Priority Health	BILLING POLICY No. 085
HOSPICE CARE	
Date of origin: Apr. 15, 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Hospice care is a type of palliative care for people who are terminally ill and for their families.

POLICY SPECIFIC INFORMATION

The following criteria must be met in order to qualify for hospice benefits:

- Care is provided by a certified physician
- The attending physician and the hospice physician certify the patient as terminally ill, with a medical prognosis of six months or less to live if the illness runs its normal course.
- A signed election statement of hospice benefits and waiver to all rights of Medicare payments for the terminal illness and related conditions.

After certification, the patient may elect the hospice benefit for:

- Two 90-day periods followed by an unlimited number of subsequent 60-day periods.
- After the second, 90-day period, the recertification associated with a hospice patient's third benefit period, and every subsequent recertification, must include documentation that a hospice physician or a hospice nurse practitioner had a face-to-face (FTF) encounter with the patient. The FTF encounter must document the clinical findings supporting a life expectancy of six months or less.

Certification requirements

- The hospice medical director, a physician member of the hospice's interdisciplinary group or the patient's attending physician must provide a written certification of terminal illness for each election period even if a single election continues for an unlimited number of periods.
- If the hospice medical director, a physician member of the hospice's interdisciplinary group or the patient's attending physician can't provide the hospice with written certification within two calendar days, oral certification must be obtained within two calendar days. The hospice must get written certification before submitting a claim for payment. This is also applicable to recertifications.
- Payment normally starts with the effective date of election (the admission date). If the provider forgets to date the certification, the hospice can get a notarized statement or another acceptable document from the provider verifying the certification date.
- For subsequent recertification periods, hospices may complete recertifications up to 15 days before the next benefit period starts.
- Hospices must file written certification in the patient's record before submitting a claim. Hospices must file clinical information and other documentation that support the medical prognosis in the patient's medical record with written certification. Firstly, the hospice physician may provide

clinical information verbally, then document it in the medical record and include it as part of the hospice's eligibility assessment.
- For recertifications, a hospice physician or hospice NP must have a FTF encounter with each hospice patient before starting their third benefit period and before each following benefit period. Failure to meet FTF encounter requirements will result in the patient no longer being eligible for the benefit.

A complete written certification includes:

- A statement that the patient's life expectancy is six months or less if the terminal illness runs its normal course and specific clinical findings and other documentation supporting that. A brief narrative from the provider explaining the clinical findings. Regarding the narrative:
    - Place the narrative above the provider's signature if it's part of the certification or recertification form.
    - If the narrative exists as an addendum to the certification or recertification form or to the provider's signature on the certification or recertification form, the provider must also sign the narrative in the addendum.
    - Narratives must include a statement directly above the provider's signature that the provider confirms they composed the narrative based on their review of the patient's medical record or, if applicable, their patient's exam. Providers may dictate narratives.
    - Narratives must show the patient's individual clinical circumstances and not include check boxes or standard language used for all patients. Providers must combine the patient's comprehensive medical information to compose this brief clinical justification narrative.
    - For recertifications, the narrative associated with the third benefit period recertification and every following recertification must explain why clinical findings of the face-to-face encounter support life expectancy of six months or less.
- Provider signatures, date signed and benefit period dates that the certification or recertification covers.

When a patient chooses to access hospice benefits, all services pertaining to the terminal illness/condition(s) should be billed to and compensated by the assigned and/or rendering hospice care facility. When hospice care is chosen, other healthcare providers can only bill for services not pertaining to the terminal illness/condition(s). For example, if a hospice patient receives services from their primary care provider (PCP), and the services are directly related to the terminal illness and/or condition, those services will be covered by the assigned and/or rendering hospice care facility, and not by Priority Health.

Place of service

34 – Hospice

Documentation requirements

- Physician authenticated certification of terminal status, containing enough information to support terminal status. If other clinical indicators of decline form the basis for certifying terminal status, they should be documented as well. Recertification requires the same clinical standards be met as for initial certification.
- Election of benefits statement
- Plan of care and physician's orders
- Decline in clinical status worksheet authenticated by a nurse
- Visit notes by a nurse, aide or social worker
- Admission nurse assessment
- Physical and occupational therapy evaluations
- Information from periods of time outside the billing period currently under review
- Include supporting events such as a change in the level of activities of daily living, recent hospitalizations, and the known date of death (if you are billing for a period of time prior to the billing period in which death occurred).

- Documentation should always include the admission assessment, as well as any evaluations and Interdisciplinary Group (IDG) discussions used for recertification
- Documentation should support the level of care being provided to the patient during the time period under review, i.e. routine or continuous home or inpatient, respite or general

Coding specifics

UB-04 billing format

Revenue codes

- **0551**: Skilled Nursing - Visit Charge (Pre-hospice visit-commercial plans only) (Prior Authorization Required)
- **0561**: Medical Social Services - Visit Charge (Prior Authorization Required)
- **0651**: Hospice Service - Routine Home Care (per diem)
- **0652**: Hospice Service - Continuous Home Care (per hour)
- **0655**: Hospice Service - Inpatient Respite Care
- **0656**: Hospice Service - General Inpatient Care (Non-Respite)
- **0657**: Hospice Service - Physician Services (Hospice Physician Service, bill with appropriate E&M CPT code; excludes routine management by hospice physician which is included in per diem reimbursement.)
- **0658**: Hospice Service - Room & Board - Nursing Facility
- **0690**: Pre-hospice/Palliative Care Service - General
- **0691**: Pre-hospice/Palliative Care Service - Visit Charge
- **0692**: Pre-hospice/Palliative Care Service - Hourly Charge
- **0693**: Pre-hospice/Palliative Care Service - Evaluation
- **0694**: Pre-hospice/Palliative Care Service - Consultation and Education
- **0695**: Pre-hospice/Palliative Care Service - Inpatient Care
- **0696**: Physician Services
- **0697**: Reserved for Use by the NUBC
- **0698**: Reserved for Use by the NUBC
- **0699**: Pre-hospice/Palliative Care Service Other

Hospice services billed under Part A (RCs 029X, 0410, 0412, 0419, 042X, 043X, 044X, 055X, 082X, 083X, 084X, 085X, 0943, and 0948) must be billed monthly or at the conclusion of treatment.

HCPCS codes

- **Q5001**: Hospice or home health care provided in patient's home/residence
- **Q5002**: Hospice Care provided in assisted living facility
- **Q5003**: Hospice Care provided in nursing long-term care facility (LTC) or nonskilled nursing facility (NF)
- **Q5004**: Hospice care provided in skilled nursing facility (SNF)
- **Q5005**: Hospice care provided in inpatient hospital
- **Q5006**: Hospice care provided in inpatient hospice facility
- **Q5007**: Hospice care provided in long-term care facility
- **Q5008**: Hospice care provided in inpatient psychiatric facility
- **Q5009**: Hospice or home health care provided in place not otherwise specified (NOS)
- **Q5010**: Hospice home care provided in a hospice facility Not payable

Modifiers

- **26**: Professional Component

- **GV**: Non hospice related
- **PM**: Post mortem

Incorrect application of modifiers will result in denials. Learn more about modifier use in our Provider Manual.

Resources (if applicable)

- Article - Billing and Coding: Hospice: Determining Terminal Status (A52830)
- LCD - Hospice - Determining Terminal Status (L33393)
- Reimbursement Policy for Hospice
- MLN4824456 – Medicare Provider Compliance Tips

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
8/28/2025	Language revisions and removal of Medical Policy reference