Washington State Department of Social & Health Services

Health and Recovery Services Administration (HRSA)

Hospice Services

Billing Instructions for Hospice Agencies, Hospice Care Centers, and Pediatric Palliative Care Providers

[Chapter 388-551 WAC Subchapter 1]

Copyright Disclosure

About this publication

This publication supersedes all previous HRSA *Hospice Billing Instructions* and Numbered Memorandum 05-96, 06-93, and 07-64.

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A provider may use HRSA's toll-free lines for questions regarding its programs; however, HRSA's response is based solely on the information provided to the [HRSA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern HRSA 's programs. **[WAC 388-502-0020(2)]**

How can I use the Internet to

Find information on becoming a DSHS provider?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel/.
Click **Sign up to be a WA State Medical Assistance provider** and follow the on-screen instructions to find information on becoming a DSHS provider.

Ask questions about the status of my provider application?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel/.

- Click **Sign up to be a WA State Medical Assistance provider**.
- Click **I want to sign up as a WA State Medical Assistance provider**.
- Click "**What happens once I return my application?**"

Submit a change of address or ownership?

Visit Provider Enrollment at:
http://maa.dshs.wa.gov/provrel/.
Click **I'm already a current provider** to submit a change of address or ownership.

If I don't have access to the Internet, how do I find information on becoming a DSHS provider, ask questions about the status of my provider application, or submit a change of address or ownership?

Call Provider Enrollment at:
1-800-562-3022 option 2, option 5 (toll free)

or write to:
HRSA Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

Who do I contact if I have hospice or Pediatric Palliative Care (PPC) Case Management/Coordination policy questions?

If you have questions regarding hospice or Pediatric Palliative Care Case Management/Coordination policies, or need information on notification requirements, contact:

Hospice/PPC Program Manager
1-360-725-1570 (Clinical questions phone)

Billing questions
1-360-725-1965 (Hospice/PPC notification fax)

HRSA - Division of Healthcare Services
PO Box 45506
Olympia WA 98504-5506

Where do I send my claims?

Hard Copy Claims:
Division of Healthcare Services
PO Box 9246
Olympia, WA 98507-9246

How do I obtain copies of billing instructions or numbered memoranda?

To view an electronic copy, visit DSHS on the web at: http://maa.dshs.wa.gov (click **Billing Instructions/Numbered Memoranda)**

Who do I contact if I have questions regarding…

Payments, denials, general questions regarding claims processing, HRSA managed care plans?

Visit the Customer Service Center for Providers on the web at: http://maa.dshs.wa.gov/provrel/ (click **I'm already a current provider**)

or call/fax:
1-800-562-3022 (toll free)
1-360-725-2144 (fax)

or write to:
HRSA Customer Service Center
PO Box 45505
Olympia, WA 98504-5505

Private insurance or third party liability, other than HRSA managed care plans?

Division of Eligibility and Service Delivery
Coordination of Benefits
PO Box 45565
Olympia, WA 98504-5565
1-800-562-6136 (toll free)

Assistance with Electronic Billing?

HRSA/HIPAA E-Help Desk
Toll free: 1-800-562-3022 (Option 2) or
e-mail: hipaae-help@dshs.wa.gov

ACS EDI Gateway, Inc.
Toll free : 1-800-833-2051 or
http://www.acs-gcro.com/

Medications not related to the Hospice diagnosis?

Pharmacy Only
1-800-848-2842 (toll free)

All other providers
1-800-562-3022 (toll free)

How do I find out about Internet Billing (Electronic Claims Submission)?

WinASAP and WAMedWeb
http://www.acs-gcro.com/
Select *Medicaid*, then *Washington State*

All other HIPAA transactions
https://wamedweb.acs-inc.com/

To use HIPAA Transactions and/or WinASAP 2003 enroll with ACS EDI Gateway by visiting ACS on the web at: http://www.acs-gcro.com/Medicaid_Accounts/Washington_State_Medicaid/washington_state_medicaid.htm (click **Enrollment**)
or by calling: 1-800-833-2051.

How do I find out about Internet Billing (Electronic Claims Submission)? (cont.)

Once the provider completes the EDI Provider Enrollment form and faxes or mails it to ACS, ACS will send the provider the web link and the information needed to access the web site. If the provider is already enrolled, but for some reason cannot access the WAMedWeb, then the provider should call ACS at 1-800-833-2051.

Where can I view and download rates?

Visit: http://maa.dshs.wa.gov/ProRates

How do I obtain HRSA Hospice program forms?

To **view and download** the DSHS Medicaid *Hospice Notification* form, DSHS 13-746. and the *Pediatric Palliative Care (PPC) Referral Notification* form [DSHS 13-752] visit DSHS Forms and Records Management Service on the web:
http://www1.dshs.wa.gov/msa/forms/eforms.html

How do I find out where my local Community Services Office (CSO) is located?

Visit the on-line CSO:
https://fortress.wa.gov/dshs/f2ws03esaapps/onlinecso/findservice.asp

How do I find out where my local Home and Community Services (HCS) office is located?

Visit the HCS web site:
http://www.aasa.dshs.wa.gov/Resources/clickmap.htm

How do I use the WAMedWeb to check on a client's eligibility and Hospice enrollment status?

If you would like to check client eligibility for free, call ACS at 1-800-833-2051 or HRSA at 1-800-562-3022

You may also access the WAMedWeb tutorial at:
http://maa.dshs.wa.gov/WaMedWebTutor/

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Definitions & Abbreviations

This section defines terms and abbreviations (includes acronyms) used in these billing instructions.

Acute – Having a rapid onset, severe symptoms, and short course; not chronic.

Aging and Disabilities Services Administration (ADSA) - The **A**ging and **D**isability **S**ervices **A**dministration assists children and adults with developmental delays or disabilities, cognitive impairment, chronic illness, and related functional disabilities. ADSA helps to gain access to needed services and support by managing a system of long-term care and supportive services that are high quality, cost effective, and responsive to individual needs and preferences.

Authorized Representative - An individual who has been authorized to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated. See RCW 7.70.065. [WAC 388-551-1010]

Bereavement Counseling – Counseling services provided to a client's family or significant others following the client's death.

Biologicals – Medicinal preparations including serum, vaccine autotoxins, and biotechnological drugs made from living organisms and their products. [WAC 388-551-1010 and 1210]

Brief Period – 6 days or less within a 30 consecutive day period. [WAC 388-551-1010]

Certification Statement – A document that states the client's eligibility for each election period and is:

- Created and filed by the Hospice Agency for each HRSA hospice client; and
- Signed by the physician and/or hospice medical director.

Client – An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) – A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. [WAC 388-551-1010]

Continuous Home Care – Services provided for a period of 8 or more hours in a day. It may include homemaker services and home health aide services, but must be predominantly nursing care. It can be provided only during a period of *acute medical crisis* or the sudden loss of a caregiver who was providing skilled nursing care, and only as necessary to maintain the client at home. (DSHS does not reimburse for continuous home care provided to a client in a nursing facility, hospice care center or hospital.)

Counseling – Services for the purpose of helping an individual and those caring for them to adjust to the individual's approaching death. Other counseling (including dietary counseling) may be provided for the purpose of educating or training the client's family members or other caregivers on issues related to the care and needs of the client.

Department - The state Department of Social and Health Services (DSHS). [WAC 388-500-0005]

Discharge – An agency ends hospice care for a client. [WAC 388-551-1010]

Election Period – The time, 90 or 60 days, that the client is certified as eligible and chooses to receive hospice care. [WAC 388-551-1010]

Election Statement – A written document provided by the hospice agency that is signed by the client in order to initiate hospice services.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Family – An individual or individuals who are important to, and designated in writing by, the client and need not be relatives, or who are legally authorized to represent the client. [WAC 388-551-1010]

General Inpatient (GIP) Hospice Care - Acute care that includes services administered to the client for acute pain and/or symptom management that cannot be done in other settings. In addition:

- The services must conform to the client's written plan of care (POC).
- This benefit is limited to brief periods of care delivered in DSHS-approved:
  - ✓ Hospitals;
  - ✓ Nursing facilities; or
  - ✓ Hospice care centers.

Health and Recovery Services Administration (HRSA) – The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Home - See Residence.

Home and Community Services (HCS) Offices – An Aging and Disabilities Services Administration (ADSA) office that manages the state's comprehensive long-term care system which provides in-home, residential, and nursing home services to clients with functional disabilities. [WAC 388-551-1010]

Home Health Aide – An individual registered or certified as a nursing assistant under Chapter 18.88 RCW who, ***under the direction and supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist***, assists in the delivery of nursing- or therapy-related activities, or both, to patients of a hospice agency or hospice care center.
[WAC 388-551-1010]

Home Health Aide Services – Services provided by home health aides in an in-home services agency licensed to provide home health, hospice, or hospice care center services under the supervision of a registered nurse, physical therapist, occupation therapist, or speech therapist. Such care may include:

- Ambulation and exercise;
- Medication assistance level 1 and level 2;
- Reporting changes in clients' conditions and needs;
- Completing appropriate records; and
- Personal care or homemaker services and other nonmedical tasks.

[WAC 388-551-1010]

Homemaker – An individual who provides assistance in personal care, maintenance of a safe and healthy environment, and services to enable a client's plan of care to be carried out.

Hospice Agency – A person or entity administering or providing hospice services directly or through a contract arrangement to individuals in places of temporary or permanent residence under the direction of an interdisciplinary team composed of at least a nurse, social worker, physician, spiritual counselor, and a volunteer. (Note: For the purposes of these billing instructions, requirements for hospice agencies also apply to hospice care centers.) [WAC 388-551-1010]

Hospice Care Center (HCC) - A homelike medical institution where hospice services are provided, and that meets the requirements for operation under RCW 70.127.280. [WAC 388-551-1010]

Hospice Daily Rate - The dollar amount DSHS will reimburse for each day of care.
Hospice Services - Symptom and pain management provided to a terminally ill individual and emotional, spiritual, and bereavement support for the individual and individual's family in a place of temporary or permanent residence.
[WAC 388-551-1010]

Inpatient Respite Care - See Respite Care.

Institution – An establishment that furnishes food, shelter, medically-related services, and medical care to four or more persons unrelated to the proprietor. This includes medical facilities, nursing facilities, and institutions for the mentally-retarded.
[WAC 388-500-0005]

Interdisciplinary Team – The following group that plans and delivers care to a client as appropriate under the direction of a physician:

- Counselors;
- Home health aides monitored by a registered nurse or a therapist;
- Physicians;
- Registered nurses;
- Social workers;
- Therapists (physical, occupational, and/or speech-language);
- Volunteers; and
- Others as necessary.

[WAC 388-551-1010]

Intermittent – Stopping and starting again at intervals; pausing from time to time; periodic.

Life-Limiting Condition - A medical condition in children that most often results in death before adulthood.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Maximum Allowable – The maximum dollar amount HRSA will reimburse a provider for specific services, supplies, or equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CN) and Medically Needy (MN) programs.

Medical Identification Card – The document DSHS uses to identify a client's eligibility for a medical program. These cards were formerly known as Medical Assistance Identification (MAID) cards.

Medically Necessary - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering, pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. Course of treatment may include mere observation or, where appropriate, no treatment at all.
[WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Palliative – Medical treatment designed to reduce pain or increase comfort, rather than cure. [WAC 388-551-1010]

Participation - The money a client owes before eligibility for Medicaid services.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medicaid client and that consists of:

a) First and middle initials (*or* a dash (-) must be entered if the middle initial is not indicated).
b) Six-digit birth date, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tiebreaker).

Pediatric Palliative Care (PPC) Case Management/Coordination - Palliative care for a child with a life-limiting condition.

Plan of Care (POC) – A written document based on assessment of individual needs that identifies services to meet these needs. [WAC 388-551-1010]

Provider or Provider of Service – An institution, agency, or person who:

- Has a signed agreement with the department to furnish medical care and goods and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Related Conditions – Any health condition(s) that manifests secondary to, or exacerbates symptoms associated with, the progression of the condition and/or disease, the treatment being received, or the process of dying. Examples of related conditions are:

- Medication management of nausea and vomiting secondary to pain medication; and
- Skin breakdown prevention/treatment due to peripheral edema.

Remittance and Status Report (RA) - A report produced by the Medicaid Management Information System (MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Residence – A client's home or place of living. [WAC 388-551-1010]

Respite Care – Short-term, inpatient care only provided on an intermittent, non-routine, and occasional basis and not provided consecutively for periods of longer than 6 days in a 30-day period.

Revised Code of Washington (RCW) – Laws of the State of Washington.

Revoke or Revocation – The choice to stop receiving hospice care. [WAC 388-551-1010]

Routine Home Care – Intermittent care received by the client at their place of residence, with no restriction on length or frequency of visits, dependent on the client's needs.

Terminally Ill – The client has a life expectancy of six months or less, assuming the client's disease process runs its natural course. [WAC 388-551-1010]

Third-Party - Any individual, entity, or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. [42 CFR 433.136]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

24-hour day – A day beginning and ending at midnight. [WAC 388-551-1010]

Usual and Customary Charge - The amount that may be billed to the department for a certain service or equipment. This amount *may not exceed:*

- The usual and customary charge that a provider bills the general public for the same services; or
- If the general public is not served, the charge for the same services normally offered to other contractors.

Washington Administrative Code (WAC) Codified rules of the State of Washington.

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About the Hospice Program

What Is the Hospice Program? [WAC 388-551-1000]

The HRSA Hospice program is a 24-hour a day program that allows a terminally ill client to choose physical, pastoral/spiritual, and psychosocial comfort care rather than cure. A hospice interdisciplinary team communicates with the client's non-hospice care providers to ensure the client's needs are met through the hospice plan of care. Hospitalization is used only for acute symptom management.

A client, a physician, or an authorized representative under RCW 7.70.065 may initiate hospice care. The client's physician must provide certification that the client is terminally ill and certify that the client has a life expectancy of six months or less and is appropriate for hospice care. Hospice care is provided in the client's temporary or permanent place of residence.

Hospice care ends when:

- The client or an authorized representative under RCW 7.70.065 revokes the hospice care;
- The hospice agency discharges the client;
- The client's physician determines hospice care is no longer appropriate; or
- The client dies.

Hospice care includes the provision of emotional and spiritual comfort and bereavement support to the client's family member(s).

How Does a Hospice Agency Become an HRSA-Approved Hospice Agency? [Refer to WAC 388-551-1300]

To become an HRSA-approved hospice agency, DSHS requires a hospice agency to provide documentation that it is Medicare, Title XVIII certified by the Department of Health (DOH) as a hospice agency. An HRSA-approved hospice agency must meet the requirements in:

- Chapter 388-551 WAC Subchapter I, Hospice Services;
- Title XVIII Medicare Program; and
- Chapter 388-502 WAC, Administration of Medical Programs--Providers.

To ensure quality of care for HRSA clients, HRSA's clinical staff may conduct a hospice agency site visit.

How Does a Hospice Agency Become an HRSA-Approved Hospice Care Center? [WAC 388-551-1305]

To become an HRSA-approved hospice care center. The hospice agency must complete the following:

- Be enrolled with HRSA as an HRSA hospice agency (see "How does a hospice agency become an HRSA-approved hospice agency?").

- Submit a letter of request to:

  Health and Recovery Services Administration
  Hospice Program Manager
  PO Box 45506
  Olympia, WA 98504-5506

A hospice agency must provide the following documentation confirming that the agency is:

- ✓ Medicare certified by DOH as a hospice care center;
- ✓ Approved by Centers for Medicare and Medicaid Services (CMS) in an approval letter; and
- ✓ Providing one or more of the following levels of hospice care:
  - ➢ Routine home care;
  - ➢ Inpatient respite care; and
  - ➢ General inpatient care (requires a registered nurse on duty 24 hours a day, seven days a week).

A hospice agency qualifies as an HRSA-approved hospice care center when:

- All the requirements in this section are met; and
- HRSA provides the hospice agency with written notification.

Hospice Election Periods [Refer to WAC 388-551-1310 (1)]

Hospice coverage is available for two 90-day election periods followed by an unlimited number of 60-day election periods. A client or a client's authorized representative must sign an election statement to initiate or reinstate an election period for hospice care.

An election to receive hospice care continues through the initial election period and subsequent election periods without a break in care as long as the client:

- Remains in the care of a hospice agency; and
- Does not revoke the election (see "What happens when a client ends (revokes) hospice care?")

Refer to page D.1 for more about Hospice **Election Statements** and the **Certification Process.**

Hospice Client Eligibility

Who Is Eligible? [Refer to WAC 388-551-1200 (1), (2), and (5)]

A DSHS Home and Community Services (HCS) office or Community Services Office (CSO) determines a client's eligibility for a medical assistance program and issues a notice of eligibility (financial award letter). A hospice agency is responsible for verifying a client's eligibility with the client or the client's HCS or CSO. A client who elects to receive hospice care, and has the physician's hospice certification, is eligible to receive hospice care through HRSA's Hospice program when:

- The client presents a current Medical ID Card with one of the following program identifiers:

Medical ID Card Identifier	Medical Program
CNP	Categorically Needy Program (General Assistance – Disability Determination Pending [GA-X] clients are eligible for hospice services and will be identified by the CNP identifier on their Medical ID Cards.)
CNP **CHIP**	Categorically Needy Program – Children's Health Insurance Program
CNP **Emergency Medical Only**	Categorically Needy Program – Emergency Medical Only - requires prior authorization.
LCP-MNP	Limited Casualty Program – Medically Needy Program

- The client's physician certifies the client has a life expectancy of six months or less;
- The client elects to receive hospice care and agrees to the conditions of the "election statement" as described in "Election Statements and the Certification Process" on page D.1;

- The hospice agency serving the client:

  ✓ Notifies HRSA within 5 working days of the admission of all clients, including:

  - Medicaid-only clients;
  - Medicaid-Medicare dual eligible clients;
  - Medicaid clients with third-party insurance; and
  - Medicaid-Medicare dual eligible clients with third-party insurance; and

  ✓ Meets the hospice agency requirements listed in "What are the notification requirements for hospice agencies?" See instructions on page D.7;

- The hospice agency provides additional information for a diagnosis when HRSA requests and determines, on a case-by-case basis, the information that is needed for further review; and

- The hospice agency checks the WAMedWeb to verify the HRSA-approved hospice start-of-care date (see *Important Contacts* section).

What Does the Hospice Agency Do to Confirm the Client's Pending Medical Eligibility?

1. Call the client's Home and Community Services (HCS) office or Community Services Office (CSO) to confirm pending eligibility.

For example:

2. Has the application been received by the CSO/HCS office?

3. Does the CSO or HCS office need additional information before it can approve or deny benefits?

4. Has the application been processed and the client is subject to a spenddown? (See Important Contacts section.)

5. Submit the DSHS/Medicaid Hospice Notification form, DSHS 13-746, to 1-360-725-1965 (fax) on all pending clients. This is required to ensure that the CSO or HCS worker determines eligibility for Medicaid under the correct program and may prevent inappropriate denials. Submitting these forms ensure it is handled by the correct office and avoids duplication of services by hospice and HCS.

6. Ask to receive confirmation of the client's eligibility status at the time the application is approved. If the client is not approved for a program which covers hospice services, you will need to know this information. Ask for the case to be reviewed or considered for a different program.

7. Once the hospice agency receives confirmation of a client's eligibility the hospice agency must resubmit the DSHS/Medicaid Hospice Notification form, DSHS 13-746, by fax to: 1-360-725-1965.

8. Use the WAMedWeb to check on client's medical eligibility.

Are Clients Enrolled in Managed Care Eligible for Hospice Services? [Refer to WAC 388-551-1200 (3)]

Clients whose Medical ID Cards have an HMO identifier in the HMO column are enrolled in an HRSA managed care plan. A client enrolled in one of HRSA's managed care plans must receive all hospice services, including nursing facility room and board, directly through that plan. The client's managed care plan is responsible for arranging and providing for all hospice services for a client enrolled in a managed care plan. The plan's telephone number is located on the client's Medical ID Card. **A hospice agency must notify HRSA within 5 working days when a client elects to receive hospice services, by faxing a completed DSHS/Medicaid Hospice Notification form, DSHS 13-746, to 1-360-725-1965. The hospice agency must comply with the managed care plan's policies and procedure to obtain authorization.**

> **Note:** To prevent denials of billed claims, please check the client's Medical ID Card/WAMedWeb *prior* to scheduling services and at the *time of the service* to make sure proper authorization or referral is obtained from the managed care plan.

Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM provider, the identifier in the HMO column will be "PCCM." These clients must obtain, or be referred for, services via the PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's Medical ID Card for the PCCM provider. (See the *Billing* section for further information.)

> **Note:** To prevent denials of billed claims, please check the client's Medical ID Card/WAMedWeb *prior* to scheduling services and at the *time of the service* to make sure proper authorization or referral is obtained from the PCCM provider.

Medicare Part A [WAC 388-551-1200 (4)]

A client who is also eligible for Medicare Part A is not eligible for the hospice Medicaid daily rate through HRSA's hospice program. HRSA pays hospice nursing facility room and board for these clients if the client is admitted to a nursing facility or hospice care center and is not receiving general inpatient care or inpatient respite care.

Hospice Coverage

What Covered Services, Including Core Services and Supplies, Are Included in the Hospice Daily Rate?

[Refer to WAC 388-551-1210]

HRSA reimburses a hospice agency for providing covered services. This includes core services and supplies, through HRSA's hospice daily rate. These are subject to the conditions and limitations described in these billing instructions. To qualify for reimbursement, covered services, including core services and supplies included in the hospice daily rate, must be:

- Related to the client's hospice diagnosis;
- Identified by a client's hospice interdisciplinary team;
- Written in the client's plan of care (POC);
- Safe and meet the client's needs within the limits of the Hospice program; and
- Made available to the client by the hospice agency on a 24-hour basis.

Note: Services are intermittent except during brief periods of acute symptom control. The client/family has 24-hour access to a registered nurse (RN)/physician.

The hospice daily rate includes the following core services that must be either:

- Provided by hospice agency staff, or
- Contracted through a hospice agency, if necessary, to supplement hospice staff in order to meet the needs of a client during a period of peak patient loads or under extraordinary circumstances:

- Physician services related to administration of the POC; or
- Nursing care provided by:

  ✓ A registered nurse (RN); or
  ✓ A licensed practical nurse (LPN) under the supervision of an RN.

- Medical social services provided by a social worker under the direction of a physician.
- Counseling services provided to a client and the client's family members or caregivers.

Covered services and supplies may be provided by a service organization or an individual provider when contracted through a hospice agency. To be reimbursed the hospice daily rate, a hospice agency must:

- Assure all contracted staff meet the regulatory qualification requirements;
- Have a written agreement with the service organization or individual provider providing the services and supplies; and
- Maintain professional, financial, and administrative responsibility.

> **Note:** Personal care is not a core service. A home health aide needed by a client from a hospice agency under the plan of care is different than personal care from a caregiver. Record in the client's record what services the hospice agency is providing and what Community Options Program Entry System (COPES) or personal care services are being provided by others. Document frequency and services of both to show non duplication.

The following covered services and supplies are included in the appropriate hospice daily rate as described in the "Hospice Reimbursement" section, subject to the limitations described in these billing instructions:

- **A brief period of inpatient care,** for general or respite care provided in a Medicare-certified hospice care center, hospital, or nursing facility;
- **Adult day health**;
- **Communication** with non-hospice providers about care not related to the client's terminal illness to ensure the client's POC needs are met and not compromised;
- **Coordination of care**, including coordination of medically necessary care not related to the client's terminal illness;
- **Drugs, biologicals, and over-the-counter medications** used for the relief of pain and symptom control of a client's terminal illness and related conditions;

> **Note:** The provider of the drugs and biologicals bills HRSA separately for enteral/parenteral supplies only when there is a pre-existing diagnosis requiring enteral/parenteral support. This pre-existing diagnosis **must not** be related to the diagnosis that qualifies the clients for hospice.

- **Home health aide, homemaker, and/or personal care services** that are ordered by a client's physician and documented in the POC. (Home health aide services are provided through the hospice agency to meet a client's extensive needs due to the client's terminal illness. These services must be provided by a qualified home health aide and are an extension of skilled nursing or therapy services. [Refer to 42 CFR 484.36];

- **Interpreter services** as necessary for the POC;

- **Medical equipment and supplies** that are medically necessary for the palliation and management of a client's terminal illness and related conditions;

- **Medical transportation services** as required by POC related to the terminal illness;

- **Physical therapy, occupational therapy, and speech-language therapy** to manage symptoms or enable the client to safely perform activities of daily living (ADLs) and basic functional skills;

- **Skilled nursing care**; and

- **Other services or supplies** that are documented as necessary for the palliation and management of the client's terminal illness and related conditions.

The hospice agency is responsible for determining if a nursing facility has requested authorization for medical supplies or medical equipment, including wheelchairs, for a client who becomes eligible for the Hospice program. HRSA does not pay separately for medical equipment or supplies that were previously authorized by HRSA and delivered on or after the date HRSA enrolls the client in hospice.

Note: If the covered services listed above are not documented in the POC but are considered necessary by medical review for palliative care and are related to the hospice diagnosis, the hospice agency is responsible for payment.

What Services Are Not Included in the Hospice Daily Rate?

The following services are not included in the hospice daily rate:

- Dental care;
- Eyeglasses;
- Hearing aids;
- Podiatry;
- Chiropractic services;
- Ambulance transportation, if not related to client's terminal illness;
- Brokered transportation, if not related to the client's terminal illness;
- Community Options Program Entry System (COPES) or Title XIX Personal Care Services, **if** the client is eligible for these services. Eligibility is determined by the local Aging and Disabilities Services Administration (ADSA) field office and will be **reimbursed by ADSA**; and
- Any services ***not*** related to the terminal condition.

If the above service(s) are covered under the client's Medicaid program, the provider of service must follow specific program criteria and bill HRSA separately using the applicable fee schedule and billing instructions.

How Do I Request a Noncovered Medical Service or Related Equipment? **[Refer to WAC 388-501-0160]**

Providers may request prior authorization (see "Important Contacts" section) for HRSA to pay for a noncovered medical service or related equipment. **This is called an exception to rule.** HRSA cannot approve an exception to rule if the exception violates state or federal law or federal regulation.

For HRSA to consider the request, sufficient client-specific information and documentation must be submitted for the HRSA medical director or designee to determine if:

- The client's clinical condition is so different from the majority that there is no equally effective, less costly covered service or equipment that meets the client's need(s); and

- The requested service or equipment will result in lower overall costs of care for the client.

The HRSA medical director or designee evaluates and considers requests on a case-by-case basis according to the information and documentation submitted from the provider. Within fifteen working days of HRSA's receipt of the request, HRSA notifies the provider and the client, in writing, of HRSA's decision to grant or deny the exception to rule.

Note: Clients do not have a right to a fair hearing on exception to rule decisions

Limitation Extension

What is a Limitation Extension?

A Limitation Extension (LE) is authorization for cases when HRSA determines that it is medically necessary to provide more units of service than allowed in HRSA's WAC and billing instructions.

How do I get LE authorization?

LE authorization must be in writing and is obtained by faxing or sending the required information as described below.

You must obtain written authorization for both of the following:

- LE - additional General Inpatient (GIP) days beyond the six allowed. Indicate the days of service that the additional days are being requested for;

- Prior Authorization (PA) - clients with AEM coverage

Your authorization request must include the following:

1. Name of agency and provider number;
2. Client's name and PIC number;
3. Procedure code and description of supply needed;
4. Copy of the original prescription; and
5. Explanation of client-specific medical necessity to exceed limitation.

To request prior authorization (PA) Fax a completed Basic Information form, DSHS 13-756, to 1-360-586-1471.

-or-

Send a request, along with any required forms, to:

HRSA – Medical Request Coordinator
Medical and Enteral Authorization Unit
PO Box 45506
Olympia, WA 98504-5506
1-360-586-1471 (fax)

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Hospice Coverage Table

Allowable Places of Service and Hospice Revenue Codes for Pediatric Palliative Care

The following is a chart explaining where hospice care may be performed:

Place of Service / Client Residence				
Type of Service/Levels of Care	**Client's Home (AFH, BH, AL)**	**Nursing Facility (NF)**	**Hospital**	**Hospice Care Center (HCC)**
Level 1: Routine Home Care (RHC) **(651)**	Yes Not in comb w/ any other code	Yes Not in comb w/ any other level of care	No	Yes Not in comb w/ any other level of care
Level 2: Continuous Home Care (CHC) **(652)** Hourly nursing	Yes Not in comb w/ any other code	No	No	No
Level 3: Inpatient Respite **(655)** Includes R/B	No	Yes For clients not residing in NF Not in comb w/ any other code	Yes Not in comb w/any other code	Yes For clients not residing in HCC Not in comb w/ any other code
Level 4: General Inpatient Care (GIP) **(656)** Includes R/B	No	Yes Not in comb w/ any other code	Yes Not in comb w/ any other code	Yes Not in comb w/ any other code
Nursing Facility (NF) R/B **(115,125,135)**	No	Yes Not in comb w/ 655 or 656	No	No
Hospice Care Center (HCC) **(145)** R/B Admin day rate	No	No	No	Yes Not in comb w/ 656 or 655
Pediatric Palliative Care (PPC) **(659)**	Yes Not for clients in a group home	No	No	No

Hospice Revenue Codes

Enter the following revenue codes and ***service descriptions*** in the appropriate form locators.

Revenue Code	Description of Code
115*	***Hospice (Room and Board - Private)*** Enter the words **"Room and Board"** in form locator 43. Enter the nursing facility's provider number in form locator 78.
125*	***Hospice (Room and Board - Semi-Private 2 Bed)*** Enter the words **"Room and Board"** in form locator 43. Enter the nursing facility's provider number in form locator 78.
135*	***Hospice (Room and Board - Semi-Private 3-4 Beds)*** Enter the words **"Room and Board"** in form locator 43. Enter the nursing facility's name or provider number in form locator 78 or in the remarks form locator.
145	***Hospice Care Center (Hospice Deluxe Room and Board)*** Enter the words **"Room and Board"** in form locator 43.
651	**Level 1: *Routine Home Care* (Hospice Daily Rate)**
652	**Level 2: *Continuous Home Care***
655	**Level 3: *Inpatient Respite Care***
656	**Level 4: *General Inpatient Care***

Note: For limitations, see **Billing** section.

Note: For hospice, you must choose one of four levels of care. Only nursing facility or hospice care center room and board can be billed with level 1. Do not bill other codes with levels 2, 3, or 4. Do not bill any other code with 659.

* For Revenue Codes 115, 125, and 135, download the Nursing Home Fee Schedule at: http://maa.dshs.wa.gov/ProRates/index.nursing_home_rates.html.

Pediatric Palliative Care (PPC) Revenue Codes

Revenue Code	Description of Code
659	***Other Hospice Services*** (Pediatric Palliative Care (PPC) Case Management/Coordination will be reimbursed according to the fee schedule.) See below for examples of use.
659	PPC - RN
659	PPC – PT
659	PPC – OT
659	PPC – ST
659	PPC – Case Management Time (Bill the date of service where each "two-hour time requirement" is met.)

Hospice Services Provided *Inside* the Client's Home

Revenue Codes		
651, 652, and 659 are paid according to the client's place of residence. Non-CBSA***** and out-of-state areas are paid as outlined in "All Other Areas."		
Counties	**CBSA**	**Policy/Comments**
All Other Areas	50	
Asotin	30300	
Benton	28420	
Chelan	48300	
Clark	38900	
Cowlitz	31020	
Douglas	48300	
Franklin	28420	
King	42644	
Kitsap	14740	
Pierce	45104	
Skagit	34580	
Skamania	38900	
Snohomish	42644	
Spokane	44060	
Thurston	36500	
Whatcom	13380	
Yakima	49420	

*** CBSA = Core Based Statistical Area**

Hospice Services Provided *Outside* Client's Home

Revenue Codes		
655 and 656 are paid according to the provider's place of business. Non-CBSA and out-of-state areas are paid as outlined in"All Other Areas."		
Counties	**County Code**	**Policy/Comments**
All Other Areas	50	
Asotin	30300	
Benton	28420	
Chelan	48300	
Clark	38900	
Cowlitz	31020	
Douglas	48300	
Franklin	28420	
King	42644	
Kitsap	14740	
Pierce	45104	
Skagit	34580	
Skamania	38900	
Snohomish	42644	
Spokane	44060	
Thurston	36500	
Whatcom	13380	
Yakima	49420	

*** CBSA = Core Based Statistical Area**

Note: See **Hospice Reimbursement** section for nursing facility and hospice care center reimbursement information.

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Hospice Provider Requirements

Election Statements and the Certification Process

[Refer to WAC 388-551-1310 (2)-(4)]

Election Statements

The election statement must be filed in the client's hospice medical record within two calendar days following the day the hospice care begins and requires all of the following:

- Name and address of the hospice agency that will provide the care;
- Documentation that the client is fully informed and understands hospice care and waiver of other Medicaid and/or Medicare services;
- Effective date of the election; and
- Signature of the client or the client's authorized representative.

Hospice Certification Process

The hospice certification process is described as follows:

When a client elects to receive hospice care, HRSA requires a hospice agency to

- Obtain a signed written certification of the client's terminal illness; or

- Document in the client's medical file that a verbal certification was obtained and follow up with a documented verbal certification and written certification signed by:

  - ✓ The medical director of the hospice agency or a physician staff member of the interdisciplinary team; and
  - ✓ The client's attending physician (if the client has one); and

- Place the signed written certification of the client's terminal illness in the client's medical file:

  - ✓ Within 60 days following the day the hospice care begins; and
  - ✓ Before billing HRSA for the hospice services.

Note: The hospice certification must specify that the client's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.

- For subsequent election periods, HRSA requires the hospice agency to:

  - ✓ Obtain a signed, written certification statement of the client's terminal illness; or
  - ✓ Document in the client's medical file that a verbal certification was obtained and follow up with a documented verbal certification and written certification signed by the medical director of the hospice agency or a physician member of the hospice agency; and
  - ✓ Place the written certification of the client's terminal illness in the client's medical file:
    - ➢ Within two calendar days following the beginning of a subsequent election period; and
    - ➢ Before billing HRSA for the hospice services.

When a client's hospice coverage ends within an election period (e.g. the client revokes hospice care), the remainder of that election period is forfeited. The client may reinstate the hospice benefit at any time by providing an election statement and meeting the certification process requirements.

Note: The hospice agency must notify the HRSA Hospice Program Manager of the start-of-care date within 5 working days of the first day of hospice services for all HRSA-eligible clients. This includes clients with third-party and/or Medicare coverage. If a client has Medicaid and you do not plan to bill Medicaid. You still must send HRSA a completed DSHS Medicaid Hospice Notification form [DSHS 13-746] to prevent duplication of payment between Medicare and Medicaid.

What Are HRSA's Requirements for the Hospice Plan of Care? [WAC 388-551-1320]

Hospice agencies must establish a written plan of care (POC) for a client that describes the hospice care to be provided. The POC must be in accordance with the Department of Health (DOH) requirements, as described in WAC 246-335-085, and meet the requirements in these billing instructions.

A registered nurse or physician must conduct an initial physical assessment of a client and develop the POC with at least one other member of the hospice interdisciplinary team.

At least two other hospice interdisciplinary team members must review the POC no later than two working days after it is developed.

The POC must be reviewed and updated every two weeks by at least three members of the hospice interdisciplinary team that includes at least:

- A registered nurse;
- A social worker; and
- One other hospice interdisciplinary team member.

Hospice Coordination of Care [Refer to WAC 388-551-1330]

A hospice agency must facilitate a client's continuity of care with nonhospice providers to ensure that medically necessary care, both related and not related to the terminal illness, is met. This includes:

- Determining if HRSA has approved a request for prescribed medical equipment, such as a wheelchair. If the prescribed item is not delivered to the client before the client becomes covered by a hospice agency, HRSA will rescind the approval [see WAC 388-543-1500];

  Example: A nursing facility orders a wheelchair for one of its clients. That client then chooses and is authorized for hospice care. The wheelchair arrives after the client has begun the first 90-day election period. The hospice agency may pay for the wheelchair or provide the medically necessary equipment. HRSA reimburses the hospice agency for the medical equipment through the appropriate hospice daily rate as described in WAC 388-551-1510 (6).

  Note: It may be appropriate to rent equipment in some cases.

- Communicating with other department programs and documenting the services a client is receiving in order to prevent duplication of payment and to ensure continuity of care. Other department programs include, but are not limited to, programs administered by the ADSA; and

- Documenting each contact with non-hospice providers.

> **Note:** The POC and service plan must both show the specific duties/services each will provide to prevent duplication of services.

When a client resides in a nursing facility, the hospice agency must:

- Coordinate the client's care with all providers, including pharmacies and medical vendors; and

- Provide the same level of hospice care the hospice agency provides to a client residing at home.

Once a client chooses hospice care, hospice agency staff must notify and inform the client of the following:

- By choosing hospice care from a hospice agency, the client gives up the right to:

  - ✓ Covered Medicaid hospice services (e.g., adult day health) and supplies received at the same time from another hospice agency; and

  - ✓ Any covered Medicaid services and supplies received from any other provider that are necessary for the palliation and management of the terminal illness and related medical conditions.

- Services and supplies are not paid through the hospice daily rate if they are:

  - ✓ Proven to be clinically unrelated to the palliation and management of the client's terminal illness and related medical conditions;

  - ✓ Not covered by the hospice daily rate;

  - ✓ Provided under a Title XIX Medicaid program when the services are similar to the hospice care services; or

  - ✓ Not necessary for the palliation and management of the client's terminal illness and related medical conditions.

A hospice agency must have written agreements with all contracted providers.

What Happens When a Client Leaves Hospice Care Without Notice? [WAC 388-551-1340]

When a client chooses to leave hospice care or refuses hospice care without giving the hospice agency a revocation statement, as required by WAC 388-551-1360, the hospice agency must do all of the following:

- Inform and notify in writing HRSA's Hospice Program Manager within 5 working days of becoming aware of the client's decision;
- Not bill HRSA for the client's last day of hospice services;
- Fax a completed copy of the DSHS Medicaid Hospice Notification form, DSHS 13-746, to the HRSA hospice/PPC notification number at 1-360-725-1965 to notify that the client is discharging from the hospice program;
- Notify the client, or the client's authorized representative, that the client's discharge has been reported to HRSA; and
- Document the effective date and details of the discharge in the client's hospice record.

May a hospice agency discharge a client from hospice care? [WAC 388-551-1350]

A **hospice agency** may discharge a client from hospice care when the client:

- Is no longer certified (decertified) for hospice care;
- Is no longer appropriate for hospice care (see page A.1); or
- The hospice agency's medical director determines the client is seeking treatment for the terminal illness outside the plan of care.

At the time of a client's ***discharge***, the hospice agency must:

- Inform and notify in writing HRSA's Hospice Program Manager within 5 working days of the reason for discharge;
- Fax a completed copy of the DSHS Medicaid Hospice Notification form, DSHS 13-746, to the HRSA hospice/PPC notification number at 1-360-725-1965;
- Keep the discharge statement in the client's hospice record;
- Provide the client with a copy of the discharge statement; and

- Inform the client that the discharge statement must be:

  ✓ Presented with the client's current Medical ID Card when obtaining Medicaid-covered healthcare services, supplies, or both; and

  ✓ Used until the department issues the client a new Medical ID Card which identifies that the client is no longer a hospice client.

May a client choose to end (revoke) hospice care? [WAC 388-551-1360]

A client or authorized representative may choose to stop hospice care at any time by signing a **revocation** statement.

The revocation statement documents the client's choice to stop Medicaid hospice care. The revocation statement must include all of the following:

- Client's (or authorized representative's) signature;
- Date the revocation was signed;
- Actual date that the client chose to stop receiving hospice care; and
- The client-specific reason for revocation.

The hospice agency must keep an explanation supporting any difference in the signature and revocation dates in the client's hospice records.

When a client revokes hospice care, the hospice agency must:

- Inform and notify HRSA's Hospice Program Manager within 5 working days of becoming aware of the client's decision;

- Fax a completed copy of the DSHS Medicaid Hospice Notification form DSHS, 13-746, to the HRSA hospice/PPC notification number at 1-360-725-1965;

- Not bill HRSA for the client's last day of hospice services;

- Keep the revocation statement in the client's hospice record;

- Provide the client with a copy of the revocation statement; and

- Inform the client that the revocation statement must be:

  ✓ Presented with the client's current Medical ID Card when obtaining Medicaid-covered healthcare services, supplies, or both; and

  ✓ Used until the department issues the client a new Medical ID Card that identifies that the client is no longer a hospice client.

After a client revokes hospice care, the remaining days within the current election period are forfeited. The client may immediately enter the next consecutive election period. The client does not have to wait for the forfeited days to pass before entering the next consecutive election period.

What happens when the client dies? [WAC 388-551-1370]

When a client dies, the hospice agency must:

- Inform and notify in writing HRSA's Hospice Program Manager within 5 working days; and

- Fax a completed copy of the DSHS Medicaid Hospice Notification form, DSHS 13-746, that documents the date of death to the HRSA hospice/PPC notification number at 1-360-725-1965.

What Are the Notification Requirements for Hospice Agencies? [Refer to WAC 388-551-1400]

To ensure a hospice client receives quality of care, and to ensure HRSA determines accurate coverage and reimbursement for services that are related to the client's terminal illness or related conditions, a hospice agency must meet the following notification requirements. To be reimbursed for providing hospice services, the hospice agency must report to the HRSA Hospice Program Manager within 5 working days from when an HRSA client begins the first day of hospice care, or has a change in hospice status:

- The name and address of the hospice agency;
- The date of a client's first day of hospice care;

> **Note:** When a hospice agency does not notify HRSA within 5 working days of the date of the client's first day of hospice care, HRSA authorizes the hospice daily rate or nursing facility room and board reimbursement effective the fifth working day prior to the date of notification.

- A change in a client's primary physician;
- A client's revocation of the hospice benefit (home or institutional);
- The date a client leaves hospice without notice;
- A client's discharge from hospice care;
- A client who admits to a nursing facility (This does not apply to an admit for inpatient respite care or general inpatient care.);
- A client who admits to or discharges from a nursing facility/hospice care center, except for General Impatient (GIP) Hospice Care or respite;
- A client becomes eligible for Medicare or third-party liability insurance;

- A client who dies; or
- A client who transfers to another hospice agency. Both the former agency and the current agency must provide HRSA with:

  ✓ The client's name, the name of the former hospice agency serving the client, and the effective date of the client's discharge; and

  ✓ The name of the current hospice agency serving the client, the hospice agency's provider number, and the effective date of the client's admission.

HRSA does not require a hospice agency to notify the HRSA Hospice Program Manager when a hospice client is admitted to a hospital for palliative care.

Note: Failure to properly notify HRSA of a client's discharge or revocation from hospice care could result in the client being denied medically necessary services, and the provider being denied payment.

For example: The client revokes hospice care. The hospice agency fails to notify HRSA's Hospice Program Manager within 5 working days. The client and/or family attempt to get a prescription filled at the pharmacy. The pharmacist does not fill the prescription because the client is on hospice. The client or family is then forced to go without, or pay for the prescription. According to WAC, the pharmacy cannot legally force Medicaid clients to pay for their drugs when the drugs are a covered service.

Should I Notify HRSA if Medicaid Is Not Primary?

Yes! Notify HRSA even if the client has Medicare or other Third Party Liability (TPL) insurance and you are not intending to bill HRSA. In order to bill HRSA, the hospice agency must ensure that the client meets Medicaid criteria.

Notify the HRSA Hospice Program Manager ANYTIME there is a change in the client's hospice ***election status***. If you need clarification or have questions, call the HRSA Hospice Program Manager (see *Important Contacts* section).

Notifying Clients of Their Rights (Advance Directives)

[42 CFR, Subpart I]

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give ***all adult clients*** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

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Hospice Reimbursement

How Does HRSA Determine What Rate to Pay?

[Refer to WAC 388-551-1510]

> **Note:** Prior to submitting a claim to HRSA, a hospice agency must file written certification in a client's hospice record. (Refer to "Election Statements and the Certification Process" on page D.1.)

- HRSA pays for hospice care provided to clients in one of the following settings:
  - ✓ A client's residence.
  - ✓ An HRSA-approved nursing facility, hospital, or hospice care center.
- To be paid by HRSA, the hospice agency must provide and/or coordinate HRSA-covered hospice services including:
  - ✓ Medicaid hospice services; and
  - ✓ Services that relate to the client's terminal illness any time during the hospice election.
- Hospice agencies must bill HRSA for their services using hospice-specific revenue codes (see **Allowable Places of Service and Hospice Revenue Codes** section).
- HRSA pays hospice agencies for services (not room and/or board) at a daily rate calculated by one of the following methods:
  - ✓ Payments for services delivered in a client's residence (routine and continuous home care) are based on the county location of the client's residence for that particular client; or
  - ✓ Payments for respite and general inpatient hospice care are based on the county location of the providing hospice agency.

> **Note:** The daily rate for authorized out-of-state hospice services is the same as that for in-state non-Metropolitan Statistical Area (MSA) hospice services.

When Does HRSA Pay for the Client's Last Day of Hospice Care? [Refer to WAC 388-551-1510 (6) and (9)]

What Types of Care Does HRSA Pay for?

- HRSA pays for routine hospice care, continuous home care, respite care, or general inpatient care for the day of death.

What Does HRSA Not Pay for?

- Does not pay room and board for the day of death;
- Does not pay hospice agencies for the client's last day of hospice care when a client discharges, revokes, or transfers; and
- Does not pay hospice agencies or hospice care centers a nursing facility room and board payment for:

  - ✓ A client's last day of hospice care (e.g., client's discharge, revocation, or transfer); or
  - ✓ The day of death.

How Does HRSA Reimburse for Nursing Facility Residents?

[Refer to WAC 388-551-1510 (8)]

HRSA pays nursing facility room and board payments to hospice agencies, not licensed as hospitals, at a daily rate as follows:

- Directly to the hospice agency at 95% of the nursing facility's current Medicaid daily rate in effect on the date the services were provided;

- The hospice agency pays the nursing facility at a daily rate not greater than the nursing facility's current Medicaid daily rate.

How Does HRSA Reimburse for Hospice Care Center (HCC) Residents? [Refer to WAC 388-551-1510 (9)]

HRSA pays an HCC a daily rate for room and board based on the average room and board rate for all nursing facilities in effect on the date the services were provided.

Client Participation [Refer to WAC 388-551-1510]

Hospice clients may be responsible to pay for part of their care (participation). If the client is assigned participation, the hospice agency is responsible for collecting (the hospice agency may contract out if it does not choose to collect) the client's monthly participation amount stated in the Notice of Action (award) letter sent by DSHS to the client. If the client is on the COPES program, the participation goes to the COPES provider. The HCS office or CSO sends a copy of the letter to the hospice agency when requested with the DSHS Medicaid Hospice Notification form, DSHS #13-746.

Note: Do NOT bill HRSA for the participation amount. Instead, bill HRSA your usual and customary charge. See below instructions for how to indicate a client's participation amount on your claim.

The correct amount of the client's participation is the responsibility of the hospice agency and must be:

- **For Hospice Care Centers (HCC):**

  - ✓ Indicated on the UB-04 claim form in form locator 31 using value code D3 followed by the client's participation amount, whether or not the HCC collects participation from the client, or HRSA may recoup the participation amount from the HCC. When billing, enter the total charges (form locator 47) minus the client participation (form locator 31) in form locator 55 (Est. Amount Due); and

  - ✓ Collected by the HCC each month as directed by the notice of action (award letter) issued by the department.

- **For Nursing Facilities:**

  - ✓ Indicated on the UB-04 claim form in form locator 39 using value code 31 followed by the client's participation amount, whether or not the nursing facility collects participation from the client, or HRSA may recoup the participation amount from the hospice agency. When billing, enter the total charges (form locator 47) minus the client participation (form locator 39) in form locator 55 (Est. Amount Due);

  - ✓ Collected by the hospice agency or nursing facility (if contracted to do so) each month as directed by the notice of action (award letter) issued by the department; and

  - ✓ Forwarded to the nursing facility.

How Does DSHS Reimburse for Clients Under the Community Options Program Entry System (COPES) Program? [WAC 388-551-1510 (9)]

The department's Aging and Disability Services Administration (ADSA) pays for services provided to a client eligible under the COPES program directly to the COPES provider and:

- The client's monthly participation amount in that case is paid separately to the COPES provider; and
- Hospice agencies must bill HRSA directly for hospice services, not the COPES program.

When Does HRSA Reimburse Hospitals Providing Care to Hospice Clients? [WAC 388-551-1520 (1)]

HRSA pays hospitals that provide inpatient care to clients in the hospice program when the medical condition is **not** related to their terminal illness. (Refer to HRSA's current *Inpatient Hospital Billing Instructions* or *Outpatient Hospital Billing Instructions*.)

How Does DSHS Reimburse for the Following Physician Services?

Administrative and Supervisory Services

Administrative and general supervisory activities performed by physicians are **included** in the hospice daily rate. These physicians are either employees of the hospice or are working under arrangements made with the hospice agency. The physician serving as the medical director of the hospice and/or the physician member of the hospice interdisciplinary team would generally perform the following activities:

- Physician participation in the establishment of plans of care;
- The supervision of care and services;
- The periodic review and updating of plans of care; **and**
- The establishment of governing policies.

Note: The above activities cannot be billed separately

Physician Services not Related to the Hospice Diagnosis Provided by Physicians Not Employed by the Hospice Agency to Hospice Clients
[WAC 388-551-1520 (2)]

HRSA pays providers, who are attending physicians and not employed by the hospice agency, the usual and customary charge through the Resource-Based Relative Value Scale (RBRVS) fee schedule published in HRSA's current *Physician-Related Services Billing Instructions*:

- For direct physician care services provided to a hospice client;
- When the provided services are not related to the terminal illness; and
- When the client's providers, including the hospice provider, coordinate the health care provided.

Download the Physician Related Services Fee Schedule at
http://maa.dshs.wa.gov/RBRVS/Index.html#P

Professional Services Related to the Hospice Diagnosis

Refer to the Physician Related Services Fee Schedule found in HRSA's current *Physician-Related Services Billing Instructions.*

Who can bill professional services?

HRSA reimburses for professional services only when they are billed by one of the following:

- Primary Physician;

- Hospice Agency (using Hospice Clinic # beginning with 7xxxxxx);

- Consulting physicians or those providing backup care for the primary physician**.** Consulting physicians must be coordinated with the hospice agency; or

- Radiologist/laboratory: When billing for the professional component, include **modifier 26** in field 24 D on the 1500 claim form, along with the appropriate procedure code. (See #1 or #2 below, as applicable.) Charges for the technical component of these services, such as lab and x-rays, are **included** in the hospice daily rate and may not be billed separately.

What provider number do I use?

Bill HRSA for all professional services in one of the following ways:

1. When the primary physician performs the service, bill using the National Provider Identifier (NPI) number and the DSHS provider number. See # Memo 07-03 for more information regarding field placement on the 1500 Claim Form.

   Include the following information on the 1500 claim form:

Field #	What do I need to put here?
33 – GRP#	Primary Physician's or Clinic's Provider Number

- OR -

2. When a physician, other than the primary physician, performs the service, bill using the primary physician provider number. *Include the following information on the 1500 claim form:*

Field #	What do I need to put here?
17 and 17a	Primary Physician Name or Clinic Name and Provider Number
33 – PIN#	Performing Provider Number
33 – GRP#	Hospice Agency, lab, radiology, consulting physician, or clinic provider number

How Does HRSA Reimburse for Medicaid-Medicare Dual Eligible Clients? [WAC 388-551-1530]

HRSA does not pay for any hospice care provided to a client covered by Medicare part A (hospital insurance).

HRSA may pay for hospice care provided to a client:

- Covered by Medicare Part B (medical insurance); and
- Not covered by Medicare Part A.

Hospice agencies must bill:

- Medicare before billing HRSA; and
- HRSA for hospice nursing facility room and board, using the nursing facility's name or the HRSA-assigned provider number in form locator 78 on the UB-04 claim form.

Fee Schedule

You may view HRSA's **Hospice Services Fee Schedule** on-line at
http://maa.dshs.wa.gov/RBRVS/Index.html

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Pediatric Palliative Care Case Management/Coordination Services

About the Services [WAC 388-551-1800]

Through a hospice agency, HRSA pediatric palliative care (PPC) case management/coordination services provide the care coordination and skilled care services to clients who have life-limiting medical conditions. Family members and caregivers of clients eligible for pediatric palliative care services may also receive support through care coordination when the services are related to the client's medical needs.

Client Eligibility [WAC 388-551-1810]

Who Is Eligible?

To receive PPC case management/coordination services, a person must:

- Be 20 years of age or younger;
- Have a current Medical ID Card with one of the identifiers located on page B.1;
- Have a life-limiting medical condition with a complex set of needs requiring case management and coordination of medical services due to at least three of the following five circumstances:
  - ✓ An immediate medical needs during a time of crises;
  - ✓ Coordination with family member(s) and providers required in more than one setting (i.e. school, home, and multiple medical offices or clinics);
  - ✓ A life-limiting medical condition that impacts cognitive, social, and physical development;
  - ✓ A medical condition with which the family is unable to cope;
  - ✓ A family member(s) and/or caregiver who needs additional knowledge or assistance with the client's medical needs; and
  - ✓ Therapeutic goals focused on quality of life, comfort, and family stability.

Are Clients Enrolled in Managed Care Eligible for PPC Services?
[Refer to WAC 388-551-1200 (2)]

Yes! Clients whose Medical ID Cards have an HMO identifier in the HMO column are enrolled in an HRSA managed care plan. A client enrolled in one of HRSA's managed care plans must receive all PPC services, including nursing facility room and board, directly through that plan. The client's managed care plan is responsible for arranging and providing all PPC services for a client enrolled in a managed care plan. The plan's toll free telephone number is located on the client's Medical ID Card. HRSA does not process or reimburse claims for managed care clients for services provided under the Healthy Options contract.

> **Note:** To prevent denials of billed claims, please check the client's Medical ID Card/WAMedWeb *prior* to scheduling services and at the *time of the service* to make sure proper authorization or referral is obtained from the PCCM.

Coverage **[Refer to WAC 388-551-1820]**

What Is Covered?

HRSA's PPC case management/coordination services cover up to six (6) PPC contacts per client, per calendar month.

> **Note:** If more than six contacts are routinely needed the child may not be appropriate for PPC.

If more than 6 contacts are medically necessary, complete the following:

- HRSA Home Health & Hospice (including PPC) Authorization Request form, DSHS 13-847.
- The child's plan of care.

Fax both items above to the Home Health and Hospice Program Manager at 1-360-586-1471.

Download DSHS 13-847 at: http://www1.dshs.wa.gov/word/ms/forms/13_847.doc

What Is Included in a PPC Contact?

A PPC contact includes:

- One visit with a registered nurse, social worker, or therapist (for the purposes of these billing instructions, HRSA defines therapist as a licensed physical therapist, occupational therapist, or speech/language therapist) with the client in the client's residence to address:

  - ✓ Pain and symptom management;
  - ✓ Psychosocial counseling; or
  - ✓ Education/training;

- Two hours or more per month of case management or coordination services to include any combination of the following:

  - ✓ Psychosocial counseling services (includes grief support provided to the client, client's family member(s), or client's caregiver prior to the client's death);

  - ✓ Establishing or implementing care conferences;

  - ✓ Arranging, planning, coordinating, and evaluating community resources to meet the child's needs; and

  - ✓ Visits lasting 20 minutes or less (for example: visits to give injections, drop off supplies, or make appointments for other PPC-related services); and

  - ✓ Visits not provided in the client's home.

Note: Two hours of case management equals one contact and one visit equals one contact. You can get 6 contacts with any combination. Unbilled case management hours do not carry over to the next month.

What Is Not Covered?

HRSA does not pay for a PPC contact when a client is receiving **similar services** from any of the following:

- ✓ Home Health program;
- ✓ Hospice program;
- ✓ Private duty nursing (private duty nursing can subcontract with PPC to provide services);
- ✓ Disease case management program; or
- ✓ Any other department program that provides similar services.

HRSA does not pay for a PPC contact that includes providing counseling services to a client's family member or the client's caregiver for grief or bereavement for dates of service **after a client's death**.

How Does a Hospice Agency Become an HRSA-Approved PPC Provider? [WAC 388-551-1830]

> **Note:** This section does not apply to providers who already are HRSA-approved PPC providers.

To apply to become an HRSA-approved PPC provider, a provider must:

- Be an HRSA-approved hospice agency (see page A.1 and A.2); and
- Submit a letter to HRSA's Hospice/PPC program manager (see *Important Contacts* section) requesting to become an HRSA-approved provider of PPC and include a copy of the provider's policies and position descriptions with minimum qualifications specific to pediatric palliative care.

Provider Requirements [WAC 388-550-1840]

An eligible provider of PPC case management/coordination services must do all of the following:

- Meet the conditions in "How does a hospice agency become an HRSA-approved hospice agency?" on page A.1 of these billing instructions;
- Confirm that a client meets the eligibility criteria on page F.1 prior to providing PPC services;
- Obtain a written referral to HRSA's PPC program manager from the client's physician;
- Determine and document in the client's medical record the medical necessity for the initial and ongoing care coordination of PPC services;
- Document in the client's medical record:
  - ✓ A palliative plan of care (POC) (a written document based on assessment of a client's individual needs that identifies services to meet those needs.);
  - ✓ The medical necessity for those services to be provided in the client's residence; and
  - ✓ Discharge planning.
- Provide medically necessary skilled interventions and psychosocial counseling services by qualified interdisciplinary hospice team members.
- Assign and make available a PPC case manager (nurse, therapist, or social worker) to implement care coordination with community-based providers to ensure clarity, effectiveness, and safety of the client's POC.

- Notify the HRSA PPC Program Manager within 5 working days from the date of occurrence of the client's:

  ✓ Date of enrollment in PPC;

  ✓ Discharge from the hospice agency or PPC when the client:

  - ➢ No longer meets PPC criteria;
  - ➢ Is able to receive all care in the community;
  - ➢ Does not require any services for sixty days; or
  - ➢ Discharges from PPC to enroll in HRSA's Hospice program;

  ✓ Transfer to another hospice agency for pediatric palliative care services; or

  ✓ Death.

Note: The Referral for Pediatric Palliative Care (PPC), DSHS # 13-752, is located at http://www1.dshs.wa.gov/msa/forms/eforms.html. A sample notification form is included at the end of these billing instructions.

- Maintain the client's file which includes the POC, visit notes, and all of the following:

  ✓ The client's start of care date and dates of service;

  ✓ Discipline and services provided (in-home or place of service);

  ✓ Case management activity and documentation of hours of work; and

  ✓ Specific documentation of the client's response to the palliative care and the client's and/or client's family's response to the effectiveness of the palliative care (e.g., the client might have required acute care or hospital emergency room visits without the pediatric palliative care services).

- Provide when requested by HRSA's PPC program manager, a copy of the client's POC, visit notes, and any other documents listing the information identified above.

If HRSA determines that documentation in the POC or attachment to the POC does not meet the criteria for a client's PPC eligibility or does not justify the billed amount, any payment to the provider is subject to recoupment by HRSA.

> **Note:** Therapy services may be provided in outpatient settings and billed with the client's Medical ID Card. Some children are not appropriate for outpatient therapy and would be best served in the home. The documentation on the PPC POC would note the medical necessity.

Pediatric Palliative Care (PPC) Revenue Code

Revenue Code	Description of Code
659	***Other Hospice Services*** (Pediatric Palliative Care (PPC) Case Management/Coordination will be reimbursed according to the fee schedule.) See below for examples of use:
659	PPC – RN
659	PPC – PT
659	PPC – OT
659	PPC – ST
659	PPC – Case Management Time (Bill the date of service each two-hour time requirement was met.

Reimbursement

How Does HRSA Pay for PPC Services?

HRSA pays providers for PPC case management/coordination services per contact using the average of statewide Core Based Statistical Area (CBSA) home health care rates for skilled nursing, physical therapy, speech-language therapy, and occupational therapy.

HRSA makes adjustments to the reimbursement rate for PPC contacts when the legislature grants a vender rate change. New rates become effective as directed by the legislature and are effective until the next rate change. The reimbursement rate for authorized out-of-state PPC services is paid at the "All Other Areas" CBSA rate.

Fee Schedule

You may view HRSA's **Hospice Services Fee Schedule** on-line at http://maa.dshs.wa.gov/RBRVS/Index.html

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Billing

What Are the General Billing Requirements?

Providers must follow the general billing requirement in **DSHS's *General Information Booklet*** (http://maa.dshs.wa.gov/download/BillingInstructions/General_Information_BI.pdf). These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims;
- What fee to bill DSHS for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- How to bill for services provided to clients eligible to both Medicare and Medicaid; and
- Record keeping requirements.

How to Complete the UB-04 Claim Form

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual are available from the National Uniform Billing Committee at: http://www.nubc.org/index.html. **Instructions specific to Hospice and PPC providers are below.**

To see a sample of the UB-04 Claim Form, see the *General Information Booklet*.

Form Locator	Type of Bill	Field Required	Entry
4	Type of Bill	Yes	These types of Bill Codes are to be used to correctly identify Washington State Medicaid Hospice Claims: 081x – Special Facility – Hospice (non-hospital based) 082x - Special Facility – Hospice (hospital based) (The x is the billing Frequency Code and should be replaced with the appropriate code from the data specifications)
39a	Value Codes	Situational	Use this field to report a client's Participation amount. Enter code 31 (Patient Liability Amount) in the "Code" column and the client's total participation from the award letter in the "Amount" column.

How to Complete the CMS-1500 Claim Form

Note: HRSA encourages providers to make use of electronic billing options. For information about electronic billing, refer to the *Important Contacts* section.

For instructions on completing the 1500 Claim Form. Refer to HRSA's current *General Information Booklet* at http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html

The following CMS-1500 claim form instructions relate to **Hospice Services Billing Instructions**. Click the link above to view general CMS-1500 Claim Form instructions.

For questions regarding claims information, call HRSA toll-free:
1-800-562-3022

CMS-1500 Claim Form Field Descriptions

Field No.	Name	Field Required	Entry	
19	**Reserved for Local Use**	When applicable	If the client has no Part A coverage, enter the statement "Client has Medicare Part B coverage only" in this field.	
Code(s) only appropriate for Washington State Medicaid:				
24B	**Place of Service**	Yes	**Code Number**	**To Be Used For**
			12	Client's Residence
			21	Inpatient Hospital
			23	Emergency Room
			24	Outpatient Hospital, Office or Ambulatory Surgery Center
			31	Nursing Facility
			34	Hospice Care Center
			99	Other

How to Complete the CMS-1500 Claim Form for Medicare Part B/Medicaid Crossovers

The 1500 Claim Form (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide. The numbered boxes on the claim form are referred to as ***fields***. A number of the fields on the form do not apply when billing the HRSA. Some field titles may not reflect their usage for this claim type. Use the instructions below to complete the 1500 Claim Form for crossover claims.

Note: The 1500 Claim Form, used for Medicare/Medicaid Benefits Coordination, *cannot* be billed electronically.

General Instructions

- Use an original, red and white 1500 Claim Form (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional 1500 Claim Form.
- All information must be entered within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the 1500 Claim Form.
- Attach a complete, legible Medicare EOMB or the claim will be denied.

<table>
<tr><th>Field No.</th><th>Name</th><th>Field Required</th><th colspan="2">Entry</th></tr>
<tr><td colspan="5">Code(s) only appropriate for Washington State Medicaid:</td></tr>
<tr><td rowspan="8">24B</td><td rowspan="8">Place of Service</td><td rowspan="8">Yes</td><td>Code Number</td><td>24B</td></tr>
<tr><td>12</td><td>Client's Residence</td></tr>
<tr><td>21</td><td>Inpatient Hospital</td></tr>
<tr><td>23</td><td>Emergency Room</td></tr>
<tr><td>24</td><td>Outpatient Hospital, Office or Ambulatory Surgery Center</td></tr>
<tr><td>31</td><td>Nursing Facility</td></tr>
<tr><td>34</td><td>Hospice Care Center</td></tr>
<tr><td>99</td><td>Other</td></tr>
<tr><td>24G</td><td>Days or Units</td><td>Yes</td><td colspan="2">Enter 1</td></tr>
</table>

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