# Hospice Services Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to providers who render hospice services and pre-hospice election professional services to members of the CarePartners of Connecticut plans selected above.

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

## Policy

CarePartners of Connecticut covers member cost sharing and supplemental benefits of claims unrelated to the terminal illness for members who have elected hospice, in accordance with the member's benefits and CMS guidelines, as applicable.

## General Benefit Information

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting CarePartners of Connecticut Provider Services at 888-341-1508.

### Hospice Benefit Information

#### Pre-Election Hospice Evaluation and Counseling Services

G0337 (hospice evaluation and counseling services) furnished by a contracting provider, 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 have not yet elected the hospice benefit. The visit may include evaluation of the need for pain and symptom management, counseling with respect to hospice care and other care options and advising the member regarding advanced care planning.

## Referral/Prior Authorization/Notification Requirements

Prior authorization is not required for hospice services. Contact CarePartners of Connecticut Provider Services at 888-341-1508 to determine the appropriate care manager to inform CarePartners of Connecticut of hospice election and revocation.

## Billing Instructions

Unless otherwise stated, CarePartners of Connecticut follows industry-standard coding guidelines. Refer to current industry-standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

Use of labs not participating in the member's applicable network(s) may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, CarePartners of Connecticut may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

- G0337 (pre-election hospice evaluation) should be submitted to CarePartners of Connecticut.
- Claims submitted for services during hospice election must be submitted separately from claims submitted when the member is not on hospice.
- Claims for Medicare-covered services **related** to the terminal illness should be sent to the hospice agency
- Claims for Medicare-covered services **unrelated** to the terminal illness should be sent to the appropriate Medicare Administrative Contractor (MAC)
- Providers must submit the explanation of benefits (EOB) from the primary payer with the claim when CarePartners of Connecticut is the secondary payer
- Refer to the Medicare Claims Processing Manual for procedure codes that may be billed for hospice services.

### Submitting the Cost-Sharing Portion of Claims Unrelated to the Terminal Illness

In most cases, providers must first bill the MAC for payment of the claim and then submit an EOB to CarePartners of Connecticut with the claim and the appropriate modifier. Claims missing the required information will deny.

### Modifier and Condition Codes

Hospice services provided by an 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 modifier and/or condition code for consideration of payment.

- 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 unrelated to the treatment of the member's terminal illness

## Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates and applicable fee schedules.

Payment responsibility is based on hospice election/revocation information available electronically from CMS at the time of claims adjudication. As information is updated, claims may be subject to readjudication.

Once hospice is elected, the Medicare fee-for-service MAC pays the hospice directly for hospice services as well as any Medicare-covered services unrelated to the terminal illness. If a member revokes their hospice election, 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 CMS.

CarePartners of Connecticut becomes the secondary payer and pays for services unrelated to the terminal illness if the services are not covered by Medicare but are covered by CarePartners of Connecticut as a supplemental benefit (minus applicable member cost-sharing).

## Additional Resources

Medicare Claims Processing Manual 100-04, Chapter 11: Processing Hospice Claims

## Document History

- July 2024: Annual policy review; no changes
- November 2023: Annual policy review; administrative updates
- August 2022: Annual policy review; administrative changes
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021; policy reviewed by committee; clarified billing instructions and compensation/reimbursement information
- January 2019: Policy created

## Audit and Disclaimer Information

CarePartners of Connecticut 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 a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance. For more information about CarePartners of Connecticut's audit policies, refer to the CarePartners of Connecticut public Provider website.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication 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 requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.