

Revision Dates: 10/1/2018 10/1/2003

## General Information

AHCCCS covers End of Life Care for acute care and ALTCS members who meet the specified medical criteria/requirements. Hospice services provide palliative and supportive care for terminally ill ALTCS, KidsCare, and EPSDT members and their families or caregivers in order to ease the physical, emotional, spiritual and social stresses, which are experienced during the final stages of illness and during dying and bereavement.

A physician must certify that the member is terminally ill. Hospice care is limited to those members who are in the final stages of a terminal illness (i.e., members who have a prognosis of death within six months).

The initial physician certification is effective for 90 days. If the member continues to need services, the physician must recertify for a second 90-day period. Subsequent recertifications for 60-day periods are required if the member continues to require hospice services.

Hospice services are provided in the member's own home, a Home and Community Based Service (HCBS) approved alternative residential setting as specified in AMPM Policy 1230, or in the following inpatient settings when conditions of participation are met as specified in 42 C.F.R. 418:

1. Hospital,
2. Nursing care institution, and/or
3. Free standing hospice.

A hospice uses a medically-directed interdisciplinary care team of professionals and volunteers to meet the physical, psychological, social, spiritual, and other special needs, which are experienced during the final stages of illness, dying and bereavement.

A comprehensive list of covered hospice services can be found in AMPM 310-J, Hospice Services.

Hospice services may be provided in the home on an intermittent, regularly scheduled, and/or an on-call, around-the-clock basis according to member and family needs, as long as a member's end of life needs are able to be met.

## Authorization Requirements

Hospice services require prior authorization. For information on Prior Authorization please refer to Chapter 8, Prior Authorization, of the Fee-For-Service Provider Billing Manual and to AMPM 820, Prior Authorizations.

Also refer to the Prior Authorization webpage for the most up-to-date, current information regarding the PA process, which can be found at:

<https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/index.html>

For Tribal ALTCS members, hospice services are prior authorized by the Tribal ALTCS Case Manager.

## Billing Requirements

Hospice providers must bill for services on the UB-92 claim form using bill types 81X - 82X. The third digit must be 1 through 4 or 6 through 8.

Payment is made to a hospice provider for only one of four revenue codes. AHCCCS reimbursement rates for the four levels of service are all-inclusive rates that include durable medical equipment, medication, and other health care services (physician) related to the member's terminal illness.

Members requiring medical services not related to the terminal illness may receive them without having payment for these services included in the all-inclusive rate. Acute medical care services in this instance are non-inpatient services provided to ALTCS eligible members who are not covered by Medicare. Acute medical care services must be coordinated between the primary care physician and the case manager.

The following revenue codes may be billed to AHCCCS.

NOTE: Medicare claims with A, B, C, or D in the third digit cannot be processed. They refer only to the Notice of Election for Medicare.

- Revenue Code 0651 (Routine Home Care Day)
  - A routine home care day is a day during which a member is at home (or in a nursing facility) and not receiving continuous care.
  - Reimbursement is the lesser of either the hourly rate multiplied by the hours billed *or* the per diem rate.
  - When hospice care is furnished to a fee-for-service member in a nursing facility, the hospice should bill only the routine home care rate.
    - The nursing facility is reimbursed directly by AHCCCS for the room and board and other services furnished by the facility.
- Revenue Code 0652 (Continuous Home Care Day)

- A continuous home care day is a day during which a member receives services consisting predominantly of nursing care on a continuous basis at home. Continuous home care is only furnished during brief periods of crisis as necessary to maintain terminally ill members at their places of residence. A minimum of eight hours of care must be furnished on a particular day to qualify for the continuous home care rate.
- Home health aide, homemaker services, or both may also be provided on a continuous basis.
- Continuous home care is not available to nursing facility residents.
- Reimbursement is the lesser of either the billed charge *or* the AHCCCS hourly rate multiplied by the number of hours billed.
- Revenue Code 0655 (Inpatient Respite Care Day)
  - An inpatient respite care day is a day during which a member receives care in an approved facility on a short-term basis. Institutional (inpatient hospice) services may be delivered at the provider's site or through subcontracted beds in an institutional setting such as a hospital or nursing facility when the member's condition is such that care can no longer be rendered in the member's home.
  - The inpatient rate is paid from the date of admission up to, but not including, the date of discharge.
    - For the date of discharge, the appropriate home care rate is paid.
    - If the patient dies as an inpatient, the inpatient rate is paid for the date of discharge.
    - Payment for the sixth and any subsequent day of respite care is made at the routine home care rate.
- Revenue Code 0656 (General Inpatient Care Day)
  - A general inpatient care day is a day on which a member receives general inpatient care for pain control, or acute or chronic symptom management that cannot be managed in other settings.
  - The inpatient rate is paid from the date of admission up to, but not including, the date of discharge.
    - For the date of discharge, the appropriate home care rate is paid.
    - If the patient dies as an inpatient, the inpatient rate is paid for the date of discharge.
- For dates of service on or after January 1<sup>st</sup>, 2016 G0154 has been replaced with the following:

G0299 (Direct skilled nursing services of a registered nurse – RN – in the home health or hospice setting).

G0300 (Direct skilled nursing of a licensed practical nurse – LPN – in the home health or hospice setting).

## References

For additional information on hospice definitions, scope of service, licensure standards, limitations and requirements please refer to AMPM 310-J.

For additional information on the Prior Authorization process, please refer to Chapter 8, Prior Authorization, of the Fee-For-Service Provider Billing Manual and to AMPM 820, Prior Authorizations. Also refer to the Prior Authorization webpage for the most up-to-date, current information regarding the PA process, which can be found at:

<https://www.azahcccs.gov/PlansProviders/FeeForServiceHealthPlans/PriorAuthorization/index.html>

## Revision History

Date	Description of changes	Page(s)
10/1/2018	The General Information section was updated with clarifying language The list of services covered by hospice was replaced with a reference to AMPM 310-J, which fully lists all services. An Authorization Requirements section was added, including a link to the new FFS PA webpage. The Revenue Codes were updated to 4 digits. Information on codes G0299 and G0399 was added. References section added.	1 1 2 2-3 3-4 4
09/1/2016	Formatting updated	All