Washington Apple Health

HOSPICE SERVICES
Provider Guide

(Hospice Agencies, Hospice Care Centers, and Pediatric Palliative Care Providers)

June 1, 2016

Washington State Health Care Authority

About this guide*

This publication takes effect June 1, 2016, and supersedes earlier guides to this program.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

What has changed?

Subject	Change	Reason for Change
Hospice Reimbursement	**Changes to hospice reimbursement are retroactive to January 1, 2016 (updated 8/19/16).** Added two sections: *Billing for routine home care – revenue code 0651* *End-of-life service intensity add-on payment*	Policy change from Centers for Medicare and Medicaid Services (CMS).

* This publication is a billing instruction.

How can I get agency provider documents?

To download and print agency provider guides, go to the agency's website.

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Important Changes to Apple Health Effective April 1, 2016

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. A Provider FAQ is available on the Washington Apple Health (Medicaid) providers webpage.

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO **the same month** they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

- **New clients** are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health Managed Care.

- **Renewing clients** are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

How does this policy affect providers?

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's **Get Help Enrolling** page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's new policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs will replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the Mental Health Provider guide. BHOs use the Access to Care Standards (ACS) for mental health conditions and American Society of Addiction Medicine (ASAM) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act for individuals who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for individuals who are not eligible for Medicaid. Beacon Health Options is also

responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health fee-for-service managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women
- Individuals in Institutions for Mental Diseases (IMD)
- Long-term care residents who are currently in fee-for-service
- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid fee-for-service clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A BHSO fact sheet is available online.

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will **not** be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who **live in** Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards

to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who **live outside** Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.

Contact Information for Southwest Washington

Beginning on April 1, 2016, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can be located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

MOLINA HEALTHCARE	Molina Healthcare of Washington, Inc. 1-800-869-7165

COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009

Beacon Health Options	Beacon Health Options 1-855-228-6502

Resources Available

Topic	Contact Information
Who do I contact if I have questions regarding hospice or Pediatric Palliative Care (PPC) Case Management/Coordination policies or need information on notification requirements?	• Hospice/PPC Program Manager 360-725-1611 (clinical questions phone number) • Billing questions 800-562-3022 (customer service line for claims) • HCA - Division of Healthcare Services PO Box 45506 Olympia, WA 98504-5506
Who do I contact if I have questions regarding medications not related to the hospice diagnosis?	Pharmacy only providers 800-848-2842 All other providers 800-562-3022
How do I obtain Medicaid agency's Hospice program forms?	View and download the *HCA/Medicaid Hospice Notification* form, HCA 13-746, and the *Pediatric Palliative Care (PPC) Referral and 5 - Day Notification* form, HCA 13-752.
Where is the Hospice Services fee schedule?	See the Medicaid agency's Hospice Fee Schedule.
How do I obtain prior authorization or a limitation extension?	For all requests for prior authorization or limitation extensions, the following documentation is required: • A completed, TYPED *General Information for Authorization* form, HCA 13-835. This request form **MUST** be the initial page when you submit your request. • A completed *Hospice (including PPC) Authorization Request* form, HCA13-848, and all the documentation listed on this form and any other medical justification. Fax your request to: 866-668-1214. See the Medicaid agency's Resources Available web page.
How do I find out where my local Community Services Office (CSO) is located?	See Community Services Office.
How do I find out where my local Home and Community Services (HCS) office is located?	See Home and Community Services.

Definitions

This section defines terms and abbreviations, including acronyms, used in this provider guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

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

Aging and Long-Term Support Administration (ALTSA) - The Aging and Long-Term Support Administration in the Department of Social and Health Services (DSHS) that assists children and adults with developmental delays or disabilities, cognitive impairment, chronic illness, and related functional disabilities.

Authorized representative - A person 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. (RCW 7.70.065).

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

Biology – Medicinal preparations, including serum, vaccine autotoxins, and biotechnological drugs made from living organisms and their products.

Brief period – Six days or less within a 30 consecutive day period.

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 Medicaid agency hospice client.
- Signed by the physician and/or hospice medical director.

Concurrent care – Palliative and curative medically necessary services delivered at the same time as hospice services, providing a blend of curative and palliative services for clients age 20 and younger who are:

- Enrolled in hospice.
- Also able to receive other Medicaid-covered services not included in the hospice benefit. (WAC 182-551-1860)

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. (The Medicaid agency 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 a client 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.

Curative care – Treatment aimed at achieving a disease-free state.

Discharge – A hospice agency ends hospice care for a client.

DSHS – Department of Social and Health Services.

Election period – The time, 90 or 60 days, that the client is certified as eligible for and chooses to receive hospice care.

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

Family – A person or people who are important to, and designated in writing by, the client and need not be relatives, or who is legally authorized to represent the client.

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 agency -approved:
  - ✓ Hospitals.
  - ✓ Nursing facilities.
  - ✓ Hospice care centers.

Home - See Residence.

Home health aide – A person registered or certified as a nursing assistant under RCW 18.88A.020 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.

Home Health Aide Services – Services provided by home health aides employed by 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, occupational therapist, or speech therapist. This care may include:

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

Homemaker – A person 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 for clients 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 this provider guide, requirements for hospice agencies also apply to hospice care centers.)

Hospice aide – A person registered or certified as a nursing assistant under Chapter 18.88A 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 clients of a hospice agency or hospice care center.

Hospice aide services – Services provided by hospice aides employed by an in-home services agency licensed to provide hospice, or hospice care services under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist. This care may include:

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

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.

Hospice daily rate - The dollar amount the Medicaid agency will reimburse for each day of care.

Hospice services - Symptom and pain management provided to a terminally ill client,and emotional, spiritual, and bereavement support for the clientand client's family in a place of temporary or permanent residence.

Inpatient respite care - See Respite Care.

Interdisciplinary team – The group of people involved in the client care providing hospice services or hospice care center services, including, at a minimum, a physician, registered nurse, social worker, spiritual counselor, and volunteer. (WAC 182-551-1010)

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.

Palliative – Medical treatment designed to reduce pain or increase comfort, rather than cure.

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

Pediatric Palliative Care (PPC) - 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.

Referring provider – A client's primary or general practitioner, or a physician or nurse practitioner who has consulted with the cient's primary or general practitioner.

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
- Skin breakdown prevention/treatment due to peripheral edema

Residence – A client's home or place of living.

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

Revoke or revocation – The choice to stop receiving hospice care.

Routine home care – Intermittent care received by the client at the client's 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.

24-hour day – A day beginning and ending at midnight.

About the Hospice Program

What is the hospice program?

(WAC 182-551-1000)

The Medicaid agency hospice program is a 24-hour a day program that allows a terminally ill client to choose physical, pastoral, spiritual, and psychosocial comfort care and focus on quality of life. 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 (POC). Hospitalization is used only for acute symptom management.

A client, 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.
- 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 approved to provide Medicaid services?

(WAC 182-551-1300 and -1305)

To become a Medicaid-approved hospice agency with Medicaid, the Medicaid agency requires a hospice agency to provide documentation that it is Medicare, Title XVIII-certified by the Department of Health (DOH) as a hospice agency and meet the requirements in:

- Chapter 182-551 WAC Subchapter I, Hospice Services.
- Chapter 182-502 WAC, Administration of Medical Programs-Providers.
- Title XVIII Medicare Program.

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

How does a hospice care center become an approved provider with Medicaid?

To become an approved hospice care center with Medicaid, the hospice agency must:

- Be enrolled as an approved hospice agency with Medicaid.
  (See How does a hospice agency become approved to provide Medicaid services?)

- Submit a letter of request to:

  Health Care Authority - Medicaid Program
  Hospice Program Manager
  P.O. Box 45506
  Olympia, WA 98504-5506

A hospice agency must provide all 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.
- ✓ Providing one or more levels of hospice care such as:
  - ➢ Routine home care.
  - ➢ Inpatient respite care.
  - ➢ General inpatient care (requires a registered nurse on duty 24 hours a day, seven days a week).

A hospice agency qualifies as an approved hospice care center with Medicaid when:

- All the requirements are met.
- The Medicaid agency provides the hospice agency with written notification.

How are hospice election statements used?

(WAC 182-551-1310 (1))

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

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.
- Does not revoke the election (see What happens when a client leaves hospice care without notice?).

See Pediatric Palliative Care.

When are face-to-face encounters required?

(WAC 182-551-1310)

The reffering provider must have a face-to-face encounter with every hospice client:

- Within 30 days of the 180th day recertification.
- Before each subsequent recertification to determine if the client continues to meet eligibility for hospice care. (In other words, a physician or ARNP certifies that the client's life expectancy is six months or less, that the client's condition continues to decline, and that the client continues to meet criteria for hospice level of care.)

> **Note:** The Medicaid agency does not pay for face-to-face encounters to recertify a hospice client.

The referring provider must attest that the face-to-face encounter took place.
The hospice agency must:

- Document in the client's medical file that a verbal certification was obtained.
- Follow-up a documented verbal certification with a written certification signed by the medical director of the hospice agency, or physician staff member of the hospice agency.

- Place a 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.
  - ✓ Before billing the Medicaid agency for the hospice services.

Hospice agencies **must** submit a written certification to the Medicaid agency with the hospice claim related to the recertification. The written notification can be added to the claim after the claim has been received by the Medicaid agency.

For instructions on how to add attachments to claims, see the ProviderOne Billing and Resource Guide.

Hospice Provider Requirements

(WAC 182-551-1310 (2)-(4))

Are election statements required in the client's hospice medical record?

Yes. The election statement must be filed in the client's hospice medical record within two calendar days following the day the hospice care begins. An election statement 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 or Medicare services, or both
- Effective date of the election
- Signature of the client or the client's authorized representative

What is the hospice certification process?

The hospice certification process is as follows:

When a client elects to receive hospice care, the Medicaid agency 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 a written certification signed by:
  - ✓ The medical director of the hospice agency or a physician staff member of the interdisciplinary team.
  - ✓ The client's attending physician (if the client has one).

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

  - ✓ Within 60 days following the day the hospice care begins.
  - ✓ Before billing the Medicaid agency 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, the Medicaid agency requires the hospice agency to:

  - ✓ Obtain a signed, written certification statement of the client's terminal illness.

  - ✓ 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.

  - ✓ 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.

    - ➢ Before billing the Medicaid agency 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 Medicaid agency Hospice program manager of the start-of-care date within five working days of the first day of hospice services for all Medicaid agency-eligible clients. This includes clients with third-party or Medicare coverage or both. If a client has Medicaid and the hospice agency does not plan to bill Medicaid, the hospice agency still must send the Medicaid agency a completed *HCA/Medicaid Hospice Notification* form, HCA 13-746, to prevent duplication of payment between Medicare and Medicaid.

What are the Medicaid agency's requirements for the hospice plan of care (POC)?

(WAC 182-551-1320)

Hospice agencies must establish a written 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 this provider guide.

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 all of the following:

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

What are the requirements for the coordination of care?

(WAC 182-551-1330)

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

- Determining if the Medicaid agency 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, the Medicaid agency will rescind the approval (see WAC 182-543-9100 (6) and (7)(c)).

Example: A nursing facility orders a wheelchair for one of its clients. The client chose and authorized hospice care services. 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. The Medicaid agency reimburses the hospice agency for the medical equipment through the appropriate hospice daily rate as described in WAC 182-551-1510 (5).

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

- Communicating with DSHS Medicaid-funded programs and documenting the services a client is receiving in order to prevent duplication of payment and to ensure continuity of care. Other programs include, but are not limited to, programs administered by DSHS' Aging and Long-Term Support Administration (ALTSA).

- Documenting each contact with non-hospice providers.

> **Note:** Both the Plan of Care (POC) and service plan must show the specific duties and services each will provide to prevent duplication of services.

When a client resides in a nursing facility, the hospice agency must do both of the following:

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

- 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 both of the following:

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

  - ✓ Any covered Medicaid services and supplies received from any other provider as 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 any of the following:

  - ✓ 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

  - ✓ 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 182-551-1340)

When a client chooses to leave hospice care or refuses hospice care without giving the hospice agency a revocation statement as required by WAC 182-551-1360, the hospice agency must do all of the following:

- Inform and notify in writing the Medicaid agency's Hospice program manager within five working days of becoming aware of the client's decision
- Not bill the Medicaid agency for the client's last day of hospice services
- Fax a completed copy of the Medicaid agency's *HCA/Medicaid Hospice Notification* form, HCA 13-746, to the Medicaid agency, hospice/PPC notification number at 360-725-1965 to notify that the client is discharged from the hospice program
- Notify the client, or the client's authorized representative, that the client's discharge has been reported to the Medicaid agency
- 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 182-551-1350)

A **hospice agency** may discharge a client from hospice care when the client is any of the following:

- No longer certified (decertified) for hospice care
- No longer appropriate for hospice care (see About the hospice program)
- Seeking treatment for the terminal illness outside the POC

At the time of a client's discharge, the hospice agency must do all of the following:

- Inform and notify in writing the Medicaid agency's Hospice program manager within five working days of the reason for discharge
- Fax a completed copy of the Medicaid agency's *HCA/Medicaid Hospice Notification* form, HCA 13-746, to the Medicaid agency hospice/PPC notification number at 360-725-1965
- Keep the discharge statement in the client's hospice record
- Provide the client with a copy of the discharge statement

May a client choose to end (revoke) hospice care?

(WAC 182-551-1360)

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:

- The client's (or authorized representative's) signature
- The date the revocation was signed
- The actual date that the client chose to stop receiving hospice care
- 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 do all of the following:

- Inform and notify the Medicaid agency's hospice program manager within five working days of becoming aware of the client's decision.
- Fax a completed copy of the Medicaid agency's *HCA/Medicaid Hospice Notification* form, HCA, 13-746, to the Medicaid agency hospice/PPC notification number at 360-725-1965.
- Do not bill the Medicaid agency 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.

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 182-551-1370)

When a client dies, the hospice agency must do both of the following:

- Inform and notify in writing the Medicaid agency's Hospice program manager within five working days.
- Fax a completed copy of the Medicaid agency's *HCA/Medicaid Hospice Notification* form, HCA 13-746, that documents the date of death to the Medicaid agency hospice/PPC notification number at 360-725-1965.

What are the notification requirements for hospice agencies?

(WAC 182-551-1400)

To ensure a hospice client receives quality of care, and to ensure the Medicaid agency determines accurate coverage and reimbursement for services that are related to the client's terminal illness or related conditions a hospice agency must meet certain notification requirements.

To be reimbursed for providing hospice services, the hospice agency must complete *HCA/Medicaid Hospice Notification* form, HCA 13-746 and forward the form to the Medicaid agency's hospice program manager within five working days from when a Medicaid agency client begins the first day of hospice care, or has a change in hospice status. The hospice agency must notify the Medicaid hospice program of all of the following:

- The name and address of the hospice agency
- The date of a client's first day of hospice care
- 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's admittance to a nursing facility (This does not apply to a client admitted for inpatient respite care or general inpatient care)
- A client's admittance to or discharge from a nursing facility/hospice care center, except for General Inpatient (GIP) hospice care or respite
- A client who is eligible for or becomes eligible for Medicare or third-party liability insurance
- A client who dies

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

What are the notification requirements when a client transfers to another hospice agency?

Both the former hospice agency and the current hospice agency must provide the Medicaid agency with all of the following:

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

The Medicaid agency does not require a hospice agency to notify the Medicaid agency's Hospice program manager when a hospice client is admitted to a hospital for palliative care.

Note: Failure to notify the Medicaid agency properly of a client's discharge or revocation from hospice care could result in denial of payment for services provided by the hospice agency.

For example: The client revokes hospice care. The hospice agency fails to notify the Medicaid agency's Hospice program manager within five working days. The client or the client's 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 the Medicaid agency be notified if Medicaid is not primary?

Yes. Notify the Medicaid agency even if the client has Medicare or other third-party liability insurance and you are not intending to bill the Medicaid agency. In order to bill the Medicaid agency, the hospice agency must ensure that the client meets Medicaid criteria.

Notify the Medicaid agency Hospice program manager when there is a change in the client's hospice **election status**. If you need clarification or have questions, call the Medicaid agency Hospice program manager (see Resources Available).

Medicaid clients with third-party liability

If a client has third-party liability (excluding Medicare) that covers nursing services only, with no allowance for room and board, PA is not required before providing services. Providers must separate services onto two different claims and include an explanation of benefit (EOB) for each claim: nursing services on one claim, room and board on another.

Is it required that clients be notified of their rights (Advance Directives)?

(42 CFR, Subpart I)

Yes. 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.
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Hospice Client Eligibility

Note: If the hospice client is eligible to receive health care coverage in a Modified Adjusted Gross Income (MAGI) program, regardless of setting, they will **not** have a shared financial responsibility toward the costs of services and an award letter will **not** be sent to these clients. MAGI clients are identified in the ProviderOne client benefit inquiry screen with the following codes: N01, N02, N03, N04, N05, N10, N11, N13, and N23.

Who is eligible?

(WAC 182-551-1200 (1), (2), and (5))

A DSHS Home and Community Services (HCS) office or Community Services Office (CSO) determines a client's eligibility for a Washington Apple Health 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 the Medicaid agency's Hospice program when:

- 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 Hospice election periods and the What is the hospice certification process?
- The hospice agency serving the client:
  - ✓ Meets the hospice agency requirements listed in What are the notification requirements for hospice agencies?
  - ✓ Notifies the Medicaid agency within five working days of the admission of all clients, including:
    - ➢ Medicaid-only clients.
    - ➢ Medicaid-Medicare dual eligible clients.
    - ➢ Medicaid clients with third-party insurance.
    - ➢ Medicaid-Medicare dual eligible clients with third-party insurance.
    - ➢ Alien Emergency Medical (AEM) clients currently enrolled in another program.

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

- AEM clients that are currently enrolled in the cancer treatment or dialysis programs may receive Hospice Services. PA is required prior to admission.

Note: See the Health Care Coverage Program Benefit Packages and Scope of Service Categories web page for a list of benefit packages.

Note: For a description of a client's *MAGI Family-Related MA program* codes see Appendix E of the *ProviderOne Billing and Resource Guide*.

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Washington Apple Health.** For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's ProviderOne Billing and Resource Guide.

If the patient is eligible for Washington Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see the agency's Health Care Coverage—Program Benefit Packages and Scope of Service Categories web page.

Note: Patients who wish to apply for Washington Apple Health can do so in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org

2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

How should the hospice agency confirm the client's pending medical eligibility?

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

  ✓ The following are examples of questions the agency may ask when confirming pending medical eligibility:

    - Has the application been received by the CSO/HCS office?
    - Does the CSO or HCS office need additional information before benefits can be approved or denied?
    - Has the application been processed? Is the client subject to a spenddown? (See Resources Available.)

- Submit the Medicaid agency's *HCA/Medicaid Hospice Notification* form, HCA 13-746 by fax to 360-725-1965 for 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 ensures that eligibility is correctly handled, and avoids duplication of services by hospice and HCS.

- Use one of the eligibility determination methods outlined in the ProviderOne Billing and Resource Guide to check on the client's medical eligibility.

- 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, ask for the case to be reviewed or considered for a different program.

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

Are clients enrolled in an agency-contracted managed care eligible for hospice services?

(WAC 182-551-1200 (3))

Yes. When verifying eligibility using ProviderOne, if the client is enrolled in an agency-contracted managed care plan, managed care enrollment will be displayed on the benefit inquiry screen. A client enrolled in one of the Medicaid agency'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. Clients can contact their managed care plan by calling the telephone number provided to them.

A hospice agency must notify the Medicaid agency within five working days when a client elects to receive hospice services. Fax a completed *HCA/Medicaid Hospice Notification* form, HCA 13-746, to 360-725-1965. The hospice agency must comply with the managed care plan's policies and procedures to obtain authorization.

> **Note:** To prevent billing denials, check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the Medicaid agency's Provider One Billing and Resource Guide for instructions on how to verify a client's eligibility.

Where is information about Medicare part A?

(WAC 182-551-1200 (4))

A client who is also eligible for hospice under Medicare part A is not eligible for the hospice Medicaid daily rate through the Medicaid agency's hospice program. The Medicaid agency pays hospice nursing facility room and board if the client is admitted to a nursing facility or a hospice care center, and is not receiving general inpatient care or inpatient respite care. (Also, see WAC 182-551-1530)

Hospice Coverage

What is included in the hospice daily rate?

(WAC 182-551-1210)

The Medicaid agency reimburses a hospice agency for providing covered services through the Medicaid agency's hospice daily rate. The hospice daily rate includes core services and supplies. These are subject to the conditions and limitations described in this provider guide.

For reimbursement of covered services, including core services and supplies that are included in the hospice daily rate, the service 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.
- 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 either be:

- 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 including:

  - ✓ Physician services related to administration of the POC.
  - ✓ Nursing care provided by:
    - ➢ A registered nurse (RN).
    - ➢ 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 meets the regulatory qualification requirements.
- Have a written agreement with the service organization or individual provider providing the services and supplies.
- 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 (POC) 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 the frequency and services of both to show non-duplication.

Subject to the limitations described in this guide, the following covered services and supplies, as described in Hospice Reimbursement, are included in the appropriate hospice daily rate:

- **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 the Medicaid agency 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 client for hospice.

- **Home health aide, homemaker, or personal care services, or all three** 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 need 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. See Title 42 CFR 484.36)

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

- **Durable medical equipment and related supplies, prosthetics, orthotics, medical supplies, related services, or related repairs and labor charges** that are medically necessary for the palliation and management of a client's terminal illness and related conditions

- **Medical transportation services, including ambulance** as required by POC related to the terminal illness (see WAC 182-546-5550(1)(d))

- **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**

- **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. The Medicaid agency does not pay separately for medical equipment or supplies that were previously authorized by the Medicaid agency and delivered on or after the date the Medicaid agency 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 is 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 Long-Term Support Administration (ALTSA) field office and will be **reimbursed by ALTSA**)
- 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 the Medicaid agency separately using the applicable fee schedule and this provider guide.

How do I request prior authorization for a noncovered service?

(WAC 182-501-0160)

Providers may request prior authorization for the Medicaid agency to pay for a noncovered medical service or related equipment. **This is called an exception to rule (ETR).** The Medicaid agency cannot approve an ETR if the exception violates state or federal law or federal regulation.

> **Note**: **Authorization does not guarantee payment.** The agency's authorization process applies only to medically necessary covered health care services and is subject to client eligibility and program limitations. Not all categories of eligibility receive all health care services. **Example:** Therapies are not covered under the Family Planning Only Program. All covered health care services are subject to retrospective utilization review to determine if the services provided were medically necessary and at the appropriate level of care. Requests for non-covered services are reviewed under the exception to rule policy. See WAC 182-501-0160.

For the Medicaid agency to consider the request, ETR sufficient client-specific information, and documentation must be submitted to the agency 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).
- The requested service or equipment will result in lower overall costs of care for the client.

> **Note:** For more details, see Authorization Documentation.

The Medicaid agency evaluates and considers ETR requests on a case-by-case basis according to the information and documentation submitted by the provider. Within 15 working days of the Medicaid agency's receipt of the request, the Medicaid agency notifies the provider and the client, in writing, of the Medicaid agency's decision to grant or deny the ETR.

> **Note:** Clients do not have a right to a fair hearing on ETR decisions.

What is a limitation extension (LE)?

A limitation extension (LE) is authorization for cases when the Medicaid agency determines that it is medically necessary to provide more units of service than allowed in this provider guide and WAC 182-501-0169.

How is an LE authorized?

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 being requested
- Prior Authorization (PA) - clients with AEM coverage

How do I request PA or LE?

For all requests for prior authorization or limitation extensions, the following documentation is required:

- A completed, TYPED *General Information for Authorization* form, 13-835, which MUST be the initial page when you submit your request. **Include all CPT procedure codes and plan of care for concurrent care services.**
- A completed faxed or written *Hospice (including PPC) Authorization Form*, 13-848.

This documentation should be submitted:

- **By Fax**

Fax prior authorization requests to:

866-668-1214

- **By Mail**

Mail prior authorization requests to:

Authorization Services Office
PO Box 45535
Olympia, WA 98504-5535

For urgent requests and information, call 360-725-5144 and leave a message. The agency returns most calls within one business day.

See Resources Available.

Do children who are hospice care clients have access to curative services?

(WAC 182-551-1860)

Yes. In response to the Patient Protection and Affordable Care Act, clients age 20 and younger who are on hospice services also have access to curative services.

Note: The legal authority for these clients' hospice **palliative** services is in Section 2302 of the Patient Protection and Affordable Care Act of 2010 and Section 1814(a)(7) of the Social Security Act; and for a client's **curative** services is Title XIX Medicaid and Title XXI Children's Health Insurance Program (CHIP) for treatment of the terminal condition.

Concurrent/curative treatment

Unless otherwise specified within this provider guide, concurrent/curative treatment, related services, or related medications requested for clients age 20 and younger are subject to the Medicaid agency's specific program rules governing those services or medications.

The treating medical providers must request these services, including treatment planning, actual treatment, and related medications, through the agency's prior authorization (PA) process. Prior authorization requests for concurrent/curative treatment or medications are subject to medical necessity review under WAC 182-501-0165.

The Medicaid agency will notify the hospice agency when there is an approval or denial for hospice curative treatment. It is the hospice agency's responsibility to continue to coordinate care.

Services included under the Medicaid agency's concurrent/curative care benefit

The following services aimed at **achieving a disease-free state** are included under the curative care benefit paid for by the Medicaid agency:

- Radiation
- Chemotherapy
- Diagnostics, including laboratory and imaging
- Licensed health care professional services
- Inpatient and outpatient hospital care
- Surgery
- Medication
- Equipment and related supplies
- Ancillary services, such as medical transportation

Notes: For authorization requirements for providers to request concurrent/curative treatment, see How do I request PA or LE?

If the concurrent/curative treatment, related services, or related medications are not covered by the Medicaid agency, the provider must request an exception to rule (ETR) under WAC 182-501-0160. Requests for ETR are subject to a medical necessity review under WAC 182-501-0165.

If the Medicaid agency denies a request for a covered service, refer to WAC 182-502-0160 that specifies when a provider or a client may be responsible to pay for a covered service.

See How do I request PA or LE?

Services that are the hospice agency's responsibility

- The following services are to be provided by the hospice agency in accordance with current guidelines, while the client is receiving concurrent care:
  - ✓ Hospice covered services as described in WAC 182-551-1210
  - ✓ Services rendered for **symptom management,** including but not limited to:
    - ➢ Radiation
    - ➢ Chemotherapy
    - ➢ Surgery
    - ➢ Medication
    - ➢ Equipment and related supplies
  - ✓ Ancillary services, such as medical transportation

Hospice Coverage Table

What places of service are allowable?

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 combination w/ any other code	Yes Not in combination w/ any other level of care	No	Yes Not in combination w/ any other level of care
Level 2: Continuous Home Care (CHC) **(652)** Hourly nursing	Yes Not in combination 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 combination w/ any other code	Yes Not in combination w/any other code	Yes For clients not residing in HCC Not in combination w/ any other code
Level 4: General Inpatient Care (GIP) **(656)** Includes R/B	No	Yes Not in combination w/ any other code	Yes Not in combination w/ any other code	Yes Not in combination w/ any other code
Nursing Facility (NF) R/B **(115,125,135)**	No	Yes Not in combination w/ 655 or 656	No	No
Hospice Care Center (HCC) **(145)** R/B Admin day rate	No	No	No	Yes Not in combination w/ 656 or 655
Pediatric Palliative Care (PPC) **(659)**	Yes Not for clients in a group home	No	No	No

Which hospice revenue codes are allowable?

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

Revenue Code	Description of Code	Billing Provider Taxonomy
0115*	**Hospice (Room and Board - Private)**	251G00000X
0125*	**Hospice (Room and Board - Semi-Private 2 Bed)**	251G00000X
0135*	**Hospice (Room and Board - Semi-Private 3-4 Beds)**	251G00000X
0145	**Hospice Care Center (Hospice Deluxe Room and Board)**	315D00000X
0651	**Level 1: Routine Home Care (Hospice Daily Rate)**	251G00000X
0652	**Level 2: Continuous Home Care**	251G00000X
0655	**Level 3: Inpatient Respite Care**	251G00000X
0656	**Level 4: General Inpatient Care**	251G00000X

Note: For limitations, see Billing and Claim Forms.

Note: For hospice, 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 Rate Schedule.

Which pediatric palliative care (PPC) revenue codes are allowable?

Revenue Code	Description of Code
0659	**Other Hospice Services** (Pediatric Palliative Care (PPC) Case Management/Coordination will be reimbursed according to the fee schedule) See below for examples of use.
0659	PPC – RN (registered nurse)
0659	PPC – PT (physical therapy)
0659	PPC – OT (occupational therapy)
0659	PPC – ST (speech therapy)
0659	PPC – Case Management Time (Bill the date of service where each “two-hour time requirement” is met)

Which hospice services may be provided in the client's home?

Revenue Codes	
0651, 0652, and 0659 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	**County Code**
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**

Which hospice services may be provided outside the client's home?

Revenue Codes	
0655 and 0656 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**
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 for nursing facility and information about hospice care center reimbursement.

Hospice Reimbursement

How does the Medicaid agency determine what rate to pay?

(WAC 182-551-1510)

Note: Prior to submitting a claim to the Medicaid agency, a hospice agency must file written certification in a client's hospice record. (See Are election statements required in the client's hospice medical record? and What is the hospice certification process?)

- The Medicaid agency pays for hospice care provided to clients in one of the following settings:
  - ✓ A client's residence
  - ✓ A Medicaid agency-approved nursing facility, hospital, or hospice care center
- To be paid by the Medicaid agency, the hospice agency must provide and/or coordinate Medicaid agency-covered hospice services including:
  - ✓ Medicaid hospice services.
  - ✓ Services that relate to the client's terminal illness any time during the hospice election.
- Hospice agencies must bill the Medicaid agency for their services using hospice-specific revenue codes (see Allowable Places of Service and Hospice Revenue Codes).
- The Medicaid agency pays hospice agencies for services (not room or board or both) 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.
  - ✓ 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.

How does the Medicaid agency pay for the client's last day of hospice care?

See WAC 182-551-1510 (6) and (9)

What types of care does the Medicaid agency pay for?

The Medicaid agency pays for routine hospice care, continuous home care, respite care, or general inpatient care for the day of death.

What types of care does the Medicaid agency not pay for?

- Room and board for the day of death
- Hospice agencies for the client's last day of hospice care when a client discharges, revokes, or transfers
- 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)
  - ✓ The day of death

How does the Medicaid agency reimburse for nursing facility charges?

(WAC 182-551-1510 (8))

For nursing facility room and board, including swing beds*, the Medicaid agency pays hospice agencies that are 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
- Nursing facility charges are not covered for AEM clients. See WAC **182-507-0120**

How does the Medicaid agency reimburse for hospice care center (HCC) residents?

(WAC 182-551-1510 (9))

The Medicaid agency 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.

What is client participation?

(WAC 182-551-1510)

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 client's monthly participation amount stated in the notice of action (award) letter sent by the Medicaid agency to the client (the hospice agency may contract out if it does not choose to collect). 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 *HCA/Medicaid Hospice Notification* form, HCA 13-746.

> **Note:** Do NOT bill the Medicaid agency for the participation amount. Instead, bill the Medicaid agency 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.

*See Swing bed rates.

For hospice care centers (HCC) and nursing facilities:

- The client participation amount on hospice claims must be reported in the *Value Code* section using value code 31.
- The client participation amount should not be factored into the billed amount. Bill the full amount, report the participation amount using value code 31, and the billing system (ProviderOne) will subtract the amount.
- Participation is 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 Medicaid agency.
- The participation amount is forwarded to the nursing facility by the hospice agency.

How does the Medicaid agency reimburse for clients under the community options program entry system (COPES) program?

(WAC 182-551-1510 (9))

Aging and Long-Term Support Administration (ALTSA) in DSHS pays the COPES provider directly for services provided to a client eligible under the COPES program and:

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

When does the Medicaid agency reimburse hospitals providing care to hospice clients?

(WAC 182-551-1520 (1))

The Medicaid agency pays hospitals that provide inpatient care to clients in the hospice program when the medical condition is **not** related to their terminal illness. (See the Medicaid agency's Inpatient Hospital Services Provider Guide or Outpatient Hospital Services Provider Guide.)

How does the Medicaid agency 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 agency or are working under arrangements made with the hospice agency. The physician serving as the medical director of the hospice agency and/or the physician member of the hospice interdisciplinary team would generally perform activities such as:

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

Note: The above activities cannot be billed separately.

Licensed health care services

Services not related to the hospice diagnosis provided by physicians, ARNPs, and PA-Cs not employed by the hospice agency
(WAC 182-551-1520 (2))

The Medicaid agency pays providers who are attending physicians and not employed by the hospice agency, the usual and customary charge through the Physician-Related/Professional Services Fee Schedule:

The Medicaid agency pays these providers:

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

Professional services related to the hospice diagnosis

See the agency's Physician-Related/Professional Services Fee Schedule.

Who can bill for professional services?

The Medicaid agency reimburses for professional services only when they are billed by one of the following:

- Primary physician
- Hospice agency (using Hospice Clinic National Provider Identifier (NPI))
- Consulting physicians or those providing backup care for the primary physician**.** (consulting physicians must be coordinated with the hospice agency)
- Radiologist/laboratory

When billing for the professional component, include **modifier 26** in field 24 D on the CMS-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 is required when billing the Medicaid agency?

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

- When the primary physician performs the service, bill using their NPI number.

- OR-

- When a physician, other than the primary physician, performs the service, bill using the primary physician NPI number as the referring provider on the claim.

How does the Medicaid agency reimburse for Medicaid-Medicare dual eligible clients?

(WAC 182-551-1530)

The Medicaid agency does not pay for any hospice care provided to a client covered by Medicare Part A (hospital insurance).

- The Medicaid agency may pay for hospice care provided to a client:
  - ✓ Covered by Medicare Part B (medical insurance).
  - ✓ Not covered by Medicare Part A.

For hospice care provided to a Medicaid-Medicare dual eligible client, hospice agencies must bill:

- Medicare before billing the Medicaid agency.
- The Medicaid agency for hospice nursing facility room and board, using the nursing facility's NPI number in form locator 78 on the UB-04 claim form.

Billing for routine home care – revenue code 0651

Changes to routine home care (RHC) reimbursement are effective for claims with dates of service on and after January 1, 2016.

Payments for RHC are based on a two-tiered payment methodology:

- Days one through sixty are paid at the base RHC rate.
- Days sixty-one and after are paid at a lower RHC rate.

When billing for RHC level of care, enter the appropriate procedure code and modifier. In order for the claim to process correctly, the revenue code, procedure code, and modifier must be submitted on each line billed.

Procedure Code and Modifier	Description of Code or Modifier
Q5001	Hospice care provided in client's home/residence
Q5002	Hospice care provided in assisted living facility
Q5003	Hospice care provided in non-skilled nursing facility
Q5010	Hospice home care provided in a hospice facility
TG	Complex/high tech level of care (for RHC days 1-60)
TF	Intermediate level of care (for RHC days 61+)

- If an RHC client discharges and readmits to hospice within sixty calendar days of that discharge, the prior hospice days will continue to follow the client and count toward the client's eligible days in determining whether the receiving hospice agency may bill at the base or lower RHC rate.

- If an RHC client discharges from a hospice agency for more than sixty calendar days, a readmit to the hospice agency will reset the client's hospice days.

End-of-life service intensity add-on payment

The end-of-life service intensity add-on (SIA) payment may be billed for dates of services on and after January 1, 2016.

Hospice services are eligible for an end-of-life SIA payment when all the following criteria are met:

- The day on which the service is provided is an RHC level of care.

- The day on which the service is provided occurs during the last seven days of life, and the client is discharged deceased.

- The service is provided by a Registered Nurse (RN) or Social Worker (SW) that day for at least fifteen minutes and up to four hours total.

- The service is not provided by the SW via telephone.

When billing for an SIA payment, enter the appropriate revenue and procedure code. In order for the claim to process correctly, the revenue code and procedure code must be submitted on each line billed.

Revenue Code	Description of Code	Procedure Code	Description of Code
0551	Skilled Nursing	G0299	Direct skilled nursing services of an RN in a home health or hospice setting, each unit = 15 minutes
0561	Medical Social Service Visit	G0155	Services of SW in home health or hospice setting, each unit = 15 minutes

Note: For SIA payments, there is a maximum limit of 112 units per a client's lifetime.

Where is the fee schedule?

See the Medicaid agency's Hospice Fee Schedule**.**

Pediatric Palliative Care

How are pediatric palliative care (PPC) services provided?

(WAC 182-551-1800)

PPC services are provided through a hospice agency. The Medicaid agency's case management/coordination services for PPC 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 also may receive support through care coordination when the services are related to the client's medical needs.

How does a hospice agency become an approved PPC provider?

(WAC 182-551-1830)

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

To apply to become a Medicaid agency-approved PPC provider, a provider must:

- Be an approved hospice agency with Medicaid (see About the Hospice program).
- Submit a letter to the Medicaid agency's Hospice/PPC program manager (see Resources Available) requesting to become a Medicaid agency-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 182-550-1840)

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 approved to provide Medicaid services?
- Confirm that a client meets the eligibility criteria prior to providing PPC services.
- Obtain a written referral to the Medicaid agency'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.
  - ✓ 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 Medicaid agency's PPC program manager within five 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.
    - ➢ Discharges from PPC to enroll in the Medicaid agency's Hospice program.
  - ✓ Transfer to another hospice agency for pediatric palliative care services.
  - ✓ Death.

Note: See *Pediatric Palliative Care (PPC) Referral & 5-Day Notification* form, HCA 13-752.

- 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
  - ✓ 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 the Medicaid agency's PPC program manager, a copy of the client's POC, visit notes, and any other documents listing the information identified above.

If the Medicaid agency determines that the documentation in the POC or attachments 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 the Medicaid agency.

Note: Therapy services may be provided in outpatient settings and billed with the client's Services Card. Outpatient therapy may not be appropriate for some children and may be best served in the home. The documentation on the Pediatric Palliative Care (PPC) Plan of Care (POC) would note the medical necessity.

Who is eligible for Pediatric Palliative Care (PPC) services?

(WAC 182-551-1810)

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

- Be age 20 or younger.
- Be covered by a benefit package that covers PPC case management/coordination services. See the Medicaid agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.
- 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 six circumstances:
  - ✓ An immediate medical need 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 in which the family is unable to cope
  - ✓ A family member(s) or caregiver, or both, who needs additional knowledge or assistance with the client's medical needs
  - ✓ Therapeutic goals focused on quality of life, comfort, and family stability

Note: See the Health Care Coverage Program Benefit Packages and Scope of Service Categories table for an up-to-date listing of benefit packages.

Are clients enrolled in managed care eligible for PPC services?

(WAC 182-551-1200 (2))

Yes. When verifying eligibility using ProviderOne, if the client is enrolled in a Medicaid agency-managed care plan, managed care enrollment will be displayed on the client benefit inquiry screen. A client enrolled in one of the Medicaid agency-contracted 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 for all PPC services for a client enrolled in a managed care plan. Clients can contact their managed care plan by calling the telephone number provided to them. The Medicaid agency does not process or reimburse claims for managed care clients for services provided under the Apple Health contract.

> **Note:** To prevent billing denials, check the client's eligibility **before** scheduling services, and at the **time of the service** to make sure proper authorization or referral is obtained from the plan.
>
> See the Medicaid agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

How many PPC services are covered?

(WAC 182-551-1820)

The Medicaid agency's PPC case management/coordination services cover up to six PPC contacts per client, per calendar month.

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

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

- A completed, **typed** *General Information for Authorization* form, HCA 13-835. This form **must** be the initial page when you submit your request
- A completed *Hospice (including PPC) Authorization Request* form, HCA 13-848, and all the documentation listed on this form and any other medical justification

Fax the request to: 866-668-1214.

What is included in a PPC contact?

A PPC contact includes:

- One visit with a registered nurse, social worker, or therapist with the client in the client's residence to address:

  - ✓ Pain and symptom management.
  - ✓ Psychosocial counseling.
  - ✓ Education/training.

  Note: For the purposes of this provider guide, the Medicaid agency defines **therapist** as: a licensed physical therapist, occupational therapist, or speech and language therapist.

- 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
  - ✓ Visits lasting 20 minutes or less (for example: visits to give injections, drop off supplies, or make appointments for other PPC-related services)
  - ✓ 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 have six contacts with any combination. Unbilled case-management hours do not carry over to the next month.

When are PPC services not covered?

The Medicaid agency 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*
- Disease case management program
- Any other Medicaid agency program that provides similar services

***Alert!** Private duty nursing is not covered unless the hospice agency requests an exception to rule by completing the *Hospice (including PPC) Authorization Request* form, HCA 13-848.

The Medicaid agency 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.

Pediatric palliative care (PPC) revenue code

Revenue Code	Description of Code
0659	**Other Hospice Services** (Pediatric Palliative Care (PPC) Case Management/Coordination will be reimbursed according to the fee schedule.) See below for examples of use:
0659	PPC – RN (registered nurse)
0659	PPC – PT (physical therapy)
0659	PPC – OT (occupational therapy)
0659	PPC – ST (speech therapy)
0659	PPC – Case-Management Time (Bill the date of service for each two-hour time requirement that was met.)

How does the Medicaid agency pay for PPC services?

The Medicaid agency pays providers for PPC case management/coordination services per contact.

The Medicaid agency adjusts the reimbursement rate for PPC contacts when the legislature grants a vendor 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.

Billing and Claim Forms

What are the general billing requirements?

Providers must follow the agency's ProviderOne Billing and Resource Guide. These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- How to bill for clients eligible for both Medicare and Medicaid.
- How to handle third-party liability claims.
- What standards to use for record keeping.

How are national provider identifier (NPI) numbers reported on hospice claims?

The agency has implemented a change in the process for reporting the nursing home NPI number on a hospice claim for a client in a nursing home.

Use the following claim forms to report the nursing home NPI:

837 Institutional and ProviderOne institutional DDE – service facility NPI information:

- For the HIPAA 837 Institutional claim type the **Service Facility NPI** field is located within Loop 2310E, data element NM109.

- For the ProviderOne Institutional DDE claim screen, the **Service Facility NPI** field is listed on the **Other Claim Info** tab at the top of the claim form. On the **Other Claim** page open the Miscellaneous Claim expander and enter the NPI number in the **Service Facility** box.

Paper UB04 claim form information

- The paper UB04 claim form does not contain a **Service Facility NPI** field, but it still contains an **Other Provider NPI** field. Providers that submit hospice paper UB-04 claims will continue to use the **Other Provider NPI** field.

How do I complete the UB-04 claim form?

Instructions on how to bill institutional claims and crossover claims electronically can be found on the Medicaid Providers Training page under Medicaid 101.

Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the National Uniform Billing Committee (NUBC).

The attending provider must be included on the UB-04 claim form, or the claim will be denied.

Form Locator	Description	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.
17	Patient Discharge Status Code	Yes	See the National Uniform Billing Committee (NUBC).

How do I complete the CMS-1500 claim form?

Instructions on how to bill professional claims and crossover claims electronically can be found on the agency's Medicaid Providers Training page under Medicaid 101.

Also, see Appendix I of the agency's ProviderOne Billing and Resource Guide for general instructions on completing the CMS-1500 claim form.

The following CMS-1500 claim form instructions relate to hospice services:

Field No.	Name	Field Required	Entry	
19	**Reserved for Local Use**	When applicable	If the client does not have 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
24G	**Days or Units**	Yes	Enter 1	

Electronic submitters: External cause codes (V00-Y99) are required to be submitted in groups of three in order for a claim to be processed. This does not apply to paper claim submissions. For questions email: HIPAA-Help@hca.wa.gov.