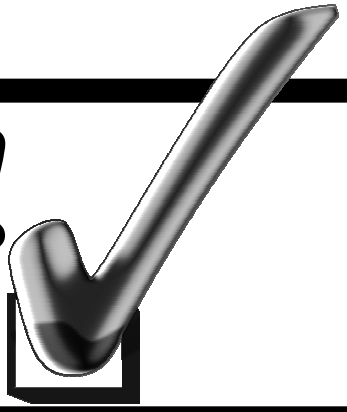
IMPORTANT!

Molina Provider News:



Hospice Billing and Reimbursement Tip Sheet

Hospice services are forms of palliative care that include medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.

Medicaid reimburses medically necessary hospice services to all members.

Authorization Requests
As of 1/1/2019, prior authorization is not required for hospice services.

Claim Submission
Providers must submit claims, whether paper or electronic, within 6 months after discharge. Claims may be submitted:

- Online:
  Molina Portal (for existing registered providers/users): https://provider.molinahealthcare.com.

  ** *The Molina Legacy Provider Portal is no longer accepting new provider registrations. As of March 1, 2022, the Molina Legacy Provider Portal will no longer accept new user registrations. Providers should register on the* ***Availity Portal*** *at* https://availity.com/molinahealthcare to avoid any disruption in accessibility and functionality.

- Via a clearinghouse, **Payer ID #51062**
- On paper to:
  Molina Healthcare
  PO Box 22812
  Long Beach, CA 90801

When Molina is secondary, claims, whether paper or electronic, must be submitted within 90 days from the final determination by the primary insurance carrier. If Medicare is the primary carrier, claims must be submitted to Molina within 36 months from discharge or one (1) year from Medicare's determination, whichever is later.

Before filing a claim, please review the following:

- Member eligibility and ID#
- Claim's timely filing
- Primary versus secondary insurance
- Patient Liability has been confirmed through DCF documentation or the DCF website
- Rendered services are covered
- Rendered services were authorized

Hospice Revenue Codes
Procedure Codes S9126, T2042, T2043, T2044, T2045 and T2046 are not used by Medicaid and therefore require the corresponding revenue code to process charges.

Revenue Code	Description	Limits
0182	Bed hold for therapeutic leave	Sixteen days per each state fiscal year (July 1 through June 30)
0185	Bed hold for hospitalization	Eight days for each hospitalization
0651	Routine home care	
0652	Continuous home care	
0654	Room and board ICF-IID	
0655	Inpatient respite care	
0656	General inpatient care	
0657	Physician services	
0658 or 0659 **(659 not eligible with POS 34 as of 7/1/18)**	Room and board (nursing facility)	

Medicaid will reimburse both revenue codes 0658 or 0659 **(659 not eligible with POS 34 as of 7/1/18)** and 0651 when billed on the same date of service.

Medicaid reimburses certain physician services that are not included in the per diem. **These services are billed using rev code 0657 and require an accompanying CPT/HCPCS code.** Multiple visits per day are allowed when billed with a different CPT code. When physician services and hospice care are provided in the same month, both services should be billed on the same claim form.

Revenue codes 0651 and 0652 are not covered for Dual Members.

Revenue codes 0655, 0656 and 0657 are payable for Dual Members.

Revenue codes 0658 and 0659 (659 not eligible with POS 34 as of 7/1/18) are payable without a Medicare EOB for Dual Members.

- Benefit code **HSD** should be used

All Hospice revenue codes are not covered for members in an LTC division.

Levels of Care

Medicaid reimburses hospice according to the level of care rendered. Each day of hospice care is classified into one of the following levels:

- **Revenue Code 0182 – Bed Hold for Therapeutic Leave** – provides a bed hold when the patient requires a leave of absence for therapeutic care.
- **Revenue Code 0185 – Bed Hold for Hospitalization –** provides a bed hold when the patient requires a leave of absence for hospitalization.
- **Revenue Code 0651 - Routine Home Care** – provides hospice care to the patient at their place of residence which can be a nursing home, assisted living facility or hospice residential facility who does not require a higher level of hospice care. This service is two levels bases on the length of time the member is in hospice care on a cumulative basis without a 60-day break in stay. If readmission occurs after 60 days, the calculation starts over.
- **Revenue Code 0652 - Continuous Home Care** – provides direct nursing care to a patient at home or a nursing facility during a brief medical crisis. Reimbursed at an hourly rate.

- **Revenue Code 0655 - Inpatient Respite Care** – provides short term inpatient care for the purpose of relieving the patient's primary caregiver.
- **Revenue Code 0656 - General Inpatient Care** – when the patient is admitted to a hospice unit, hospital, or nursing facility to provide pain control that cannot be provided in other settings.
- **Revenue Code 0657** - **Physician Services** – provides physician services in a hospice setting that are not included in the per diem.

In addition, Medicaid reimburses hospice for room and board services provided in a nursing facility.

- **Revenue Code 0658 and 0659 (659 not eligible with POS 34 as of 7/1/18) – Room and Board in a Nursing Facility**

Service Intensity Add-On (SIA) Payment

SIA revenue codes 551 & 561 may be billed in addition to the per diem rate for routine home care (RHC) level of care, revenue code 651. The reimbursement is equal to the continuous home care (CHC) hourly rate, revenue code 0652A.

SIA is an additional payment provided for the last 7 days of the member's life. The SIA Add-On amount is in addition to the per diem rate. The SIA Add-On amount is equivalent to 0652A rate. Payment can be applied on each revenue codes 0551 and 0561 line(s). The discharge status code must indicate the member is deceased/expired (20, 40, 41, 42) to be considered for the SIA payment for the last 7 days of life.

The service must be provided by registered nurse (RN) or medical social worker (SW) for at least 15 minutes up to 4 hours per day. RN and SW hours are combined and cannot exceed 4 hours in total. One unit billed equals 15 minutes of service. A maximum of 16 units (240 minutes) are payable for revenue codes 0551 & 0561 combined per day. The Add-On amount is an hourly payment rate multiplied by the amount of care provided, up to 4 hours per day.

Patient Responsibility

Patient Responsibility is the cost of Medicaid Long-Term Care (LTC) services not paid for by the Medicaid program, for which the member is responsible. Patient responsibility is the amount member must contribute toward the cost of their care. The amount of patient responsibility is determined by the Department of Children & Families (DCF) and is based on income and choice of residence.

DCF calculates and determines member patient responsibility. Members are responsible for the patient responsibility determined by DCF when residing in a participating residential facility. Providers are responsible for collecting patient responsibility and room and board for Molina members. Molina will reduce payments made to SNF's, Hospices, ALF's and AFCH's by the amount of patient responsibility determined by DCF.
Providers may view member patient responsibility information via the 'DCF Provider View' option in the Florida Medicaid Secure Provider Web Portal found at: https://sso.flmmis.com/adfs/ls/?wa=wsignin1.0&wtrealm=https%3A%2F%2Fhome.flmmis.com%2Fhome%2F&wctx=rm%3D0%26id%3Dpassive%26ru%3D%252Fhome%252F&wct=2021-10-19T12%3A49%3A22Z&whr=https%3A%2F%2Fsso.flmmis.com%2Fadfs%2Fls%2Fid

Providers may also contact DCF if there are any questions about the information found on the DCF Provider Portal or if they are unable to obtain needed information by contacting the DCF Customer Call Center at: (866)-762-2237.

For additional information, please visit the resources listed below and our website at www.molinahealthcare.com. Providers may also contact Molina Healthcare at 866-472-4585.

Thank you for your continued care to our Members!

Provider Resources

Medicaid Provider Reimbursement Handbook, UB-04
https://ahca.myflorida.com/medicaid/review/Reimbursement/RH_08_080701_UB-04_ver1_3.pdf
Medicaid Provider General Handbook
https://ahca.myflorida.com/medicaid/review/General/59G_5020_Provider_General_REQUIREMENTS.pdf
Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy
https://ahca.myflorida.com/medicaid/review/Specific/59G-4.192_LTC_Program_Policy.pdf
Medicaid Provider Handbook, Coverage Policies, and Fee Schedules
https://ahca.myflorida.com/medicaid/review/Promulgated.shtml