Hospice Services Provider Guide

Use this guide as a supplement to Hospice Services Oregon Administrative Rules (Chapter 410 Division 142). See current Hospice Services rules for official policies regarding billing.

Contents (last updated November 1, 2016)

Client eligibility and enrollment

Refer to General Rules and OHP Rules for information about the service coverage according to OHP benefit plans and the Prioritized List of Health Services.

The OHP eligibility verification page explains how to verify eligibility using the Provider Web Portal, Automated Voice Response, or electronic data interchange (EDI) 270/271 transaction.

Hospice and nursing facility coordination *See OAR 410-142-0290*

If you provide hospice care to nursing facility residents, please submit the resident's information, including the date hospice care began, to the DHS Aging and People with Disabilities Division (APD) using the OHP 525 *(Hospice in a Nursing Facility Notification Form).*

Also report the following changes using this form:

- Change in residence (*e.g.,* to a new nursing facility)
- Change in hospice provider
- Hospice care ends or resumes
- Date of death

Verify the following with the nursing facilities with whom you are currently contracted:

- Accuracy of list of identified clients;
- Current or potential eligibility for Medicaid coverage;
- You have a current, signed contract on file.

Hospice providers also take the overall lead to create and coordinate patient care while working closely with the nursing facility to implement and follow the care plan.

How to bill for hospice services

Use the Provider Web Portal institutional claim, 837I or UB-04.

- **Billing instructions** are available on the OHP provider billing tips page.

- **For information about electronic billing,** go to the Electronic Business Practices Web page.

Bill the usual charge or the rate based upon the geographic location (Core-Based Statistical Area - CBSA) in which the care is furnished, *whichever is lower*.

For nursing facility residents:

- Bill OHA for the nursing facility's bundled room and board rate, in addition to the hospice services provided.
- Nursing facility room and board charges should only be for chargeable days that the resident was Medicaid-eligible and on hospice. To learn more about chargeable NF days, please review Oregon Administrative Rule 411-070-0050 Days Chargeable.
- Once OHA pays, then pay the nursing facility for the patient's room and board according to your contract with that facility.

For Routine Home Care:

Effective January 1, 2016, Routine Home Care (RHC) hospice services for fee-for-service clients is reimbursed based on a two-tier system. RHC provided during the first 60 days of hospice care will be reimbursed at the higher rate, while RHC provided during hospice days 61 and beyond will be reimbursed at the lower rate.

Beginning October 1, 2016, hospice providers must use the appropriate Revenue Codes for billing RHC as indicated below:

- Revenue Code 651 for RHC provided during hospice days 1-60
- Revenue Code 650 for RHC provided during hospice days 61 and beyond

For a patient who is discharged and readmitted to hospice:

- Within 60 days of that discharge – prior hospice days count in determining whether the allowable rate is high or low.
- After 60 days of that discharge – a new election to hospice will reset the patient's 60-day window for RHC to be paid at the higher rate.

The higher rate is only allowed for RHC provided during the first 60 days of hospice care. The count does not start over if the patient moves to a different hospice provider, unless there is more than 60 days break in hospice services.

Type of Bill codes

OHA accepts the following codes:

Non-Hospital-Based	Hospital-Based	Description
811	821	**Admission through discharge claim:** Encompasses an entire course of hospice treatment and no further bills will be submitted for this client (*i.e.*, client revokes or expires within the first billing period).
812	822	**First claim:** Use this code for the first of an expected series of payment bills for course of treatment.
813	823	**Interim-continuing claim:** Use when a bill has been submitted and further bills are expected to be submitted
814	824	**Last billing:** Use for a bill which is the last of series for a hospice course of treatment. The through date of this bill is the discharge date or the date of death.

How to enter CBSA codes on hospice claims

Include the Core-Based Statistical Area (CBSA) code for your county as a dollar amount in the Value Code field. The CBSA code tells HSD the amount to pay. Claims will process without payment ("zero pay") if this information is missing or invalid.

Claim format	Instructions
Paper:	Enter the following values in FL 39, 40, or 41 of the UB-04: ■ Value Code - 61 ■ Amount - In the dollar section, enter the CBSA code as a dollar amount (*e.g.,* code 99938 will display as 99938.00).
Web:	Click on the "Value" link. Enter the following values: ■ Sequence – 1 ■ Value Code - 61 ■ Amount - Enter the CBSA code as a dollar amount (*e.g.,* code 99938 will display as $99938.00).

CBSA codes

- **Albany (includes Linn County)** – 10540 *(enter as $10,540)*
- **Bend (includes Deschutes County)** - 13460 *(enter as $13,460.00)*
- **Corvallis (includes Benton County)** - 18700 *(enter as $18,700.00)*
- **Grants Pass (includes Josephine County)** – 24420 *(enter as $24,420)*
- **Eugene-Springfield (includes Lane County)** - 21660 *(enter as $21,660.00)*
- **Medford (includes Jackson County) -** 32780 *(enter as $32,780.00)*
- **Portland-Beaverton** (includes Clackamas, Columbia, Multnomah, Washington and Yamhill counties) - 38900 *(enter as $38,900.00)*
- **Salem** (includes Marion and Polk counties) - 41420 *(enter as $41,420.00)*
- **All other areas** - 99938 *(enter as $99,938.00)*

Revenue codes

On paper claims, enter "0001" in line 23. For each remaining line on the claim, enter the revenue code which most accurately describes the service provided.

- 651 – Routine Home Care – provided during hospice days 1-60
- 650 – Routine Home Care – provided during hospice days 61 and beyond
- 652 – Continuous Home Care (billed in *hours*, not days)
- 655 – Inpatient Respite Care
- 656 – General Inpatient Care
- 659 – Other Hospice (use for in-home respite care)

For nursing facility room and board:

- 191 – Complex Medical
- 192 – Pediatric
- 199 – Special Contract
- 658 – Basic

For current rates, please refer to the Hospice Program Rates on the Hospice Services guidelines page.

Claim status and adjustments

For information about the paper remittance advice and other ways to get claim status information via the Provider Web Portal, AVR or EDI 835 (Electronic Remittance Advice), go to the OHP remittance advice page.

For information about how to adjust a claim, refer to the Claim Adjustment Handbook.