: When a Medi-Cal member transfers from one hospice to another, it is sometimes difficult to determine what benefit period the Medi-Cal member is in. In such cases, the receiving hospice provider may not know if a face-to-face recertification is necessary. The receiving hospice provider is required to document in the Medi-Cal member's medical record all efforts to obtain the previous hospice benefit period, either from the transferring hospice provider or from other sources. If the receiving hospice provider cannot determine the correct benefit period, the face-to-face recertification clock starts from the time the receiving hospice provider completes the intake process. ‹‹This information, along with all certification statements, must be maintained in the Medi-Cal member's medical record for auditing purposes and be available to DHCS upon request.››

Medi-Cal Member Revokes

‹‹If the Medi-Cal member revokes hospice care, the Medi-Cal member, as well as the hospice provider, must inform BD/DHCS in writing by submitting the hospice revocation form (same as Hospice Election Form) signed by the Medi-Cal member (or their authorized representative). Subsequently, if the Medi-Cal member re-elects hospice care, the hospice provider must submit a new DHCS 8052 to BD/DHCS as described in more detail above. The hospice provider must retain the initial certification of terminal illness from the hospice physician in the terminally ill Medi-Cal member's medical record.›› The hospice care period starts again with the two, 90-day periods followed by the unlimited 60-day periods.

Medi-Cal Member Discharges

‹‹If the Medi-Cal member is discharged from hospice care due to the Medi-Cal member's death or due to a decision made by the hospice care team, the hospice provider must inform BD/DHCS in writing by emailing to *MCHospiceClerk@dhcs.ca.gov*. Send all information via a secure, encrypted format to maintain Medi-Cal member confidentiality and ensure compliance with all applicable state and federal privacy requirements related to PII and PHI.››

Service Restrictions

The response from the eligibility verification system for Medi-Cal members who elect to receive hospice care in lieu of curative treatment and services will state "Primary diagnosis/limited to hospice." The Medi-Cal member will not be eligible to receive services related to the terminal diagnosis from providers other than a hospice provider or the attending physician. Accordingly, whenever this phrase is returned from the eligibility verification system, other providers should identify the name of the Medi-Cal member's hospice provider and inform the hospice provider that the Medi-Cal member is seeking other medical assistance related to the terminal diagnosis.

‹‹Services Unrelated to Primary/Terminal Hospice Diagnosis››

The special message “Primary diagnosis/limited to hospice” does not mean Medi-Cal members are prohibited from receiving other services that are unrelated to the primary diagnosis, such as physician examinations, drugs, or other medical care.

For example, if a Medi-Cal member on hospice suffers an injury or has a pre-existing condition, such as diabetes, all necessary medical care would be covered in the usual manner subject to applicable Medi-Cal policies.

‹‹If the hospice provider determines that the Medi-Cal member has revoked their election (even though the eligibility verification system response indicates otherwise) necessary services may be rendered in the usual manner subject to applicable Medi-Cal policies.››

For All Status Changes

‹‹Though not required, hospice providers are requested to enter the admission date in the *Admission Date* field (Box 12) and the appropriate status code in the *Status* field (Box 17) on the outpatient *UB-04* claim.›› Utilizing these fields will assist in providing accurate reimbursement. Data values allowed for the *Status* field are:

Status Code Descriptions

Status Code	Description
01	Discharged to home or self care
30	Still a patient (for continuing hospice care for same Medi-Cal member)
40	Expired at home
41	Expired in a medical facility, such as a hospice, Nursing Facility Level A, Nursing Facility Level B, or freestanding hospice
42	Expired, place unknown
50	Discharged/transferred to hospice, home
51	Discharged/transferred to hospice, medical facility

It is recommended that the *Remarks* field (Box 80), or an attachment to the claim, be utilized to report previous discharge, decertification, revocation or transfer information for this Medi-Cal member. ‹‹Hospice providers should include the National Provider Indicator of the facility from which the Medi-Cal member transferred, the dates the Medi-Cal member was admitted and the date that tenure ended.››

It is also recommended that an occurrence code be entered in the *Occurrence Code* fields (Boxes 31–34). The occurrence code works in tandem with the status code to clarify the billing scenario. All occurrence code values are accessible in the *National Uniform Billing Committee (NUBC) UB-04 Data Specifications Manual*. The following are examples of scenarios in which occurrence codes are helpful:

Occurrence Code Descriptions

Occurrence Code	Description	Application
27	Date of hospice certification or recertification	Could be used in conjunction with status code 30 (still a patient) in a claim scenario in which the Medi-Cal member gets certified for a new benefit period.
42	Date of discharge	Could be used in conjunction with status code 01 (discharged to home or self care) in a claim scenario where the Medi-Cal member is determined to no longer be terminally ill and is discharged. Can also be used if a Medi-Cal member chooses to revoke the hospice benefit.
55	Date of death	Could be used in conjunction with status code 20 (expired), 40 (expired at home), 41 (expired in a medical facility) or 42 (expired in a place unknown) in a claim scenario in which the Medi-Cal member passes away.

Classification of Care

Each day of hospice care is classified into one of four levels of care:

- Routine home care
- Continuous home care
- Inpatient respite care
- General inpatient care (no respite)/hospice general care

Level of Care Core Services

Core services within each level of care include:

- Nursing services
- Physical and occupational therapy
- Speech-language pathology
- Medical social services, home health aide and homemaker/ attendant services
- Medical supplies and appliances
- Drugs and biologicals
- Physician services
- Short-term inpatient care
- Counseling

Routine Home Care

Routine home care is received at the Medi-Cal member's home; it is not continuous home care. Routine home care (revenue codes 0650 [high rate for 0 – 60 days], 0659 [low rate for 61+ days] and 0552 [service intensity add-on (SIA) payment for last seven days of life]) is reimbursable to hospice providers for each day the Medi-Cal member is under the care of the hospice provider and not receiving another level of care, whether or not the patient is visited in the home by the hospice provider on the days being billed. Revenue codes 0650 and 0659 are reimbursable for days when no home visit is made, only if the service(s) provided are consistent with the Medi-Cal member's plan of care.

Continuous Home Care

Continuous home care consists of continuous, predominately skilled nursing care provided on an hourly basis, for a minimum of eight hours during brief crisis periods. Home health aide and/or homemaker services may also be provided.

Respite Care

Respite care occurs when the Medi-Cal member receives care in an approved inpatient facility on a short-term basis to provide relief for family members or others caring for the Medi-Cal member. Each episode is limited to no more than five days.

General Inpatient Care

General inpatient care occurs when the Medi-Cal member receives general care in an inpatient facility for pain control, or acute/chronic symptom management that cannot be managed in other settings.

Primary Care Physician Services

‹‹Hospice providers are required to provide all necessary services related to the terminal diagnosis within the four levels of care – except for primary care physician services, that may be provided and billed directly by the attending physician, and special physician services related to the primary diagnosis, that may be billed separately by the hospice provider.››

Services Covered

Special physician services are those furnished by a physician hospice employee or a physician under arrangement with the hospice for managing symptoms that cannot be remedied by the Medi-Cal member's attending physician because of (1) immediate need or (2) the attending physician does not have the required special skills. (For example, a urologist assists the Medi-Cal member in voiding when the bladder is pathologically obstructed).

Services Not Covered

When a Medi-Cal member is under the care of a hospice provider, separate payment will not be made, or treatment authorizations approved, for the following when they are directly related to the terminal diagnosis:

- Hospital
- Nursing Facility Level A or B
- Home Health Agency care
- Medical supplies and appliances
- Drugs and biologicals
- Durable Medical Equipment (DME)
- Medical transportation
- Any other services, as specified in *California Code of Regulations* (CCR), Title 22, related to the patient's terminal diagnosis

Note: Medi-Cal members younger than the age of 21 and under the care of a hospice are eligible for curative treatment related to the terminal diagnosis as specified in the Patient Protection and Affordable Care Act, Section 2302.

Copayments

In accordance with federal requirements, no Medi-Cal copayments may be collected from Medi-Cal members who are receiving hospice services for any Medi-Cal services, including services that are not related to the terminal illness.

End of Life Services

Medi-Cal members who elect hospice care may also be eligible for end of life services if they meet the specified criteria. Refer to the *End of Life Option Act Services* section in the appropriate Part 2 manual for more information.

Emergency Services

‹‹In the event a Medi-Cal member who has elected hospice care seeks assistance at an emergency room or requests emergency transportation, the emergency service provider should obtain the name of the Medi-Cal member's hospice provider and notify the hospice provider immediately. The hospice provider must take appropriate action and document appropriately in the Medi-Cal member's medical record.››

Requirements

Providers are reminded that *Health and Safety Code*, Section 1317, states that emergency services and care shall be provided to any person requesting such services or care, or for whom such services or care are requested, for any condition in which the person (Medi-Cal member) is in danger of loss of life, or serious injury or illness, at any licensed health facility that maintains and operates an emergency department. In addition, emergency services and care shall be rendered without first questioning the Medi-Cal member regarding the ability to pay.

Note: ‹‹Hospice services do not meet the definition of or otherwise qualify as emergency services.››

Palliative Care Services

Medi-Cal providers may bill for medically necessary palliative care services for eligible Medi-Cal members diagnosed with a serious and/or life-threatening illness, as determined and documented by the Medi-Cal member's treating health care provider.

More information can be found in the *Palliative Care* section of the appropriate Part 2 Medi-Cal provider manual.

Residential Care Facilities for the Elderly (RCFE)

The following revenue codes are reimbursable when rendered in Residential Care Facilities for the Elderly (RCFE).

RCFE Revenue Code Descriptions

Revenue Code	Description
0552	Routine home care (service intensity add-on [SIA] rate)
0650	Routine home care (high rate)
0652	Continuous home care
0655	Inpatient respite care
0656*	General inpatient care (no respite)/hospice general care
0657	Physician's services
0659	Routine home care (low rate)

Note: Providers billing hospice care revenue codes 0552, 0650, 0652, 0655, 0656, 0657 or 0659 for patients who are entitled to Medicare, but not eligible for Part A coverage on the date of service, may bill Medi-Cal directly. Medicare denial documentation is not required with these claims.

Billing Instructions

Claims submitted for these services on the *UB-04* claim require type of bill code with the first two digits “86” and a third claim frequency digit as detailed in the *National Uniform Billing Data Element Specification* manual. Refer to the *UB-04 Completion: Outpatient Services* section in the appropriate Part 2 manual for additional information about *Type of Bill* field (Box 4).

For information on documenting coexisting or additional diagnoses related to a patient’s terminal illness on hospice claims, refer to the *Hospice Care: General Billing Instructions* section in the appropriate Part 2 manual.

Room and Board Not Reimbursable

Hospice providers rendering services in an RCFE may not be reimbursed for room and board revenue code 0658.

‹‹Out of State Services

Medi-Cal does not cover or reimburse hospice providers for hospice services provided to eligible Medi-Cal members outside the state of California.››

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends
*	Revenue code 0656 must be billed in conjunction with HCPCS code T2045. A *Treatment Authorization Request* (TAR) is required.