

Hospice Services Quick Reference Guide

UnitedHealthcare Community Plan of Florida

We created this document to provide an overview of guidelines for clinical coverage, prior authorization and claims submission for hospice services. Please refer to this information when providing hospice care for UnitedHealthcare Community Plan of Florida members. If you have questions, call Provider Services at **877-842-3210**.

Coverage Rationale and Definitions

Hospice care is an alternative treatment approach based on the recognition that impending death requires a change from curative treatment to palliative care for the terminally ill individual and support for the family.

- Palliative care focuses on the treatment and relief of a life-threatening medical condition in order to help an individual and their family maintain their normal activities with minimal disruptions and with as much physical and emotional comfort as possible.
- Terminally ill is defined as a medical prognosis of limited expected survival, of six months or less at the time of referral to a hospice, of an individual who is experiencing an illness for which palliative care is appropriate.

Coverage Guidelines

Services are covered for members requiring medically necessary hospice services who:

- Are certified as terminally ill in accordance with Centers for Medicare & Medicaid Services (CMS) regulation 42 CFR 418.22.
- Have elected hospice care in accordance with CMS regulation 42 CFR 418.24.

Please note that members younger than 21 are not required to forego curative treatment as a result of their hospice election, and may continue to receive medically necessary covered services under the Florida Medicaid program. More information about clinical coverage criteria, covered services and benefit limitations is available in the Florida Agency for Health Care Administration (AHCA) Hospice Services Coverage Policy. To read the policy, click [here](#), then select “Hospice Services.” To read the UnitedHealthcare Community Plan coverage determination guidelines for hospice care, click [here](#).

Clinical Review

Hospice care providers are required to maintain a Certification of Terminal Illness (CTI) and appropriate documentation of the member’s treatment plan. We may request a copy of the CTI at any time while the member is receiving hospice care. We may also ask you to submit an updated CTI with a physician narrative documenting continued qualifications for hospice services for members receiving hospice care for more than 12 months, and again every six months thereafter.

If a member’s condition improves or stabilizes sufficiently over time while receiving hospice care, such that the member no longer has a prognosis of six months or less from the most recent recertification evaluation or definitive interim evaluation, the member should be considered for discharge from hospice care. If a member is discharged, they may be re-enrolled for a new benefit period when a decline in their clinical status is such that their life expectancy is again six months or less. Members in the terminal stage of their illness who originally qualify for the hospice benefit but stabilize or improve while receiving hospice care, yet have a reasonable expectation of continued decline for a life expectancy of less than six months, remain eligible for hospice care.

Prior Authorization Requirements

- **For Managed Medical Assistance (MMA) members:** Prior authorization is **not** required for hospice services.
- **For Long-Term Care (LTC) members:** For members in LTC, the member’s care manager is responsible for obtaining prior authorization for hospice services and entering the authorization into the member’s plan of care.
 - Care managers can request prior authorization using the Prior Authorization and Notification tool on Link. To sign in to Link, go to UHCprovider.com and click on the Link button in the top right corner. Then, select the Prior Authorization and Notification tile on your Link dashboard. Learn more at UHCprovider.com/paan.

Billing Guidelines

In accordance with AHCA guidelines, care providers are required to submit claims for hospice care using the UB-04 claim form. For more information from AHCA about using the UB-04 claim form, click [here](#).

Submitting Claims

To submit claims, use the Claim Submission tool on Link. Sign in to Link by going to UHCprovider.com and clicking on the Link button in the top right corner. Then, select the Claim Submission tile on your Link dashboard. For more information, please see our [Claim Submission Quick Reference Guide](#).

Patient Responsibility

Care providers are responsible for ensuring the amount of patient responsibility for hospice services matches the most current documentation from the Florida Department of Children and Families.

- If the hospice patient has a patient responsibility, enter value code 31 and the amount on the claim form in the field for patient responsibility. The amount entered should be the amount for the entire month even when billing for a partial month. When we receive your claim, we'll do a prorated calculation for partial days.

AHCA Hospice Services Billing Codes

Please use the revenue and procedure codes listed in the chart when billing for hospice care. More information from AHCA about hospice service billing codes is available [here](#).

Revenue Code	Procedure Code	Description	Maximum Limit
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
0184		Bed hold, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) residents only	Eight days for each hospitalization
0651		Routine home care	Per Hospice Admission: Days 0-60 = High Rate Days 61+ = Low Rate
0551*	G0299	Service Intensity Add-On (SIA) - Registered Nursing Visit During Routine Home Care	15 minute units up to 4 hours total per day, combined**
0561*	G0155	Service Intensity Add-On (SIA) - Medical Social Service Visit During Routine Home Care	
0652		Continuous home care	
0654	Q5005 or Q5006	Room and board ICF/IID	
0655		Inpatient respite care	
0656		General inpatient care	
0657		Physician services	
0658		Room and board (nursing facility)	

Please note: Not all of the listed codes are included in your Participation Agreement. Please refer to your fee table for billing per your contracted hospice codes.

* Florida Medicaid reimburses for Service Intensity Add-On (SIA) care (codes 0551/G0299, 0561/G0155), in addition to routine home care (code 0651), during the last seven days of an eligible recipient's life.

** SIA care (codes 0551/G0299, 0561/G0155) hours are combined and cannot exceed four hours total per day. Hours provided concurrently count separately.



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

Note: Selecting the rule name hyperlink will redirect you to the Florida Administrative Register's (FAR) website. The FAR website will display the rule history, along with any recent notices and reference material on the rule. Selecting the PDF hyperlink under reference material will retrieve the most recently promulgated reference material associated with the rule.

Rule Number	Rule Name	Effective Date	FAR Notice
59G-13.015	Adult Cystic Fibrosis Waiver Services Procedure Codes and Fee Schedule	3/21/2018	
59G-4.013	Allergy Services	6/29/2016	
59G-4.020	Ambulatory Surgical Center Services	2/11/2019	
59G-4.022	Anesthesia Services	7/5/2016	
59G-4.025	Assistive Care Services	7/10/2017	
59G-4.125	Behavior Analysis Services	10/29/2017	
59G-4.027	Behavioral Health Overlay Services	3/13/2014	
59G-4.033	Cardiovascular Services	6/29/2016	

Contracts				
	59G-8.700	 Child Health Services Targeted Case Management	8/8/2012	 FAR
	59G-4.040	 Chiropractic Services	2/11/2019	 FAR
	59G-4.050	 Community Behavioral Health Services	3/13/2014	 FAR
	59G-13.088	 Consumer-Directed Care Plus Program	10/19/2015	 FAR
	59G-4.055	 County Health Department Clinic	6/29/2016	 FAR
	59G-4.060	 Dental Services	9/24/2018	 FAR
	59G-13.070	 Developmental Disabilities Individual Budgeting Waiver Services	6/10/2018	 FAR
	59G-4.105	 Dialysis Services	1/3/2016	 FAR
	59G-8.600	 Disenrollment from Managed Care Plans	1/30/2019	 FAR
	59G-4.070	 Durable Medical Equipment and Medical Supplies	9/28/2010	 FAR
	59G-4.085	 Early Intervention Services	8/13/2017	 FAR
	59G-4.015	 Emergency Transportation Services	10/27/2016	 FAR
	59G-4.087	 Evaluation and Management Services	6/29/2016	 FAR
	59G-4.100	 Federally Qualified Health Center	6/29/2016	 FAR
	59G-4.026	 Gastrointestinal Services	6/29/2016	 FAR
	59G-4.108	 Genitourinary Services	6/29/2016	 FAR
	59G-4.110	 Hearing Services	6/29/2016	 FAR
	59G-13.075	 Home and Community Based Services Settings	12/25/2018	 FAR
	59G-4.130	 Home Health Services	11/17/2016	 FAR

59G-4.132	 Home Health Electronic Visit Verification Program	2/22/2017	
59G-4.140	 Hospice Services	6/2/2016	
59G-4.150	 Inpatient Hospital Services	7/11/2016	
59G-4.032	 Integumentary Services	6/29/2016	
59G-4.170	 Intermediate Care Facility for Individuals with Intellectual Disabilities Services	7/11/2016	
59G-4.180	 Intermediate Care Services	2/28/1995	
59G-4.190	 Laboratory Services	6/29/2016	
59G-4.035	 Medicaid Certified School Match Program [1.34MB]	1/10/2006	
59G-4.058	 Medicaid County Health Department Certified Match Program	12/25/2018	
59G-4.197	 Medical Foster Care	12/18/2017	
59G-4.199	 Mental Health Targeted Case Management [1.14MB]	1/2/2008	
59G-4.201	 Neurology Services	10/15/2018	
59G-4.330	 Non-Emergency Transportation Services	10/27/2016	
59G-4.200	 Nursing Facility Services	5/3/2016	
59G-4.318	 Occupational Therapy Services	11/29/2016	
59G-4.207	 Oral and Maxillofacial Services	5/3/2016	
59G-4.211	 Orthopedic Services	6/29/2016	
59G-4.160	 Outpatient Hospital Services	7/11/2016	
59G-4.222	 Pain Management Services	6/29/2016	

59G-4.215	 Personal Care Services	11/17/2016	
59G-4.320	 Physical Therapy Services	11/29/2016	
59G-4.220	 Podiatry Services	6/29/2016	
59G-4.255	 Prescription Drug Coverage Denials	3/2/2006	
59G-4.250	 Prescribed Drug Services	12/24/2017	
59G-4.260	 Prescribed Pediatric Extended Care Services	2/8/2018	
59G-4.261	 Private Duty Nursing Services	11/17/2016	
59G-13.112	 Project AIDS Care Waiver Disposable Incontinence Medical Supplies Fee Schedule and Minimum Quality Standards	3/21/2018	
59G-13.110	 Project AIDS Care Waiver Services	3/21/2018	
59G-4.266	 Qualified Evaluator Network	9/28/2015	
59G-4.240	 Radiology and Nuclear Medicine Services	5/27/2019	
59G-4.264	 Regional Perinatal Intensive Care Center Services	7/11/2016	
59G-4.030	 Reproductive Services	7/11/2016	
59G-4.322	 Respiratory Therapy Services	9/24/2018	
59G-4.235	 Respiratory System Services	6/29/2016	
59G-4.280	 Rural Health Clinic	6/29/2016	
59G-4.290	 Skilled Services	2/21/1995	
59G-4.324	 Speech-Language Pathology Services	11/29/2016	
59G-4.300	 State Mental Health	2/8/2018	

59G-4.120	 Statewide Inpatient Psychiatric Program	1/3/2016	 FAR
59G-4.192	 Statewide Medicaid Managed Care Long-term Care Program	4/23/2017	 FAR
59G-4.193	 Statewide Medicaid Managed Care Long-term Care Waiver Program Prioritization and Enrollment	12/8/2016	 FAR
59G-4.310	 Targeted Case Management for Children at Risk of Abuse and Neglect	5/01/2014	 FAR
59G-4.295	 Therapeutic Group Care Services  Specialized Therapeutic Services Coverage and Limitations Handbook	8/6/2017	 FAR
59G-4.360	 Transplant Services	5/27/2019	 FAR
59G-13.132	 Traumatic Brain and Spinal Cord Injury Waiver Disposable Incontinence Medical Supplies Fee Schedule	3/21/2018	 FAR
59G-13.130	 Traumatic Brain and Spinal Cord Injury Waiver Services	3/21/2018	 FAR
59G-13.131	 Traumatic Brain Injury and Spinal Cord Injury Waiver Services Fee Schedule	3/21/2018	 FAR
59G-4.340	 Visual Aid Services	11/15/2015	 FAR
59G-4.210	 Visual Care Services	6/29/2016	 FAR