CA

51544 Hospice Care

(a)

Hospices shall be reimbursed the lesser of the amount billed or the amounts established under title XVIII of the Social Security Act pursuant to section 1902(a)(13), (42 USC 1396a(a)(13)) of such Act, for all covered services, as specified in section 51349.

(b)

With the exception of physician services, as specified in subsection (f), room and board payments as specified in subsection (h) and coinsurance for individuals entitled to Title XVIII hospice benefits as specified in subsection (i), reimbursement for hospice care shall be made at one of four rates for each day a recipient is under the care of the hospice regardless of the amount of services furnished: (1) Reimbursement for routine home care as defined in Section 51180.3, Billing Code number Z7100, shall be made for each day the recipient is at home and not receiving continuous home care. (2) Reimbursement for continuous home care, as defined in Section 51180.4, Billing Code number Z7102, shall be made on an hourly rate basis for each day, or portion thereof, a recipient qualifies for and receives such care. A minimum of eight hours of care must be provided in a 24-hour period in order to qualify for the continuous home care rate. (3) Reimbursement for respite care as defined in Section 51180.5, Billing Code number Z7104, shall be made for each day a recipient qualifies and receives such

care. Reimbursement for respite care shall be limited to no more than five consecutive days. Payment for the sixth and consecutive days shall be made at the routine home care rate. (4) Reimbursement for general inpatient care as defined in Section 51180.6, Billing Code number Z7106, shall be made for each day a recipient qualifies and receives such care.

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Reimbursement for routine home care as defined in Section 51180.3, Billing Code number Z7100, shall be made for each day the recipient is at home and not receiving continuous home care.

(2)

Reimbursement for continuous home care, as defined in Section 51180.4, Billing Code number Z7102, shall be made on an hourly rate basis for each day, or portion thereof, a recipient qualifies for and receives such care. A minimum of eight hours of care must be provided in a 24-hour period in order to qualify for the continuous home care rate.

(3)

Reimbursement for respite care as defined in Section 51180.5, Billing Code number Z7104, shall be made for each day a recipient qualifies and receives such care. Reimbursement for respite care shall be limited to no more than five consecutive days. Payment for the sixth and consecutive days shall be made at the routine home care rate.

(4)

Reimbursement for general inpatient care as defined in Section 51180.6, Billing Code number Z7106, shall be made for each day a recipient qualifies and receives such care.

(c)

Inpatient rates (general or respite) shall be paid for the date of admission and all subsequent inpatient days except the day on which the patient is discharged. For

the day of discharge, the appropriate home care rate shall be paid unless the patient dies as an inpatient. If the patient dies while an inpatient, the inpatient rate (general or respite) shall be paid for the discharge day.

(d)

Overall payments to a hospice, excluding payments for room and board as specified in subsection (h) and coinsurance and deductibles as specified in subsection (i), are subject to the same limitations which apply to Medicare payments specified in 42 CFR, part 418, Subpart G. (1) Payment for inpatient care days (general and respite) shall be limited to 20% of the total days provided by a hospice to all Medi-Cal beneficiaries in the Medicare cap period, November 1st through October 31st of the following year. (2) Total Medi-Cal payments to any one hospice shall not exceed the Medicare cap amount multiplied by the number of Medi-Cal beneficiaries who elected to receive hospice care from that hospice during the cap period.

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(e)

The following physician services are included in the four payment rates described in subsection (b). (1) General supervisory services of the medical director. (2) Participation in the establishment of plans of care, supervision of care and

services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group.

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(f)

Reimbursement for physician services not described in (e) which are provided to hospice patients by physicians employed by or under arrangement made by the hospice (Code number Z7108), shall be made to the hospice in accordance with Section 51503, 51509 or 51509.1, whichever is applicable. Reimbursement for these physician services shall be included in the amount subject to the hospice cap amount described in subsection (d)(2).

(g)

Services of the patient's attending physician, if he or she is not an employee of the hospice or providing services under arrangement with the hospice, are not considered hospice services and are not subject to the hospice cap described in subsection (d)(2). Reimbursement for these services shall not exceed the maximum allowances established in section 51503, 51509 or 51509.1, whichever is applicable.

(h)

Payment shall be made to a hospice provider for services rendered to an individual who is a resident of a Level A or Level B nursing facility at one or more of the levels of hospice care described in subsection (b), with the exception of respite

care, and for physician services provided by the hospice which are not included in one of the levels of care. Payment shall be 95 percent of the facility's Medi-Cal per diem rate where the patient resides.

(i)

Coinsurance payments shall be made to a hospice provider on behalf of individuals entitled to title XVIII hospice benefits as follows:(1) A coinsurance payment shall be made for each palliative drug and for each biological prescription furnished by the hospice while the individual is not an inpatient. The amount of coinsurance for each prescription shall approximate five percent of the cost of the drug or biological to the hospice, not to exceed $5. (2) A coinsurance payment shall be made for each day of respite care provided, not to exceed five percent of the respite care daily rate. However, the total amount of coinsurance payments for respite care shall not exceed the Medicare inpatient hospital deductible amount applicable in the year in which hospice care is elected. (3) Coinsurance may not be billed for Medi-Cal patients unless the hospice also bills and collects coinsurance from Medicare only patients.

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(2)

A coinsurance payment shall be made for each day of respite care provided, not to exceed five percent of the respite care daily rate. However, the total amount of coinsurance payments for respite care shall not exceed the Medicare inpatient hospital deductible amount applicable in the year in which hospice care is elected.

(3)

Coinsurance may not be billed for Medi-Cal patients unless the hospice also bills and collects coinsurance from Medicare only patients.

(j)

A hospice provider shall submit claims for payment for hospice care furnished in an individual's home only on the basis of the geographic location at which the service is furnished. The hospice provider shall identify on the claim the geographic location of the home in which the hospice care is furnished.