POLICY

Throughout this policy where titled positions are mentioned it is understood that the responsibility for the task is extended to the position or their designee.

High Peaks Hospice & Palliative Care, Inc. (HPH&PC) informs the patient of financial responsibility for hospice services. HPH&PC personnel inform the patient of any subsequent changes in financial responsibility. Home care services are billed based on the location where the service is provided, rather than the location of the hospice program.

Clinical staff will provide complete, accurate and timely documentation of patient information related to claims submission. Written agreements with other healthcare providers will clearly delineate HPH&PC’s financial responsibility for all care and services related to the hospice patient’s terminal illness.

Clinical staff obtains all health insurance information for all referred patients. This includes Medicare, Medicaid, commercial or any other insurance under which the patient is covered including coverage carried by their spouse. The information will be used to verify who the primary insurance carrier will be for the patient. Patients are not denied services based on lack of insurance or ability to pay. Private Pay and Charity Care procedures will be followed in these cases.

Patients who are eligible to use their Medicare Hospice Benefit coverage for hospice services must do so in writing. This election will remain in effect through all election periods and does not require a subsequent signature unless hospice care is discontinued or revocation of the Hospice Benefit occurs. Patients or their empowered representative may revoke election of the Hospice Benefit at any time in writing. Only patients or their representative can revoke this election, HPH&PC staff cannot force patients to revoke their benefit. HPH&PC may discharge a patient if they are no longer eligible for the Medicare Hospice Benefit or for cause. A patient can re-elect their Medicare Hospice Benefit at any time when they are eligible.

Deductibles, co-pays, and premiums, regardless of insurance source, will be billed to the patient. A case-by-case determination will be made as to which deductibles, co-pays, or premiums will be forgiven. Any overpayment made by Medicare, Medicaid, or any other payer source will be promptly returned.

HPH&PC will determine a patient’s ability to pay for hospice services including private pay or charity care through a standardized methodology. A sliding fee scale will be used to assign appropriate charges on the basis of this methodology. The intent of this methodology is to:

1. Establish consistent and non-discriminatory guidelines in order to assess the financial resources required for uninsured and underinsured (i.e., not covered for the full range of services) patients who wish to access and are eligible for hospice care
2. Set charges for professional visits and goods/services on the basis of actual costs
3. Implement a standardized mechanism for discounting charges based on income and household size
4. Institute a mechanism for charity care for those patients unable through any means to pay for hospice services

HPH&PC recognizes that any individual who has the means to contribute to the care received and has no other support should make a contribution to this care. This is prudent financially because of the relationship with third party insurance sources (Medicare/Medicaid/private insurers) and communities in which we serve that support hospice care so generously.

HPH&PC recognizes that the insurance sources may not cover the full cost of hospice care. HPH&PC does not deny any patient hospice services because the patient has neither insurance nor the means to pay with private resources. HPH&PC has developed a methodology that will allow a sliding scale with adjustments in fees that are based on the patient/families available resources. HPH&PC asks its patients/families to meet two requests: 1) Apply for Medicaid and 2) provide a brief synopsis of their financial resources and show proof of income. Using this information charges will be assessed and billed based on a per diem rate for level of care. The sliding scale used is based on the annual New York State Poverty Level Guidelines. The starting point for this scale will use the index amount with a 300% poverty level at this rate. The fees paid will increase by 20% for each 20% increase in income from the starting level.

PROCEDURE

1. **Clinical Staff is responsible for the collection of information for patient billing**
   a. Insurance information will be collected on all referred patients during the intake/referral process.
   b. Determine if the patient has Medicare, Medicaid, commercial insurance, or no insurance for hospice services.
      i. Medicare:
         1) Explain the benefits and terms of the Hospice Medicare coverage, provide patient with copy of “Medicare Hospice Benefit Booklet” (in the Patient/Family Resource Guide)
         2) Explain the services waived under traditional Medicare coverage
         3) Obtain a signed “Medicare Hospice Benefit Election” form
         4) Obtain a copy of the Medicare ID Number
         5) If the patient is a readmission determine which benefit period is appropriate, notify the Medical Director for a face-to-face visit if the patient is entering the 3rd and subsequent benefit periods. This visit must be completed prior to readmitting a patient.
         6) The “Medicare Hospice Benefit Election” form is filed in the Clinical Record with the informed consent statements after a copy is sent to the Billing Coordinator in the Administrative Office
      ii. Medicaid:
         1) Determine if patient is eligible for Medicaid
         2) Obtain a copy of the Medicaid ID Number
3) If submission for a Medicaid ID Number is necessary, a Social Worker will help the family complete the Medicaid application and follow-up monthly to determine if Medicaid is approved
4) Notify the Billing Coordinator if Medicaid is approved or denied

iii. Commercial Insurance
1) Determine if patient has commercial insurance to cover hospice services
2) Obtain a copy of the commercial ID Number
3) Contact insurance company for authorization to use hospice benefit
4) Complete the “Patient Commercial Insurance Coverage Summary”
5) This form is filed in the Clinical Record after a copy is sent to the Business Manager.
6) Monitor commercial insurance and notify the Billing Coordinator if commercial insurance is cancelled at any time while on HPH&PC services.

iv. If no insurance or limited insurance consider Private Pay/Charity Care
1) Used only after all other insurance options have been explored and for patients having limited or no access to insurance coverage
2) The private pay charge for hospice Home Care, Nursing Home Care, Inpatient, and Respite Care (inclusive of all professional nursing and social work visits) shall be based on a per diem charge.
3) The per diem charge includes all usual and necessary supplies, services, medications and equipment necessary to render hospice services
4) All patients without documented hospice insurance benefits will receive notification of the private pay policy during the initial intake/referral
5) The patient will exhaust every avenue of insurance coverage including an application for Medicaid benefits
   a. Determine that Medicaid has been denied within the past six months.
   b. Obtain evidence of benefit application, denial or rejection from the applicant.
6) Complete the “Financial Assistance Eligibility” form
7) Send the original form along with the Medicaid Denial Letter and proof of income to the Business Manager. Within five business days, the Business Manager and Executive Director will calculate charges for the patient.
   c. The insurance information is recorded in the Patient Clinical Record. The Billing Coordinator will follow-up to make sure insurance is correct and complete.
   d. Nursing Home Patients:
      i. Notify the nursing home’s business office when a patient is admitted to HPH&PC.
         1) Obtain signatures on “Nursing Home Room and Board Authorization” form
         2) A copy of the form is given to the nursing home’s business office.
         3) A copy of the form will be sent to the Billing Coordinator. The original is filed in the Clinical Record
      ii. Notify Nursing Home business office when patient is discharged from HPH&PC services
   e. Temporary Relocation of Patients Out of Area
      i. If a patient is traveling outside the HPH&PC service area a “Temporary Relocation Agreement” must be completed.
      ii. Contact the Business Manager to obtain billing rates for agreement
      iii. The agreement will be faxed to the receiving hospice for signature.
      iv. A copy of the agreement will be filed in the Clinical Record.
      v. The original form will be sent to the Business Manager
f. Temporary Relocation of Patients from Other Hospices
   i. A “Temporary Relocation Agreement” from another Hospice must be obtained for hospice patients visiting in the area not covered by HPH&PC.
   ii. Contact the Business Manager to obtain appropriate billing information.
   iii. Send the “Temporary Relocation Agreement” and any visit documentation to the Business Manager.

g. Continuous Care: Copies of the following documentation used for Continuous Care (See Clinical Policy “Continuous Care” CP-274) will be sent to the Billing Coordinator.
   i. Interdisciplinary Progress Notes will document care in 15 minutes increments
   ii. Continuous Care Scheduling Sheets (calendar)

h. Revocation of the Medicare Hospice Benefit
   i. Patients or their representative may revoke the election of the Medicare Hospice benefit at any time by signing the “Revocation of Medicare Hospice Benefit” form and indicating the date that the revocation is to be effective
   ii. The patient may re-elect Medicare coverage for hospice care any time if eligibility requirements are met. The new election period starts with the next benefit period.
   iii. Medicare election may only be revoked by the patient or their representative. HPH&PC may not revoke a patient’s Medicare election nor pressure a patient to do so under any circumstances. HPH&PC may discharge a patient if they are no longer eligible for the Medicare Hospice Benefit or for cause as specified in Clinical Policy “Discharge of Hospice Patient” CP219, Para A, Section 5 and 6.
   iv. This form is filed in the Clinical Record after a copy is sent to the Billing Coordinator.

2. Business Office is responsible for the following:
   a. Provide information to insurance companies to obtain payment for all patients in accordance with the conditions of their insurance or follow HPH&PC policy (Para b) if no insurance
      i. Verify all information necessary to obtain reimbursement from Medicare, Medicaid, and commercial insurers for patients
      ii. Verify information in electronic medical record for accuracy.
      iii. Verify the level of care for claims
      iv. Verify the correct physician license number, U-PIN and NPI number
   b. Private Pay and Charity Care:
      i. Calculate and approve private pay charges
      ii. Patients will be notified in writing from the Business Manager and Executive Director of the amount of the charge.
      iii. In the event the patient is determined to be wholly unable to pay for hospice care through family resources the following steps, as appropriate to the case, will be initiated upon intake:
         1) The county in which the patient resides shall be contacted regarding eligibility for Catastrophic Care coverage for potential reimbursement of unusually high expenses that the patient is unable to meet,
         2) Other community resources will be approached for potential provision of In-Kind services e.g., pharmaceutical companies’ indigent care practices. A resource listing of such companies will be provided by the Social Worker.
         3) The potential for deduction of the Life Benefit under the patient’s Life Insurance policy will be determined (sometimes called a viatical trust),
4) Alternative insurance benefits will be assessed and utilized to cover such costs as Hospice Aides, outpatient services and the like where such coverage exists,

5) Efforts will be directed toward negotiating additional benefits coverage for specific disease related services not covered under the existing policy.

c. Maintain billing files on all patients which includes the following:
   i. Patient Clinical Record Face Sheet
   ii. Insurance documentation
   iii. Patient discharge information

d. Communicate with the clinical staff to obtain corrections for billing information
   i. Correct errors in Patient Clinical Record
   ii. Document corrected information in Patient Clinical Record and on other documentation and annotate in billing comments

e. Maintain billing file of reimbursements
   i. File payments for each patient
   ii. Monitor denials and rejections of payments for each patient
   iii. Correct errors in patient billing
   iv. Print and file payment summary sheet when billing is completed on each patient.
   v. File all completed payments for patient billing in closed Clinical Records

f. Coordination of care with other providers for appropriate billing:
   i. Claims must be coordinated with other healthcare providers as described in each written contract.
   ii. Claims for supplies, medications, equipment and services related to the patient’s terminal illness are described in each provider’s written contract.
   iii. Contactors will send detailed invoices for claims

g. Auditing, monitoring and returning overpayments:
   i. Audit and monitoring protocol provides for continual assessment of documentation of clinical services and accuracy of billing.
   ii. When determined through audits or other forms of discovery, overpayments from any payer source are returned.