Hospice

Overview

Medicaid Hospice Services program is designed to provide support and comfort for Medicaid eligible recipients who have a terminal illness and have decided to receive end of life care. Covered hospice services address the needs of the individual, their caregivers and their families while maintaining quality of life as a primary focus. The hospice philosophy provides for the physical needs of recipients as well as their emotional and spiritual needs.

Covered services must be available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions. Services unrelated to the terminal illness billed by non-hospice providers may be covered subject to the specific program's limitations.

See Medicaid Services Manual (MSM) Chapter 3200 for Hospice policy.

Covered Services

For expanded definitions of covered services, please refer to MSM 3203.2

- Nursing Services
- Medical Social Services
- Physician Services
- Counseling services are available to both the individual and the family
- Medical Appliances, Supplies and Pharmaceuticals
- Home Health Aide (HHA), Personal Care Aide (PCA) and Homemaker Services
- Physical therapy, occupational therapy, respiratory therapy and speech-language pathology

Non-Covered Services

- 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.
- No reimbursement is provided for curative services for adults.

Prior Authorization (PA)

Prior authorization is required for Hospice services and is based on medical necessity. The hospice agency will not be reimbursed for hospice services until the PA has been approved. It is the responsibility of the hospice provider to ensure that PA is approved for services unrelated to the hospice benefit. To request PA and upload required documents, please use the Provider Web Portal.

Please note if the authorization request is submitted after admission, the Hospice provider is assuming responsibility for program costs if the authorization request is denied. For recipients with Medicare and Medicaid coverage (dual eligibility), prior authorization is not required until the Medicare benefit is exhausted.

Hospice Forms

All fields on the forms are required to be filled in and, if specified, the physician signature must be included. Nevada Medicaid Hospice forms requiring a physician signature, submitted without the physician signature. will not be accepted.

- Plan of Care (POC)
- FA-91 Hospice Program Action Form- to be completed for hospice discharge, change of hospice provider or revocation of hospice services
- FA-92 Hospice Program Election Notice – Adults **(aged 21 and over)**
- FA-93 Hospice Program Election Notice – Pediatrics **(under age 21)**
- FA-94 Hospice Program Physician Certification of Terminal Illness

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- FA-95 Hospice Prior Authorization Request
- FA-96 Hospice Extended Care Physician Review Form; required after recipient has been on hospice services for 12 months **(aged 21 and over)**

These forms are available under "Hospice Forms" on the Providers Forms webpage.

Hospice Authorization

Hospice services are authorized in three distinct periods as described below.

1. **Initial 90 Day:** To be submitted as soon as possible, but **not more than eight business days following admission**.
   - Forms required: POC, FA-92 or FA-93, FA-94, FA-95

2. **Subsequent 90 Day**: To be submitted prior to initial authorization end date.
   - Forms required: POC, FA-92 or FA-93, FA-94, FA-95

3. **Unlimited Subsequent 60 Day**: To be submitted prior to second 90-day authorization end date.
   - Forms required: POC, FA-92 or FA-93, FA-94, FA-95, FA-96

Face-to-Face Visit

Documentation of face-to-face visit must be submitted with authorization requests.

- For the initial election period, a face-to-face visit with the recipient is required to be performed **prior to the start of care but no more than 15 days prior to hospice admission**.
- Face-to-face visit must be completed **prior to the 180th day of recertification**, and prior to each subsequent recertification
- A face-to-face visit 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.

Hospice Lock-In

To prevent billing discrepancies, once prior authorization is obtained, recipients who elect Hospice services will be 'locked' into the care of the specific Hospice provider during the course of their election. To end the Hospice Lock-In for a recipient, the FA-91 Hospice Program Action Form must be completed indicating the purpose of the change request.

Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Billing Instructions

PT 64 bills the following revenue codes for hospice services:

Revenue Code	Description	Limitations
0551	Service Intensity Add-On for the last 7 Days of Life (RN, LPN, Social Worker) (per 15 minutes)	Up to 4 hours per day
0650	Routine Hospice Care Days 1–60 (per day)	1 unit per day
0651	Routine Hospice Care Days 61+ (per day)	1 unit per day
0652	Continuous Home Care (per hour)	Minimum 8 units per day Maximum 24 units per day
0655	Inpatient Respite Care (per day)	1 unit per day

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Revenue Code	Description	Limitations
0656	General Inpatient Care (per day)	1 unit per day

All Hospice claims are to be billed monthly. All claims should be submitted to Nevada Medicaid during the first week of the month following the month of service.

Do not include the prior authorization (PA) number on the claim. Retain the PA number for your records.

Special Billing Instructions:

Routine Home Care

A dual rate has been established for Routine Home Care (RHC) hospice services provided by provider type (PT) 64 (Hospice), which pays a higher base rate for the first 60 days of hospice care and a reduced base rate for days thereafter.

- Use revenue code 0650 (Routine-Home Care) for routine home day care for the first 60 days (RHC).
  - Please note: If a recipient is discharged and re-admitted within 60 days of that discharge, then the day count would start back to the discharge day.
  - Example: A recipient is on hospice for five days, does not receive hospice care for 50 days and is then re-admitted, the provider has 55 more days of the higher RHC rate. If a recipient is discharged and does not have hospice services for at least 60 days in a row and is re-admitted, the provider starts all over with the 60-day higher rate.
- Use revenue code 0651 (Routine-Home Care) for routine home day care for days 61+.

Service Intensity Add-On (SIA)

An add-on payment has been established for services provided by a registered nurse or social worker during the last seven days of a recipient's life. No prior authorization is required.

- Use revenue code 0551 to bill for SIA during the last seven days of the recipient's life, in 15-minute increments, up to 4 hours total per day. These services cannot be done through telehealth.

Hospice Services for Managed Care Recipients

Managed care recipients who elect hospice care must be disenrolled from their managed care program.

- The hospice is responsible for notifying the QIO-like vendor in such situations.
- The recipient electing the hospice benefit will then return to Fee-for-Service (FFS) Medicaid.
- There should be no delay in enrolling managed care recipients in hospice services.

Hospice Services for Nevada Check-Up Recipients

Nevada Check-Up recipients are **not disenrolled** from a Managed Care Organization (MCO) when they receive hospice services. Although Nevada Check Up recipients receiving hospice care remain enrolled with the MCO, claims for hospice revenue codes are submitted to fee-for-service. The only claims submitted to the MCO are services not related to hospice revenue codes. It is the responsibility of the MCO to provide reimbursement to the provider for all ancillary services. For additional information, refer to MSM Chapter 3600 Managed Care Organization.

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Ordering, Prescribing or Referring (OPR) Provider Requirements

The Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services (CMS) require all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (§455.410 Enrollment and Screening of Providers). The Affordable Care Act (ACA) requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid. Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as OPR providers.

For any services or supplies that are ordered, prescribed or referred, the National Provider Identifier (NPI) of the Nevada Medicaid-enrolled Ordering, Prescribing or Referring (OPR) provider must be included on Nevada Medicaid/Nevada Check Up claims or those claims will be denied. To prevent claim denials for this reason, please confirm that the OPR provider is enrolled with Nevada Medicaid; this can be done on the Provider Web Portal by using the Search Providers feature: medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx

Reminders for providers who submit institutional claims:

- If your provider type requires the attending physician to be listed on the Institutional claim, that attending physician must be enrolled with Nevada Medicaid.
- If the service was ordered, prescribed or referred by another provider, the NPI of the OPR provider is required to be listed on the claim form. The OPR provider must be enrolled in Nevada Medicaid.
- If the attending physician is the same as the OPR provider, leave the OPR field blank.
- The attending and OPR NPI must be for an individual provider (not an organization or group).
- For detailed claim completion information, refer to the 837I FFS Companion Guide and the PWP User Manual Chapter 3.