Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Hospice Payment Policy

The following payment policy applies to Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options (SCO) contracted providers who render hospice services and pre-hospice election professional services in an outpatient or office setting.

**Note:** Audit and disclaimer information is located at the end of this document.

**POLICY**

Tufts Medicare Preferred HMO covers cost sharing and supplemental benefits of claims unrelated to the terminal illness for members who have elected hospice.

Tufts Health Plan Senior Care Options coverage and plans include:

- An HMO Special Needs Plan (HMO SNP), which is a product for members dual-eligible for Medicare and MassHealth Standard, covers cost sharing and supplemental benefits of claims unrelated to the terminal illness, as well as Medicaid-only benefit claims.
- A Medicaid-only plan, which is a product for members eligible for MassHealth Standard, covers hospice and non-hospice services.

**DEFINITION**

Hospice services are considered to be those services rendered specifically for the management of a terminal illness. A Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options contracted provider, in conjunction with the member’s PCP, must diagnose members as being terminally ill in order to be eligible for hospice services.

**GENERAL BENEFIT INFORMATION**

Services and subsequent payment are based on the member’s benefit plan document. Providers and their office staff are required to use self-service channels to verify effective dates and copayments for commercial members prior to initiating services.

Refer to the [Electronic Services](#) section of our website for our self-service channel options. Benefit specifics should be verified prior to initiating services by logging on to our [website](#) or by contacting [Provider Relations](#).

Tufts Medicare Preferred HMO follows Medicare coverage guidelines. Tufts Health Plan cannot cover items and services not covered under the CMS-approved Tufts Medicare Preferred HMO benefit plan. Tufts Medicare Preferred HMO's benefit plan currently covers a limited number of non-Medicare covered items as supplemental benefits.

**Note:** Supplemental benefits are subject to change each year.

Tufts Health Plan Senior Care Options follows Medicare coverage guidelines for Medicare-covered benefits and Medicaid coverage guidelines for Medicaid-only covered benefits.

**Note:** To ensure timely payment for services for Tufts Health Plan Senior Care Options members, providers must verify if the member is enrolled in a dual-eligible (HMO SNP) or Medicaid-only plan.

Upon a member's election of hospice:

- Tufts Medicare Preferred HMO becomes the secondary payer and will make reimbursement based on the primary payer's decision for unrelated and supplemental benefits.
- Tufts Health Plan Senior Care Options for dual-eligible (HMO SNP) members becomes the secondary payer and will make reimbursement based on the primary payer's decision for unrelated Medicare and supplemental benefits. Tufts Health Plan Senior Care Options remains the primary payer for all Medicaid-only covered services.
- Tufts Health Plan Senior Care Options for Medicaid only members remains the primary payer for all services.

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1 Eligibility is subject to retroactive reporting of disenrollment.
**HOSPICE BENEFIT INFORMATION**

**Pre-Election Hospice Evaluation and Counseling Services**
Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Dual-Eligible (HMO SNP) and Medicaid-Only Members

Hospice evaluation and counseling services furnished by a contracted provider or a Medical Director or employee of a hospice agency is a one-time covered visit for members who have been determined to be terminally ill and who have not yet elected the hospice benefit. The visit may include: evaluation of the need for pain management and symptom management, counseling with respect to hospice care and other care options and advising the member regarding advance care planning.

**Post-Hospice Election Services**
Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Dual-Eligible (HMO SNP) Members

Once hospice is elected, Medicare fee-for-service Medicare Administrative Contractor (MAC) pays the hospice for hospice services. The MAC also pays for Medicare-covered care unrelated to the terminal illness.

Tufts Medicare Preferred HMO is responsible for payment of services for Tufts Medicare Preferred HMO members not related to the terminal illness if the services are not covered by Medicare, but are covered as a supplemental benefit. Tufts Medicare Preferred HMO cost sharing rules apply.

Tufts Health Plan Senior Care Options is responsible for payment of services for Tufts Health Plan Senior Care Options Dual-Eligible (HMO SNP) members not related to the terminal illness if the services are not covered by Medicare, but are covered by Tufts Health Plan Senior Care Options as a supplemental benefit, as well as any applicable cost sharing. Medicaid-only covered services continue to be covered by Tufts Health Plan Senior Care Options, per MassHealth regulation.

Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options dual-eligible (HMO SNP) members who have elected hospice may revoke hospice election at any time, but Medicare-covered services will continue to be paid by the MAC until the last day of the month in which hospice was revoked.

For more information on hospice Medicare coverage guidelines, refer to the [CMS Manual System Pub.100-02 Medicare Benefit Policy Transmittal 22](#)

**For Tufts Health Plan SCO Medicaid Only Members:**
Tufts Health Plan Senior Care Options is responsible for payment of hospice and non-hospice services, as allowed by MassHealth Hospice regulation, for Tufts Health Plan SCO Medicaid-only members.

For more information on hospice Medicaid coverage guidelines, refer to the Commonwealth of Massachusetts Mass Health Provider Manual Series, Hospice Manual, Program Regulations (130 CMR 437.000).

**MEMBER RESPONSIBILITY**

Co-payments, deductible and/or coinsurance for Tufts Medicare Preferred HMO members may apply pursuant to the member’s benefit plan specifics.

There is no member responsibility for Tufts Health Plan Senior Care Options members.

Tufts Health Plan recommends not billing the member for the coinsurance and/or deductible amount until the claim has processed so that the appropriate member responsibility can be determined. Both the provider’s Explanation of Payment (EOP) and the Electronic Remittance Advice (ERA) will reflect the member’s responsibility amount.

**Note:** Tufts Health Plan will not allow the use of a so-called "waiver" to circumvent or override the provider's obligations under the applicable participation agreement with regard to services covered under the member's plan. By way of illustration and not limitation, the waiver is of no validity when applied to missed filing deadlines, provider's authorization requirements and attempts to collect payments other than applicable copayments, coinsurance or deductibles.
AUTHORIZATION REQUIREMENTS
Hospice services do not require prior authorization from Tufts Health Plan.

For Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Dual-eligible (HMO SNP) members, in addition to following the CMS hospice election process, contact Provider Relations to determine the appropriate care manager to inform Tufts Health Plan of hospice election and revocation.

For Tufts Health Plan Senior Care Options Medicaid-only members, contact Provider Relations to determine the appropriate care manager to inform Tufts Health Plan of hospice election and revocation.

GENERAL BILLING INSTRUCTIONS
- Submit the most updated industry-standard codes.
- Submit a modifier, when applicable, with the corresponding CPT and/or HCPCS procedure code(s).
- Refer to CMS guidelines for appropriate modifiers.
- Providers must submit one claim for care when the member is not on hospice, and then another claim for care during hospice election. These services should not be submitted on the same claim.
- All claims for Medicare-covered services submitted for Tufts Medicare Preferred HMO and Tufts Health Plan SCO Dual-eligible (HMO SNP) members that are not related to the terminal illness should be sent to the appropriate MAC. Claims must be submitted with documentation (Explanation of Benefits) to Tufts Health Plan.
- All claims for Medicaid-only members should be submitted to Tufts Health Plan SCO.

Note: Annually and quarterly, HIPAA medical code sets and modifiers undergo revision by CMS, AMA and CCI. Revisions typically include adding, deleting or redefining the description or nomenclature of new HCPCS, CPT procedure and ICD-CM diagnosis codes. As these revisions are made public, Tufts Health Plan will update its system to reflect these changes.

To view the status of submitted authorizations and claims, log on to our secure website.

EDI Claim Submitter Information
- Submit claims in appropriate HIPAA compliant 837 format. Claims billed electronically with non-standard codes will reject. Submit a corresponding CPT and/or HCPCS code for every Revenue Code submitted. Tufts Health Plan acknowledges that certain Revenue Codes may not have a corresponding CPT and/or HCPCS code; however, in all cases the provider is encouraged to find a procedure code for every Revenue Code.

Paper Claim Submitter Information
- Submit claims on the appropriate paper claim form. Claims billed with non-standard codes will deny.
- All paper CMS-1500 and UB-04 claims must be submitted on standard red claim forms. Black and white versions of these forms, including photocopied and faxed versions, will not be accepted and will be returned with a request to submit on the proper claim form.
- Submitted forms deemed incomplete will be rejected and returned to the submitter. The rejected claim and a letter stating the reason for rejection will be returned to the submitter, and a new claim with the required information must be resubmitted for processing.

HOSPICE BILLING INSTRUCTIONS FOR TUFTS MEDICARE PREFERRED HMO AND TUFTS HEALTH PLAN SCO DUAL-ELIGIBLE (HMO SNP) MEMBERS
Submitting the cost-sharing portion of claims unrelated to the terminal illness

For most cases, providers must bill the primary payer (MAC) first for payment of the claim and then submit an Explanation of Benefits (EOB) to Tufts Health Plan with the claim and the appropriate modifier. Claims missing the required information will deny.

All claims for Medicare-covered services that are related to the terminal illness should be sent to the hospice agency.

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2 HIPAA medical code sets include HCPCS, CPT Procedure and ICD-CM diagnosis codes.
Tufts Health Plan is responsible for:
- The cost sharing of payment of services not related to the terminal illness
- Supplemental benefits.

An example of a supplemental benefit is:
- An eye exam

The following code should be submitted for pre-election for hospice and evaluation counseling visit.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0337</td>
<td>Hospital evaluation and counseling services, pre-election.</td>
</tr>
</tbody>
</table>

**Modifier and Condition Codes**

Hospice services provided by the attending provider not employed or paid under arrangement by the member’s hospice provider should be billed to the MAC. Services may or may not be related to the terminal condition and should be billed with the appropriate GV/GW modifier and/or condition code 07 for consideration of payment.

Modifiers and condition codes are used when a member has elected Hospice:
- GV modifier – Attending provider (M.D, D.O. or NP) not employed or paid under arrangement by the member’s hospice provider
- GW modifier – Service NOT RELATED to the hospice member’s terminal condition
- 07 condition code – Service is NOT RELATED to the treatment of the member’s terminal illness

**Payment Responsibility**

When the claim is initially processed, payment determination is based on the hospice election and revocation information that is available electronically from CMS at the time of processing. As updates are received from CMS, claims may be subject to readjudication.

**HOSPICE BILLING INSTRUCTIONS FOR TUFTS HEALTH PLAN SCO MEDICAID-ONLY MEMBERS**

Tufts Health Plan Senior Care Options Medicaid-only members who elect hospice are covered for hospice and non-hospice covered services. All claims for services should continue to be submitted to Tufts Health Plan SCO.

The following code should be submitted for pre-election for hospice and evaluation counseling visit.

<table>
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The following codes should be submitted for hospice services.

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>T2042</td>
<td>Hospice routine home care; per diem (within the county in which the provider is located)</td>
</tr>
<tr>
<td>T2043</td>
<td>Hospice continuous home care; per hour (within the county in which the provider is located)</td>
</tr>
<tr>
<td>T2044</td>
<td>Hospice inpatient respite care; per diem</td>
</tr>
<tr>
<td>T2045</td>
<td>Hospice general inpatient care; per diem</td>
</tr>
<tr>
<td>T2042 TN</td>
<td>Hospice routine home care; per diem (outside the county in which the provider is located)</td>
</tr>
<tr>
<td>T2043 TN</td>
<td>Hospice continuous home care; per hour (outside the county in which the provider is located)</td>
</tr>
</tbody>
</table>
**ADDITIONAL BILLING INSTRUCTIONS FOR TUFTS HEALTH PLAN SCO DUAL-ELIGIBLE (HMO SNP) AND MEDICAID-ONLY MEMBERS**

Tufts Health Plan Senior Care Options Dual-Eligible (HMO SNP) and Medicaid-only members who elect hospice continue to be covered for Medicaid-only covered services. All claims for Medicaid covered services should continue to be submitted to Tufts Health Plan SCO.

Please note, when Tufts Health Plan Senior Care Options Dual (HMO SNP) and Medicaid-only members are receiving routine or continuous hospice services in a long term care setting, Tufts Health Plan Senior Care Options will reimburse the long term care facility directly for long term care room and board.

**COMPENSATION/REIMBURSEMENT INFORMATION**

Providers are reimbursed according to the applicable network contracted rates regardless of the address where the service is rendered. Claims are subject to payment edits that are updated at regular intervals and generally based on CMS, specialty society guidelines, and National Correct Coding Initiative (CCI).

**Procedure Code Guidelines**

Tufts Health Plan will not compensate for inappropriately-coded services, based on CPT/HCPCS Procedure Code Guidelines.

**Explanation of Payment (EOP)**

The EOP provides information on the status of the claim(s) submitted to Tufts Health Plan. The EOP indicates status of claims payments, denials and pending claims.

**Electronic Remittance Advice (ERA)**

The HIPAA-compliant 835 ERA is an EDI transaction that providers may request to electronically post paid and denied claims information to their accounts receivable system.

**DOCUMENT HISTORY**

- September 2015: Template conversion, template updates
- June 2015: Policy reviewed. Added Tufts Health Plan Senior Care Options, formatting changes, template updates
- December 2013: Added links to Medicare fee-for-service (MAC), claim submission language clarified, template updates.
- September 2013: Template conversion
- August 2012: Policy reviewed, minor content and template changes
- January 2011: Moved to its own policy
- July 2007: Clarified Tufts Health Plan Medicare Preferred benefit information and added definition of hospice care.

**AUDIT AND DISCLAIMER INFORMATION**

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan’s audit policies, refer to our website.

This policy provides information on Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.