Hospice

The hospice program provides home health and/or inpatient care, available 24 hours a day, which utilizes an interdisciplinary team of personnel trained to provide palliative and supportive services to a patient/family unit experiencing a life limiting disease with a terminal prognosis.

Special billing instructions

Providers are to use a single line item per Revenue code along with the total number of service units/hours for the calendar month for each client.

All Hospice claims are to be billed on a monthly basis. All claims should be submitted to Hewlett Packard Enterprise during the first week of the month following the month of service.

Covered services

Physical therapy, occupational therapy, respiratory therapy and speech-language pathology are Medicaid covered benefits when they are provided for the purpose of symptom control, or to enable the patient to maintain activities of daily living and basic functional skills.

Counseling services are available to both the individual and the family and are part of the per diem rate and the recipient's plan of care. Bereavement counseling for the client's family and significant others is available for up to one year after the patient's death and is not reimbursable.

Medicaid provides coverage for equipment provided by the hospice for use in the patient's home pursuant to the Plan of Care (POC).

Services included in the hospice benefit plan are:

- Home health aide and homemaker services
- Nursing care and services
- Social services
- Palliative care
- Management of the terminal illness and related conditions
- Routine home care
- Continuous home care
- Inpatient respite care
- General inpatient care

Services unrelated to the terminal illness billed by non-hospice providers may be covered subject to the specific program's limitations.

Non-covered services

No reimbursement is provided for curative services.

Prior authorization requirements

Prior authorization is required for all services unrelated to hospice diagnosis.

Hospice

Notes

All required documentation must be received in order for the Division of Health Care Financing and Policy (DHCFP) to issue a Billing Authorization Letter to the provider. See the Nevada Medicaid Services Manual Chapter 3200 for documentation requirements.

A hospice physician or nurse practitioner (NP) must have a face-to-face encounter with the recipient to determine continued eligibility prior to the 180th day of recertification, and prior to each subsequent recertification. The face-to-face encounter must occur no more than 30 calendar days prior to the third benefit period recertification and no more than 30 calendar days prior to every subsequent recertification. The face-to-face encounters are used to gather clinical findings to determine continued eligibility for hospice services.

It is essential to verify the recipient's Medicaid eligibility each time a service is provided. In addition, hospice providers must coordinate efforts with non-hospice providers to ensure that prior authorization is obtained from Hewlett Packard Enterprise for all services not related to hospice benefits.