Hospice

Provider Manual

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Preamble

This provider manual is intended to provide general coverage guidelines for members that are currently Medicaid Fee-for-Service (FFS) eligible. Verifying a member's eligibility is crucial to ensure correct coverage of services and limitations. Once an assignment to the IA Health Link managed care organization (MCO) has been completed, please refer to the provider manual for the IA Health Link MCO assigned.

CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. HOSPICE PROGRAM BASICS

1. Description

Hospice is a comprehensive set of services, identified and coordinated by a hospice interdisciplinary team (IDT), to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill member and family members. The priority of hospice care services is to meet the needs and goals of the hospice member and family.

The hospice must organize, manage, and administer its resources to provide the hospice care and services to members, caregivers, and families necessary for the palliation and management of the terminal illness and related conditions.

2. Terminal Illness

A terminally ill member is an individual who has a life expectancy of six months or less if the illness runs its normal course.

3. Hospice Election Periods

Hospice election periods consist of the following:

- An initial 90-day period
- A subsequent 90-day period
- An unlimited number of subsequent 60-day periods based on continued eligibility for the hospice program.

4. Physician Certification

The hospice must obtain a physician's certification that the member is terminally ill. The certification must be signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the member's attending physician (if the member has an attending physician). The attending physician is a physician who is a doctor of medicine or osteopathy and is identified by the member at the time the member elects to receive hospice care, as having the most significant role in the determination and delivery of the member's medical care.

5. Hospice Plan of Care

A hospice plan of care (POC) must be completed for each hospice member to meet the member and family's assessed needs under direction of the hospice IDT and in collaboration with other non-duplicative Medicaid services, if applicable.

The hospice POC must be reviewed, revised and documented, at a minimum, every 15 days, or less if the member's condition changes.

6. Face-to-Face Encounter

A hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice member whose total hospice support is anticipated to exceed 180 calendar days or the two initial hospice benefit periods or ninety days each. The face-to-face encounter must occur prior to, but no more than 30 calendar days prior to, the 180th day or the beginning day of the third benefit period recertification) and every benefit period recertification thereafter.

7. Hospice Responsibility for Services

All services related to the terminal illness and related conditions are the responsibility of the hospice provider.

8. Palliative Care

Hospice provides palliative care, not active or curative care. Palliative care means member and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate member autonomy, access to information, and choice.

EXCEPTION: The palliative, non-active, and non-curative requirement for hospice care does not include terminally ill children, up to age 21. Children may concurrently receive the hospice benefit and curative or active care.

9. Role of Interdisciplinary Team

The hospice IDT maintains the responsibility for directing, coordinating, and supervising the care and the services provided to the member. The hospice IDT must ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement in order to maintain a current POC.

The hospice IDT must ensure the ongoing sharing of information with other non-hospice providers furnishing services unrelated to the terminal illness and related conditions in order to maintain a current POC.

10. Medicare Certification

Only hospice providers certified to participate in the Medicare hospice program are eligible to participate as Medicaid or IA Health Link hospice providers.

11. Availability of Hospice Services Supports

Nursing services, physician services, and drugs and biologicals are considered the core services of the hospice benefit. These services must be made routinely available on a 24-hour basis 7 days a week. Covered services are included in Covered Services in this chapter.

Other services included in the hospice benefit, must be available on a 24-hour basis when medically necessary to meet the needs of the member and family.

12. Discharge from Hospice

A member will be discharged from a hospice agency if:

- The member moves out of the hospice provider's service area,
- The member transfers or changes to another hospice provider,
- The hospice physician determines that the member is no longer terminally ill.
- Based on written and approved policy developed by the hospice provider, the member (or other persons in the member's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the member or the ability of the hospice to operate effectively is seriously impaired.

If the member is discharged for cause, the hospice provider must ensure that it meets all of the criteria stated in 42 Code of Federal Regulations (CFR) 418(a)(3)(i)-(iv) before discharging.

B. COVERAGE OF SERVICES

1. Covered Services

The hospice program includes the following bulleted services. Any of the services can be combined, by duration or frequency, to meet the daily needs of the member and family.

- **Nursing care**. Skilled nursing care must be provided by or under the supervision of a registered nurse.

  A hospice must provide nursing care directly unless a waiver has been submitted and approved by the Centers for Medicare and Medicaid Services (CMS).

  Nursing care must ensure that the nursing needs of the member are met as identified in the member's initial assessment, comprehensive assessment, and updated assessments.

- **Medical social services**. Medical social services must be provided by a qualified social worker, under the direction of a physician.

  Social work services must be based on the member's psychosocial assessment and the member's and family's needs and acceptance of these services.

- **Physician services**. Physicians' services are performed by a physician or a nurse practitioner with the exception of the hospice medical director or the physician member of the hospice interdisciplinary team. The hospice medical director or the interdisciplinary team (IDT) physician must be a doctor of medicine or osteopathy.

  The hospice medical director, physician employees, and contracted physicians of the hospice, in conjunction with the member's attending physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness.

  All physician employees and physicians under contract are under the supervision of the hospice medical director.

  All hospice physicians shall coordinate care with the attending physician, if the member chooses an attending physician outside of the hospice network. If the attending physician is unavailable, the hospice medical director, hospice physician or contracted physician shall coordinate care.

- **Spiritual counseling**. Spiritual counseling must provide the following:
  - An assessment of the member's and family's spiritual needs.
  - Meet needs in accordance with the member and family's acceptance of this service and in a manner consistent with member and family beliefs and desires.
  - Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the member's spiritual needs.
  - Advise the member and family of this service.

- **Dietary counseling**. Dietary counseling is provided by a qualified professional who is able to address and assure that the identified dietary need of a hospice member is met.

- **Bereavement counseling**. Bereavement counseling is a required service but is not reimbursable.

  Services must be provided under the supervision of a qualified professional with experience or education in grief or loss counseling.

  Bereavement services are available to the family and other individuals in the bereavement plan of care up to one year following the death of the member. Bereavement counseling may also be provided to residents of:
  - A skilled nursing facility (SNF),
  - A nursing facility (NF), or
  - An intermediate care facility for the intellectually disabled (ICF/ID).

- **Hospice aide**. Hospice aides provide personal care services and household services to maintain a safe and sanitary environment in areas of the home used by the member, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the member. Hospice aide services must be provided under the general supervision of a registered nurse.
- **Homemaker**. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the hospice aide to carry out the plan of care.
- **Physical therapy, occupational therapy, and speech-language pathology**. Physical therapy, occupational therapy, and speech-language pathology services are provided for purposes of symptom control or to enable the member to maintain activities of daily living and basic functional skills.
- **Volunteer services**. Volunteers must provide day-to-day administrative or direct member care services in an amount that, at a minimum, equals five percent of the total member care hours of all paid hospice employees and contract staff.

  The hospice must maintain records on the use of volunteers for member care and administrative services, including the type of services and time worked.
- **Short-term inpatient care**. Short-term inpatient care is provided in a participating hospital. Services provided in an inpatient setting must conform to the written hospice plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings.

  Inpatient care may also be furnished to provide respite for the member's family or other persons caring for the member at home. Respite care is the only type of inpatient care that may be provided in a nursing facility when the member is otherwise receiving hospice services in a home setting.
- **Medical supplies and medical equipment**. Medical supplies include drugs and biologicals. Only drugs which are used primarily for the relief of pain and symptom control related to member's terminal illness are covered.

Medical equipment includes durable medical equipment and other self-help and personal comfort items related to the palliation or management of the member's terminal illness. Equipment is provided by the hospice for use in the member's home while the member is under hospice care. Medical supplies include those that are part of the written hospice plan of care.

- **Other services**. Any other service that is medically necessary for the palliation and management of the member's terminal illness and related conditions and for which reimbursement may otherwise be made under Iowa Medicaid or IA Health Link MCO shall be covered under the hospice program.

2. Non-Covered Services

- Medicaid-covered services, including direct physician care that are unrelated to the terminal illness or related conditions. These shall be billed separately by the respective provider.
- AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

C. HOSPICE FORMS RELATED TO SERVICE DELIVERY

For services provided through IA Health Link MCO, refer to the MCO-specific provider manual for any required hospice forms related to service delivery.

For services provided under Medicaid fee-for-service, the following hospice forms must be completed by the hospice provider, according to the purpose for each, and the originals retained in the member's case file:

- *Election of Medicaid Hospice Benefit*, form 470-2618. See Appendix A for form instructions.
- *Case Activity Report (CAR)*, form 470-0042. See Appendix B for form instructions.
- *Revocation of Medicaid Hospice Benefit*, form 470-2619. See Appendix C for form instructions.

NOTE: All hospice forms must be completed, dated, and signed on the day that the action is effective.

For hospice members who are living in a nursing facility (NF), please note the following:

- Information needed to complete these forms may require communication with the NF.
- Any required forms, must be submitted to the Department of Human Services (DHS) Centralized Facility Eligibility Unit (CFEU) **within 2 working days** after the form was completed (per preceding bullet). The mailing, fax, and email information for the CFEU is included in Appendices A, B, and C.
- Hospice provider reimbursement is directly related to the timely and accurate completion and submission to the CFEU of all hospice forms. This includes the hospice provider reimbursement (Revenue Code 651) as well as pass through NF reimbursement that the hospice provider will forward to the NF.
- A CAR form must be submitted with either the *Election of Medicaid Hospice Benefit* form, and/or the Election of Medicare Hospice Benefit form, or the *Revocation of Medicaid Hospice Benefit* form at the time of CFEU submission.
- If Medicare is the funding source for the member when hospice services begin, and if the member becomes Medicaid-eligible at a later date, the hospice provider must submit the *Election of* ***Medicare*** *Hospice Benefit* **and/or** the *Election of* ***Medicaid*** *Hospice Benefit* to the CFEU along with the CAR form.
- If a Medicaid member revokes or is discharged from the hospice benefit, any other Medicaid benefits for which the member is eligible will be initiated. The hospice provider must insure that notification to the CFEU is made for these changes.

The submission of forms, as described above for a hospice member living in an NF, applies to a hospice ICF/ID member. However, submit the CAR and the *Election of Medicaid Hospice Benefit* to the CFEU within the two working days requirement. Also, please note that reimbursement for time for a member living in an ICF/ID is also dependent on the timely submission of required forms to the DHS CFEU.

In lieu of the Election of Medicaid Hospice Benefit form or the Election of Medicare Hospice Benefit, an alternate form can be used. An alternate election form must provide the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgement that the member has been given a full understanding of hospice care
3. Acknowledgement that the member waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.

4. Acknowledgement that members are not responsible for copayment or other deductibles.

5. The member's Medicaid number.

6. The effective date of election

7. The member's signature.

D. BASIS OF PAYMENT

1. Nonreimbursable Diagnosis for Hospice

The hospice provider is to report diagnosis coding on the hospice claim required by ICD-10 coding guidelines. The principal diagnosis reported on the claim is the diagnosis most contributory to the terminal prognosis.

A list of nonreimbursable ICD-10 codes is available below:

NOT REIMBURSABLE AS HOSPICE ICD-10 PRIMARY DIAGNOSES

Coding Guideline	ICD-10 Code	ICD-10 Diagnosis
Dementia – Code the associated neurological or physical condition as primary.	F0390	Unspecified dementia without behavioral disturbance
	F0391	Unspecified dementia with behavioral disturbance
	F05	Delirium due to known physiological condition
	F0150	Vascular dementia without behavioral disturbance
	F0151	Vascular dementia with behavioral disturbance
	F0280	Dementia in other diseases classified elsewhere without behavioral disturbance
	F0281	Dementia in other diseases classified elsewhere with behavioral disturbance

Coding Guideline	ICD-10 Code	ICD-10 Diagnosis
Unspecified conditions	F0390	Unspecified dementia without behavioral disturbance
	F0391	Unspecified dementia with behavioral disturbance
	I50.9	Heart failure, unspecified
	I50.20	Unspecified systolic heart failure
	I50.30	Unspecified diastolic heart failure
	I50.40	Unspecified combined systolic and diastolic heart failure
	N18.9	Chronic kidney disease, unspecified
	N19	Unspecified kidney failure
	J96.91	Respiratory failure, unspecified with hypoxia
	J96.92	Respiratory failure, unspecified with hypercapnia
Acute respiratory failure – Acute is defined as a rapid onset and a short, severe course. Chronic respir-atory required for terminal diagnosis.	J95.821	Acute post procedural respiratory failure
	J9600	Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
	J9601	Acute respiratory failure with hypoxia
	J9602	Acute respiratory failure with hypercapnia
	J9690	Respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia
Chronic kidney disease – Renal failure required for terminal diagnosis.	N18.1	Chronic kidney disease, Stage I
	N18.2	Chronic kidney disease, Stage II (mild)
	N18.3	Chronic kidney disease, Stage III (moderate)
	N18.4	Chronic kidney disease, Stage IV (severe)
	N18.5	Chronic kidney disease, Stage V
Symptoms, signs and ill-defined conditions	R00.00 – R99	All codes included in ICD-10, Chapter 16, Symptoms, Signs, and Ill-Defined Conditions

2. Categories of Care

a. Methodology

Medicaid uses the same methodology as CMS uses to determine Medicare hospice rates. This method adjusts to disregard cost offsets attributable to Medicare coinsurance amounts and applies area wage adjustments for four categories of hospice care.

Hospice rates are prospective. There is not any retrospective adjustment.

Hospice rates are updated annually.

b. Description of Categories of Hospice Care and Assigned Revenue Codes

Medicaid provides a daily reimbursement for every day that a member is hospice eligible. The daily rate is one of the four categories of care. The categories of care are not based on the qualifications of the staff providing services. There may be a number of hospice staff who may support a hospice member during a day. Hospice staff supporting a member could include, but not limited to, a:

- Nurse practitioner (NP),
- Registered nurse,
- Hospice aide,
- Medical social worker,
- Clergy,
- Volunteer, and
- Physical therapist.

As an example, the medical expertise of the NP was required for a member. The NP provided both direct and indirect services for a total of six hours. The daily hospice reimbursement would not increase because of the NP qualifications, medical expertise or the NP's time. The daily hospice reimbursement remains a fixed rate.

All hospice services must be performed by appropriately qualified personnel; but it is the comprehensive, inclusive nature of multiple services of the hospice program that determines the daily category reimbursement rather than the qualifications of any category of staff that provides services.

Each of the four levels of care has a predetermined reimbursement rate. Payment is based on the geographic location at which the service is furnished. For hospice services provided in the member's residence, geographical region is based on the member's county of residence. For hospice services provided in an inpatient setting, geographical region is based on the county of the enrolled billing hospice provider. The metropolitan statistical area (MSA)/rural state code must be included on the claim for these revenue codes. The four categories of hospice are:

- **Routine Home Hospice Care (Revenue Code 651)**

  The hospice will be paid the Routine Home Care (RHC) rate for each day the member is at home, under the care of the hospice, and not receiving continuous home care.

  A routine rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

  A nursing facility may be considered the home for a member who has elected the hospice benefit.

  RHC is paid one of two RHC rates based on the following:

  1. The day is billed as a RHC level of care.
  2. If the day occurs during the first 60 days, the RHC will be equal to the RHC "High" rated.
  3. If the day occurs during days 61 or later, the RHC rate will be equal to the RHC "Low" rate.
  4. For a hospice member who is discharged and readmitted to hospice within 60 days of that discharge, their prior hospice days will continue to follow the member in determining the "High" or "Low" rate.
  5. For a hospice member who has been discharged from hospice care for more than 60 days, a new period of hospice will apply and be paid at the "High" rate.

  These rates are calculated on the annual hospice rates established under Medicare.

- **Service Intensity Add-on (SIA)**

  A hospice claim will be eligible for a SIA payment if the following criteria are met:

  1. The day is billed as a RHC level of care day: the day occurs during the last seven (7) days of life and the member is discharged as deceased;

     40 Expired at home

     41 Expired in a medical facility

     42 Expired place unknown

  2. Direct member is provided by a Registered Nurse (RN) or social worker that day for at least 15 minutes and up to four hours total.

  3. The service is not provided by a social worker via telephone.

- **Continuous Home Hospice Care (Revenue Code 652)**

  Continuous home care is covered when it is provided to maintain a member at home during a period of medical crisis. A period of crisis is a period of time when a member requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms.

  Nursing care must be provided by either a registered nurse or a licensed practical nurse. A nurse must be providing care for more than half of the care given in an hour period. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

The amount of payment is determined based on the number of hours of continuous care furnished to the member on that day. A minimum of eight hours must be provided during a 24-hour period which begins and ends at midnight before the continuous home care rate can be billed.

This care need not be provided all at once, i.e., four hours could be provided in the morning and another four hours provided in the evening of that day. Homemaker and aide services may also be provided to supplement the nursing care.

- **Inpatient Respite Care (Revenue Code 655)**

  Respite inpatient care is short-term inpatient care provided to the member only when necessary to relieve the family members or other persons caring for the member at home. Respite care is not paid when the hospice member is residing in a nursing facility.

  The hospice is paid at the inpatient rate for a maximum of five days at a time when the member is in an approved inpatient facility.

  Payment is made for the date of admission but not for the date of discharge. The discharge day for inpatient respite care is billed as routine home care or continuing home care, unless the member is discharged as deceased. When the member is discharged as deceased, the inpatient respite care rate is billed.

- **General Inpatient Care (Revenue Code 656)**

  General inpatient care is provided in periods of acute medical crisis when the member is hospitalized for pain control or acute or chronic symptom management. None of the other fixed payment rates (e.g., routine home care) are applicable for a day on which the member receives hospice inpatient care, except for the day of discharge from an inpatient unit.

  The discharge day for general inpatient care is billed as routine home care or continuous home care, unless the member is discharged as deceased. When the member is discharged as deceased, the general inpatient rate is billed.

- **Physician Services (Revenue Code 657)**

  Direct physician care provided to a Medicaid member by a hospice employee or any contracted physician is billed to Medicaid by the hospice agency. Reimbursement will be in accordance with the Medicaid physician payment schedule for Medicaid fee-for-service members. On the UB-04 billing form, include Revenue Code 657 **and** the CPT-4 code that identifies the physician service provided.

  NOTE: The bulleted physician services below are **not** billed using Revenue Code 657. Please refer to Nonreimbursable Hospice Physician Payment for further clarification:

  - General and supervisory physician services provided by physicians employed by or under contract with the hospice provider
  - Attending physician services
  - Voluntary physician services

3. Hospice in a Nursing Facility

For the purpose of the hospice benefit, a nursing facility (NF) may be considered the home of a member receiving hospice. Hospice in an NF is identified by the acronym hospice/NF.

a. Hospice/Nursing Facility Agreement

For hospice/NF care, the NF and the hospice provider must enter into a written agreement which states that the hospice provider takes full responsibility for the professional management of the member's hospice care and the NF agrees to provide room and board along with basic NF services. Basic NF services include:

- The performance of personal care services, including assistance in activities of daily living;
- Socializing activities;
- Administration of medication;
- Maintaining the cleanliness of the member's room; and
- Supervising and assisting in the use of durable medical equipment and prescribed therapies.

A copy of the written agreement shall be filed in member's records.

b. Inpatient Respite

Medicaid will not pay for inpatient respite care (Revenue Code 655) for a member who resides in a nursing facility.

Respite provided in a NF is designed to provide temporary relief for family members or other caregivers who are supporting the hospice member in the caregivers' residential community homes. For the purposes of the respite benefit provided under hospice, an assisted living facility is not considered a residential community home.

c. Daily Routine Care Reimbursement

Medicaid will reimburse the hospice provider for daily routine home care (Revenue Code 651) for a hospice member who resides in a nursing facility.

d. Daily Nursing Facility Reimbursement

Medicaid will also reimburse the hospice provider for 95 percent of the NF's daily reimbursement (Revenue Code 658). The cost of room and board can be obtained from the facility. The hospice agency may also use the online cumulative rate listing. Click on the following link to be redirected to the rate listing online:
http://dhs.iowa.gov/ime/providers/csrp/nrf

Use the most recent posting of the cumulative rate listing to research nursing facility rates. Each quarter the rate listing is updated, however, only the most recent sheet is updated with that data.

For hospice members entering a nursing facility, the adjustment will be effective the date of entry. For persons in a nursing care facility before the hospice election, the adjustment rate shall be effective the date of hospice election. **Reminder:** In order to ensure timely reimbursement, the hospice provider must submit the required forms to the DHS CFEU: CAR and the *Election of the Medicaid Hospice Benefit or the Election of Medicare* .

The hospice reimbursement for the NF room and board and basic NF activities is a pass-through payment. When the hospice receives Medicaid reimbursement (Revenue Code 658), the hospice provider forwards the payment amount to the NF.

e. Client Participation

Client participation is collected when the member is in an NF and receives hospice. The hospice provider is responsible for collection of the client participation. The amount collected is forwarded to the NF. The Iowa Medicaid will deduct the amount of the client participation automatically from the hospice/NF reimbursement (Revenue Code 658).

f. Hospice and Nursing Facility Reimbursement Based on Location

The location of a hospice member's home is used as the basis for hospice reimbursement when the hospice member lives in the community. However, when the hospice member lives in a nursing facility, the location of the nursing facility is used as the basis for hospice reimbursement.

4. Hospice in an Assisted Living Program

For payment of hospice services, an assisted living environment (hospice/AL) is considered a community, not a facility, living environment.

Hospice/AL does not require the submission of any hospice forms to the DHS CFEU. However, hospice/AL does require hospice form completion, with the exception of the CAR, in the hospice member's case file. All other documentation requirements, in accordance with Medicare hospice certification and Medicaid must be maintained.

5. Nonreimbursable Hospice Physician Payment

a. Physicians Employed by or Under Contract with the Hospice

The basic payment rate for hospice reimbursement reflects the costs of covered services related to the treatment of the member's terminal illness. This includes the administrative and general supervisory activities performed by the medical director, physicians, if employed by the hospice, or consulting physician. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs of these services are included in the reimbursement rates for routine home care, continuous home care, inpatient respite care, and general inpatient care.

b. Attending Physician Services

When the designated attending physician is not a hospice employee or volunteer, the reimbursement of an independent physician is made in accordance with usual Medicaid reimbursement. The physician bills Medicaid directly. The only services billed by the attending physician shall be the physician's personal professional services. Costs for services such as lab or X-rays shall not be included on the attending physician's bill.

c. Voluntary Physician Care

Physician services furnished on a volunteer basis are excluded from Medicaid reimbursement. A physician may volunteer to provide specific services and seek reimbursement for some other services. The hospice must have a liability to reimburse the physician for services provided before reimbursement is claimed.

In determining which services are furnished on a volunteer basis and which services are not, a physician must treat Medicaid members on the same basis as other patients in the hospice. For instance, a physician may not designate all physician services rendered to non-Medicaid patients as volunteered and at the same time seek payment from the hospice for all physician services rendered to Medicaid members.

EXAMPLE:

> Dr. Jones has an agreement with a hospice to serve as its medical director on a volunteer basis. Mrs. Smith, a Medicaid member, enters this hospice and designates Dr. Jones as her attending physician. Dr. Jones, who does not furnish direct member care services on a volunteer basis, renders a direct member care service to Mrs. Smith.
>
> Dr. Jones seeks reimbursement from the hospice for this service. The hospice is paid by Medicaid at the usual payment rate for the specific services Dr. Jones rendered to Mrs. Smith. The hospice then reimburses Dr. Jones for this service. Dr. Jones, by virtue of his volunteer activities, is deemed to be an employee of the hospice.

E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS FOR MEDICAID FEE-FOR-SERVICE

Claims for hospice providers are billed on federal form UB-04, *Health Insurance Claim Form*.

Click here to view a sample of the UB-04.

Click here to view billing instructions for the UB-04.

Refer to Chapter IV. *Billing Iowa Medicaid* for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at:
http://dhs.iowa.gov/sites/default/files/All-IV.pdf

APPENDIX A:
Instructions to Complete
Form 470-2618, *Election of Medicaid Hospice Benefit*

Click here to view the form online.

A. Purpose of Form

The purpose of the form is to accurately record the date on which a Medicaid member chooses the Medicaid hospice benefit.

B. When the *Election of Medicaid Hospice Benefit* Must be Completed

This form must be completed on the date when a Medicaid-eligible member or legal representative chooses to receive the Medicaid hospice benefit.

Special note for dual eligibility for Medicare and Medicaid: Any member who is eligible for hospice services under the Medicare benefit, must access funding through the Medicare benefit. Only members who are determined ineligible for Medicare can receive hospice services funded by Medicaid. If the Medicare member becomes eligible for Medicaid funding only; **and**, chooses to continue to receive hospice, the member must sign the *Election of Medicaid Hospice Benefit* to reflect the date that Medicaid hospice services began after Medicare hospice ended.

C. Responsibility for Completion

The hospice provider may assist the member or the legal representative with completion of this form, if needed. The member or the legal representative must sign and date the form.

D. Instructions

1. Section 1 – Medicaid Information

Recipient Name. Enter the Medicaid member's name as it appears on the *Medical Assistance Eligibility Card*.

Medicaid Number. Enter the member's state identification number (SID) as it appears on the *Medical Assistance Eligibility Card*. This number consists of seven numeric characters and an ending alphabetic character.

If the member has both Medicare and Medicaid eligibility, add the member's Medicare number under the member's SID.

Beginning Date of Care. Enter the date hospice service was first provided.

If the member received hospice services funded through Medicare before becoming Medicaid eligible, the *Election of Medicaid Hospice Benefit* must be completed with the date that Medicaid hospice services began.

Hospice Name. Enter the hospice provider's name.

Medicaid Provider Number. Enter the hospice's seven-digit Iowa Medicaid identification number.

Attending Physician Name and Phone Number. Enter this information if the attending physician is not an employee or contracted with the hospice provider.

2. Section 2 – Medicare Information

Medicare Patient Name. Enter the member's name as it appears on the Medicare card.

Medicare Claim Number. Enter the Medicare claim number as it appears on the Medicare card.

Begin Date. Enter the date Medicare hospice coverage began.

End Date. Enter the date Medicare hospice benefit was terminated, if applicable.

3. Section 3 – Nursing Facility Information

Facility Name. Enter the name of the NF.

Medicaid Provider Number. Enter the facility's seven-digit Iowa Medicaid provider number. ICF level always begins with 080 and SNF level always begins with 065.

Facility Address. Enter the complete mailing address of the facility.

4. Section 4 – Hospice Change

Present Hospice. Enter the provider name for the hospice before the change.

Medicaid Provider Number. Enter the provider number for the hospice before the change.

Effective Date of Change. Enter the last date that the hospice provider provided services before the change.

New Hospice. Enter the provider name for the hospice after the change.

Medicaid Provider Number. Enter the provider number for the hospice after the change.

Effective Date of Change. Enter the first date that the hospice provider provided services after the change.

Special Note: Completing Form for a Change of Hospice Providers. Section 1. Medicaid Information, and Section 5. Signatures, also need to be completed for a change in hospice providers. No other sections on the form need to be completed.

5. Section 5 – Signatures

Recipient's Signature or Mark. The hospice provider may assist the member or legal representative with completion of information on the form. The member or legal representative must sign this section

Date. The member or legal representative must write the date the form was signed.

Witness' Signature. The person who witnessed the member's or legal representative's signature must sign this form.

- A legal representative who witnessed the member's signature can sign this form.
- A hospice staff who witnessed the member's or the legal representative's signature cannot sign as a witness for this form. Enter the date this form is signed.

Date. The witness must date this form.

- A legal representative who witnessed the member's signature can date this form.
- A hospice staff who witnessed the member's or the legal representative's signature cannot date this form.

6. Section 6 – Distribution

- Retain the original in the member's case file.
- Send a copy to the member or the legal representative.
- If the member resides in an NF, send a copy to the:
  - Nursing facility.
  - DHS CFEU **within two days** of action, by mail, fax or email per the information below:

    Mailing Address:
    DHS CFEU
    Imaging Center 1
    Iowa Department of Human Services
    417 E. Kanesville Blvd.
    Council Bluffs, IA 51503-4470
    Fax: 515-564-4040
    Email: facilities@dhs.state.ia.us

APPENDIX B:
Instructions to Complete
Form 470-0042, *Case Activity Report*

Click here to view the form online.

A. Purpose of Form

The *Case Activity Report* (CAR) provides a mechanism for hospice providers to report individual member changes that may affect eligibility for a member who receives the hospice benefit and also resides in an NF.

B. When the CAR Must be Completed

- A Medicaid-eligible or dual-eligible member enters the NF and begins hospice on the same day.
- A member living in an NF chooses the hospice benefit.
- A dual-eligible member chooses the hospice benefit.
- The status of a dual-eligible hospice/NF member changes to Medicaid only.
- A hospice/NF member dies.
- A hospice/NF member does not qualify for or revokes the hospice benefit.
- A hospice/NF member changes or transfers to another NF or to another hospice provider.

C. Responsibility for Completion

The hospice provider may assist the member or the legal representative with completion of this form, if needed. The member or the legal representative must sign and date the form.

D. Instructions

1. Member Data

Name. Enter the member's first, middle initial, and the last name as it appears on the *Medical Assistance Eligibility Card*.

Date Entered Facility. This date will be one of the following:

- If the date that hospice began is the same day that the member entered the nursing facility, enter the day that the member entered the NF.
- If the date that hospice begins occurs sometime after the admission date, enter the date that hospice service actually began.

Social Security Number. Enter the social security number.

State ID. This number consists of seven numeric characters and an ending alphabetic character.

Case Number. Enter, if known. DHS income maintenance uses this number.

2. Facility Data

Provider Number/NPI Number. Enter the NF's provider numbers followed by the hospice provider numbers.

Facility Type. Check "Hospice" for facility type.

Name. Enter the name of the hospice provider.

DHS Per Diem. Enter the NF's daily reimbursement. The current rate can be located at the following link: http://dhs.iowa.gov/ime/providers/csrp/nrf

Street Address. Enter the street address of the hospice provider.

Signature of Person Completing Form. Enter the signature of the hospice staff completing form.

Date Completed. Enter the date the form was completed and sent to the DHS Centralized Facility Eligibility Unit (CFEU). CFEU submission information follows.

Contact Name. Enter the hospice contact's name.

Contact Phone Number. Enter the hospice contact's telephone and email address, if available.

3. Level of Care

Hospice eligibility does not require a level of care (LOC) determination unless the following applies:

- IME Medical Services has not completed a LOC for the NF member when hospice begins.
- If an LOC is needed for the above reason, submit documentation for a LOC determination in accordance with the Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) requirements.

4. Medicare Information for Either Skilled Patients or Hospice Patients in Nursing Facilities

Do you expect this stay to be covered by Medicare? Answer "yes" or "no" to the question. If yes, complete the next box.

Expected dates of Medicare coverage. Enter the dates of expected Medicare coverage.

- This section will be completed for hospice/NF members who are dual eligible and whose hospice benefit is funded by Medicare and the NF daily reimbursement is funded by Medicaid.
- Please note: If dual eligibility ends for the hospice/NF member and full Medicaid eligibility begins, another CAR must be completed, along with the *Election of the Medicaid Hospice Benefit*, form 470-2618.

5. Discharge Data

Date of Discharge. Enter the discharge date.

The information regarding various types of days is not completed, under "Last Month in Facility," unless the hospice/NF member dies on the last day of the month.

Reason for Discharge. Check the applicable box for discharge reason. If the reason for discharge is not listed, draw in another box at the bottom and write the reason for discharge.

6. Distribution

- Retain the original in the member's case file.
- Submit a copy to the member or the legal representative.
- If the member resides in an NF, submit a copy to the:
  - Nursing facility.
  - DHS CFEU **within two days** of action by mail, fax or email per the information below:

    Mailing Address:
    DHS CFEU
    Imaging Center 1
    Iowa Department of Human Services
    417 E. Kanesville Blvd.
    Council Bluffs, IA 51503-4470
    Fax: (515) 564-4040
    Email: facilities@dhs.state.ia.us

APPENDIX C:
Instructions to Complete
Form 470-2619, *Revocation of Medicaid Hospice Benefit*

Click here to view the form online.

A. Purpose of *Revocation of Medicaid Hospice Benefit*

If a member or legal representative wants to stop receiving hospice services, this form is completed.

A member or legal representative may revoke services at any time. The member may choose to begin hospice services at any time after a revocation also.

B. When the Form Must be Completed

This form must be completed when a conscious decision by the member or legal representative is made to stop receiving hospice services.

A revocation does not include ineligibility for the hospice benefit or death (see Discharge from Hospice).

C. Responsibility for Completion

The hospice provider may assist the member or the legal representative with completion of this form, if needed. The member or the legal representative must sign and date the form.

D. Instructions

Recipient's name and Medicaid number. Enter the member's state identification (SID) number as it appears on the *Medical Assistance Eligibility Card*. This number consists of seven numeric characters and an ending alphabetic character.

If the member has both Medicare and Medicaid eligibility, add the member's Medicare number under the member's SID.

Agency name and Agency provider number. Enter the hospice agency's name and the hospice agency's Iowa Medicaid provider number in the spaces provided.

Recipient's signature. The signature of the member or legal representative.

Date. The member or legal representative must write the date the form was signed.

Witness' signature. The person who witnessed the member's or legal representative's signature must sign this form.

- A legal representative who witnessed the member's signature can sign this form.
- A hospice staff who witnessed the member's or the legal representative's signature cannot sign as a witness for this form.

Witness' signature. The signature of the person who witnessed the member's sign this form is required.

Date. The witness must date this form.

- A legal representative who witnessed the member's signature can date this form.
- A hospice staff who witnessed the member's or the legal representative's signature cannot date this form.

E. Distribution

- Keep the original in the member's case file.
- Submit a copy to the member or the legal representative.
- If the member resides in an NF, submit a copy to the:
  - Nursing facility.
  - DHS CFEU **within two days** of action by mail, fax or email per the information below:

    Mailing Address:
    DHS CFEU
    Imaging Center 1
    Iowa Department of Human Services
    417 E. Kanesville Blvd.
    Council Bluffs, IA 51503-4470
    Fax: (515) 564-4040
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