Washington State Health Care Authority

Medicaid Provider Guide

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

[Refer to Chapter 182-551 WAC, Subchapter 1]

A Billing Instruction

About This Guide

This guide, , supersedes all previous versions of the *Hospice Agency Medicaid Provider Guide* published by the Medicaid Program of the Health Care Authority (Medicaid Agency)

What Has Changed?

Reason for Change	Effective Date	Section/ Page No.	Subject	Change
Provider Notice 12-60	August 1, 2012	Hospice Coverage Table, page 27	Hospice Revenue Codes	Streamlined descriptions for codes 115, 125,135 and 145 for consistency with other codes.
		Hospice Reimbursement pages 31 and 32	Agency Reimbursements for Nursing Facility Charges Client Participation	Added payment information about swing beds. Updated information on client participation.
		Pediatric Palliative Care page 41	PPC Contacts not Covered	Added that private duty nursing is not covered except under exception to rule (ETR).
		Billing and Claims Forms, pages 43—44	Completion of the UB-04 Claim Form	Added a reminder that all claims must have an attending provider included on the UB-04 claim. Added Form Locator 17.
		Various	Various	Made housekeeping changes to various areas for clarity and accuracy.

Copyright Disclosure

How Can I Get the Medicaid Agency's Provider Documents?

To download and print the Medicaid Agency's provider numbered memos and Medicaid provider guides, go to the Agency's website at http://hrsa.dshs.wa.gov (click the ***Medicaid Provider Guides and Provider Notices*** link).

Table of Contents

Alert! The page numbers in this table of contents are now "clickable"—do a "control + click" on a page number to go directly to a spot. As an Adobe (.pdf) document, the guide also is easily navigated by using bookmarks on the left side of the document. If you don't immediately see the bookmarks, right click on the gray area next to the document and select Page Display Preferences. Click on the bookmark icon on the left.)

Important Contacts

Note: This section contains important contact information relevant to hospice services. For more contact information, see the Medicaid Agency's *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html.

Topic	Contact Information
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) 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 1-800-848-2842 (toll free) All other providers 1-800-562-3022 (toll free)
How do I obtain Medicaid Agency's Hospice Program forms?	To view and download the Hospice Notification form, HCA 13-746, and the HCA Pediatric Palliative Care (PPC) Referral Notification form, HCA 13-752, visit the Medicaid Forms online: http://hrsa.dshs.wa.gov/mpforms.shtml

Topic	Contact Information
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 ProviderOne request form, HCA 13-835. This request form MUST be the initial page when you submit your request. • A completed Home Health & Hospice Authorization Request Form, HCA 13-847, and all the documentation listed on this form and any other medical justification. Fax your request to: 1-866-668-1214. See the Medicaid Agency's *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html,
How do I find out where my local Community Services Office (CSO) is located?	Visit the online CSO: http://www.dshs.wa.gov/onlinecso/findservice.shtml
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

Definitions & Abbreviations

[Refer to WAC 182-551-1010]

This section defines terms and abbreviations, including acronyms, used in this Medicaid provider guide. Please refer to the Agency's online Medical Assistance Glossary at http://hrsa.dshs.wa.gov/download/medical_assistance_glossary.htm for a more complete list of definitions.

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

Aging and Disabilities Services Administration (ADSA) - The Aging and Disability Services Administration with the Department of Social and Health Services (DSHS) assists children and adults with developmental delays or disabilities, cognitive impairment, chronic illness, and related functional disabilities.

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.

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.

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.

Community Services Office (CSO) - A DSHS office that administers social and health services at the community level.

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 20 years of age and younger who are:

- Enrolled in hospice; and
- Also able to receive other Medicaid-covered services not included in the hospice benefit.

(See 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 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.

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 – 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.

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; or
  ✓ Hospice care centers.

Home - See Residence.

Home and Community Services (HCS) Offices – The DSHS Aging and Disabilities Services Administration (ADSA) office that manages the state's comprehensive long-term care system and provides in-home, residential, and nursing home services to clients with functional disabilities.

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.

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, occupation 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; and
- Personal care or homemaker services and other nonmedical tasks.

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 this Medicaid provider guide, requirements for hospice agencies also apply to hospice care centers.)

Hospice Aide – An individual 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; and
- 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 individual and emotional, spiritual, and bereavement support for the individual and individual's family in a place of temporary or permanent residence.

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.

Interdisciplinary Team – The group of individuals 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.

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.

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 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.

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

About the Hospice Program

What Is the Hospice Program?

[Refer to 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. 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.
- 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?

[Refer to 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 complete the following:

- 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 of the following levels of hospice care:
  - ➢ 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 in this section are met; and
- The Medicaid Agency provides the hospice agency with written notification.

Hospice Election Periods

[Refer to WAC 182-551-1310 (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 Leaves Hospice Care without Notice?)

For information, see Pediatric Palliative Care.

Required Face-to-Face Encounters

[Refer to WAC 182-551-1310]

A hospice physician or nurse practitioner must have a face-to-face encounter with every hospice client:

- Within thirty days prior to the 180th day recertification; and
- Prior to 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 hospice physician or nurse practitioner 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 the written certification of the client's terminal illness in the client's medical file:

Hospice Provider Requirements

Election Statements and the Certification Process

[Refer to WAC 182-551-1310 (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.
- 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, 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 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 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; 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 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 5 working days of the first day of hospice services for all Medicaid Agency eligible clients. This includes clients with third-party and/or Medicare coverage. 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 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?

[Refer to WAC 182-551-1320]

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 182-551-1330]

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 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. 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. The Medicaid Agency reimburses the hospice agency for the medical equipment through the appropriate hospice daily rate as described in WAC 182-551-1510 (6).

  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' 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?

[Refer to 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 5 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 Hospice Notification form, HCA 13-746, to the Medicaid Agency 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 the Medicaid Agency; 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?

[Refer to WAC 182-551-1350]

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 About the Hospice Program); 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 the Medicaid Agency's Hospice Program Manager within 5 working days of the reason for discharge.
- Fax a completed copy of the Medicaid Agency's Hospice Notification form, HCA 13-746, to the Medicaid Agency 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.
- Inform the client that the discharge statement must be:
    - ✓ Presented with the client's current Services Card when obtaining Medicaid-covered healthcare services, supplies, or both; and

- ✓ Used until the Medicaid Agency issues the client a new Services Card which identifies that the client is no longer a hospice client.

May a Client Choose to End (Revoke) Hospice Care?

[Refer to 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:

- Client's (or authorized representative's) signature.
- Date the revocation was signed.
- 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:

- Inform and notify the Medicaid Agency's Hospice Program Manager within 5 working days of becoming aware of the client's decision.
- Fax a completed copy of the Medicaid Agency's Hospice Notification form HCA, 13-746, to the Medicaid Agency hospice/PPC notification number at 1-360-725-1965.
- 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,
- Inform the client that the revocation statement must be:
  - ✓ Presented with the client's current Services Card when obtaining Medicaid-covered healthcare services, supplies, or both; and
  - ✓ Used until the Medicaid Agency issues the client a new Services Card which 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?

[Refer to WAC 182-551-1370]

When a client dies, the hospice agency must:

- Inform and notify in writing the Medicaid Agency's Hospice Program Manager within 5 working days.
- Fax a completed copy of the Medicaid Agency's Hospice Notification form, HCA 13-746, that documents the date of death to the Medicaid Agency hospice/PPC notification number at 1-360- 725-1965.

What Are the Notification Requirements for Hospice Agencies?

[Refer to 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 the following notification requirements. To be reimbursed for providing hospice services, the hospice agency must report to the Medicaid Agency Hospice Program Manager within 5 working days from when a Medicaid Agency 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 the Medicaid Agency within 5 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.

- 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 Inpatient (GIP) Hospice Care or respite
- A client becomes eligible for Medicare or third-party liability insurance.
- A client who dies.
- A client who transfers to another hospice agency.

  Both the former agency and the current agency must provide the Medicaid Agency 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.

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 properly notify the Medicaid Agency 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 the Agency'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 the Medicaid Agency if Medicaid Is Not Primary?

Yes! Notify the Medicaid Agency even if the client has Medicare or other Third Party Liability (TPL) 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 ANYTIME 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 Important Contacts).

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

Hospice Client Eligibility

Who Is Eligible?

[Refer to 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 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 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 "Election Statements and the Certification Process" in this guide.
- 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 5 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
- 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;
- The client is covered by a Benefit Package that covers hospice services. Please see the current Medicaid Agency *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Note: Refer to the *Scope of Healthcare Services Table* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

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:

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

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

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

2. Submit the Medicaid Agency's Hospice Notification form, HCA 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 that eligibility is handled by the correct office and avoids duplication of services by hospice and HCS.

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

4. 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.

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

Are Clients Enrolled in Managed Care Eligible for Hospice Services?

[Refer to WAC 182-551-1200 (3)]

YES! When verifying eligibility using ProviderOne, if the client is enrolled in an 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'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 5 working days when a client elects to receive hospice services, by faxing a completed Hospice Notification form, HCA 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 billing denials, please 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* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM provider, this information will be displayed on the Client Benefit Inquiry screen in ProviderOne. 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.

> **Note:** To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure a proper referral is obtained from the PCCM provider. Please see the Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Medicare Part A

[Refer to 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 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. (Also, see WAC 182-551-1530.)

Hospice Coverage

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

[Refer to WAC 182-551-1210]

The Medicaid Agency reimburses a hospice agency for providing covered services. This includes core services and supplies, through the Medicaid Agency'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.
- 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;

  - ✓ 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.
- 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 Hospice Reimbursement, 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 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 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.
- **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 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**.)
- 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 these billing instructions.

How Do I Request a Noncovered Medical Service or Related Equipment?

[Refer to 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.** The Medicaid Agency cannot approve an exception to rule if the exception violates state or federal law or federal regulation.

For the Medicaid Agency to consider the request, sufficient client-specific information and documentation must be submitted for 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 details, see the Authorization Documentation table on the next page.

Agency 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 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 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 (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 the Medicaid Agency's WAC and these billing instructions.

How Do I Get an 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 being requested.

- Prior Authorization (PA) - clients with AEM coverage.

Authorization Documentation
For all requests for prior authorization or limitation extensions, the following documentation is "required:" • A completed, TYPED General Information for Authorization form, 13-835. This request form MUST be the initial page when you submit your request. • A completed Basic Information Form, 13-756, if there is not a form specific to the service you are requesting, and all the documentation listed on this form and any other medical justification. **This documentation should be submitted:** • **By Fax** Fax prior authorization requests to 1-866-668-1214. • **By Mail** Mail prior authorization requests to: Authorization Services Office PO Box 45535 Olympia, WA 98504-5535 See the Agency *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html

Concurrent Care for Children Who Are on Hospice

[Refer to WAC 182-551-1860]

In response to the Patient Protection and Affordable Care Act, clients 20 years of age and younger who are on Hospice service are also allowed to have access to curative services.

Note: The legal authority for these clients' hospice *palliative* services is 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 these billing instructions, concurrent/curative treatment, related services, or related medications requested for clients 20 years of age and younger are subject to the Medicaid Agency's specific program rules governing those services or medications.

Community providers will need to 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.

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 healthcare 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, go to Section B of the Physician-Related Services/Healthcare Professional Services MPG.

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 exception to rule 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.

Services That Are the Hospice Agency's Responsibility

- The following are services expected to be provided by the hospice agency per current rules because these are related to:

  - ✓ 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

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)*** .
125*	***Hospice (Room and Board - Semi-Private 2 Bed)***
135*	***Hospice (Room and Board - Semi-Private 3-4 Beds)***
145	***Hospice Care Center (Hospice Deluxe Room and Board)***
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 and Claim Forms.

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://www.adsa.dshs.wa.gov/professional/rates/reports/

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 (registered nurse)
659	PPC – PT (physical therapy)
659	PPC – OT (occupational therapy)
659	PPC – ST (speech therapy)
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 Reimbursement

How Does the Medicaid Agency Determine What Rate to Pay?

[Refer to 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. (Refer to "Election Statements and the Certification Process" in this guide.)

- 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; and
  - ✓ 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 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.
  - ✓ 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 the Medicaid Agency Pay for the Client's Last Day of Hospice Care?

[Refer to 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?

- 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.
- 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 the Medicaid Agency Reimburse for Nursing Facility Charges?

[Refer to WAC 182-551-1510 (8)]

The Medicaid Agency pays for nursing facility room and board, including swing beds*, 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.

*Swing bed rates can be found at: http://www.adsa.dshs.wa.gov/professional/rates/reports/

How Does the Medicaid Agency Reimburse for Hospice Care Center (HCC) Residents?

[Refer to 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.

Client Participation

[Refer to 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 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.

For Hospice Care Centers (HCC) and Nursing Facilities:

- The client participation amount on hospice claims should always 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; and
- 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?

[Refer to WAC 182-551-1510 (9)]

Aging and Disability Services Administration (ADSA) in DSHS 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 the Medicaid Agency directly for hospice services, not the COPES program.

When Does the Medicaid Agency Reimburse Hospitals Providing Care to Hospice Clients?

[Refer to 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. (Refer to the current Medicaid Agency *Inpatient Hospital Medicaid Provider Guide* or *Outpatient Hospital Medicaid 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 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

Licensed Healthcare 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 Resource-Based Relative Value Scale (RBRVS) fee schedule published in the current Agency *Physician-Related Services Medicaid Provider Guide*:

- 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://hrsa.dshs.wa.gov/RBRVS/Index.html#P

Professional Services Related to the Hospice Diagnosis

Refer to the Physician Related Services Fee Schedule found in the current Medicaid Agency's *Physician-Related Services Medicaid Provider Guide.*

Who Can Bill 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 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 on the next page, 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 the Medicaid Agency for all professional services in one of the following ways:

1. When the primary physician performs the service, bill using their National Provider Identifier (NPI) number. See # Memo 10-22 for more information regarding field placement on the claim.

- OR –

2. 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?

[Refer to 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); and
- Not covered by Medicare Part A.

Hospice agencies must bill:

- Medicare before billing the Medicaid Agency; and

- 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.

Fee Schedule

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

Pediatric Palliative Care

About the Services

[Refer to WAC 182-551-1800]

Through a hospice agency, the Medicaid Agency's case management/coordination services for pediatric palliative care (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?

[Refer to 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); and
- Submit a letter to the Medicaid Agency's Hospice/PPC program manager (see Important Contacts) 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

[Refer to 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; 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 Medicaid Agency's 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 the Medicaid Agency's Hospice program;

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

  ✓ Death.

Note: The Referral for Pediatric Palliative Care (PPC), HCA 13-752, is located at http://maa.dshs.wa.gov/mpforms.shtml.

- 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 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 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 the Medicaid Agency.

> **Note:** Therapy services may be provided in outpatient settings and billed with the client's Services 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.

Client Eligibility

[Refer to WAC 182-551-1810]

Who Is Eligible?

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

- Be 20 years of age or younger.
- Be covered by a Benefit Service Package that covers PPC case management/coordination services. Please see the Medicaid Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

  Note: Refer to the *Scope of Healthcare Services Table* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

- 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.
  - ✓ Therapeutic goals focused on quality of life, comfort, and family stability.

Are Clients Enrolled in Managed Care Eligible for PPC Services?

[Refer to 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'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 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 Healthy Options contract.

> **Note:** To prevent billing denials, please 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 *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Coverage

[Refer to WAC 182-551-1820]

What Is Covered?

The Medicaid Agency'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 six contacts are medically necessary, complete the following:

- A completed, **typed** ProviderOne request form, HCA 13-835. This request form ***must*** be the initial page when you submit your request.

- A completed Home Health & Hospice Authorization Request Form, HCA 13-847, and all the documentation listed on this form and any other medical justification.

Fax your request to: 1-866-668-1214.

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, the Medicaid Agency 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;
- ✓ 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 have 6 contacts with any combination. Unbilled case management hours do not carry over to the next month.

What Is 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 exception to rule by completing HCA form 13-847, Home Health and Hospice Authorization Request.

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
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 (registered nurse)
659	PPC – PT (physical therapy)
659	PPC – OT (occupational therapy)
659	PPC – ST (speech therapy)
659	PPC – Case Management Time (Bill the date of service each two-hour time requirement was met.)

Reimbursement

How Does the Medicaid Agency Pay for PPC Services?

The Medicaid Agency 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.

The Medicaid Agency 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 the Medicaid Agency's **Hospice Services Fee Schedule** at http://hrsa.dshs.wa.gov/RBRVS/Index.html

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the Agency's *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. 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.

Completing the UB-04 Claim Form

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 at: http://www.nubc.org/index.html.

Effective for dates of service on and after September 4, 2012, 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)

Form Locator	Description	Field Required	Entry
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 http://www.nubc.org/index.html.

Completing the CMS-1500 Claim Form

Note: Refer to the Medicaid Agency's *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html 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 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
24G	**Days or Units**	Yes	Enter **1**	