

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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This clinical coverage policy has an effective date of March 1, 2021; however, until the end of the public health emergency, the temporary coverage and reimbursement flexibilities enabled by NC Medicaid through a series of [COVID-19 Special Medicaid Bulletins](#) will remain in effect.

Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

9, Outpatient Pharmacy Program
2B-1, Nursing Facilities
3L, State Plan Personal Care Services
3A, Home Health Services
3K-1, Community Alternatives Programs for Children (CAP/C)
3K-2, Community Alternatives Programs for Disabled Adults (CAP/DA) 5A-3,
Nursing Equipment and Supplies

1.0 Description of the Procedure, Product, or Service

The NC Medicaid (Medicaid) and NC Health Choice (NCHC) hospice benefit is a comprehensive set of services, identified and coordinated by a hospice interdisciplinary group (IDG). The IDG delivers medical, nursing, social, psychological, emotional and spiritual services to enable physical and emotional comfort and support using a holistic approach to maintain the best quality of life for a terminally ill beneficiary, their family and caregivers. The priority of hospice services is to meet the needs and goals of the hospice beneficiary, family and caregivers with daily activities and to help the terminally ill beneficiary with minimal disruption to normal activities, in the environment that best meets the care and comfort needs of the beneficiary and unit of care.

The hospice IDG achieves this by organizing and managing a comprehensive care plan focused on coordinating care, services and resources to the beneficiary, caregivers, and family necessary for the palliation and management of the terminal illness and related conditions.

Only Medicare-certified and North Carolina licensed hospice agencies are eligible to participate as Medicaid hospice providers through the NC Division of Health Service Regulation (www.ncdhhs.gov). Each site providing hospice services must be separately licensed. The North Carolina Medical Care Commission has rulemaking authority for hospice. The statutes that apply to hospice agencies are General Statute 131E-200 through 207 and the licensure rules are under Title 10A of the North Carolina Administrative Code (10A NCAC 13K); (G.S. 131E, Article 9, 175-190) and administrative rules (10A NCAC Subchapter 14C).

A Hospice provider must have a contract with a nursing home or hospital if services are provided within those facilities.

Note: Throughout this policy, wherever the word “family” is used, “caregivers” are included unless specifically stated otherwise.

1.1 Definitions

1.1.1 Hospice

"Hospice" means any coordinated program of home care with provision for inpatient care for terminally ill patients and their families. This care is provided by a medically directed interdisciplinary team, directly or through an agreement under the direction of an identifiable hospice administration. A hospice program of care provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement according to GS §131E-201(3) and GS § 131E176(13a)GS § 131E-176(13a).

1.1.2 Hospice Care

Hospice care means a comprehensive set of services described in 1861(dd)(1) of the Social Security Act, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of the terminally ill patient, family member, as delineated in the specific plan of care, according to 42 CFR §418.3.

1.1.3 Hospice Provider

Hospice provider means a public agency or private organization or subdivision of either of these that is primary engaged in providing hospice care, according to 42 CFR §418.3.

For the purpose of this policy, Hospice provider also refers to Hospice, Hospice Agency or Hospice Entity.

1.1.4 Terminally Ill

Terminal ill means that the beneficiary has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course, according to 42 CFR §418.3.

1.1.5 Beneficiary

Beneficiary means eligible individual receiving NC Medicaid or NC Health Choice service.

1.1.6 Hospice Aide

Hospice Aide means an aide who is authorized to provide nursing care under the supervision of a licensed nurse, has completed a training and competency evaluation program or competency evaluation program as outlined in 42 CFR 418.76, is listed on the Nurse Aide Registry at the Division of Health Service Regulation and completes the training listed in 10A NCAC 13K .0402(b). If the nurse aide performs Nurse Aide II tasks, he or she must also meet the requirements established by the N.C. Board of Nursing as defined in 21 NCAC 36. 0405.

1.1.7 Personal Care Services

Personal Care Service are services that provides assistance with the distinct tasks associated with the performance of the activities of daily living (ADL) and the instrumental activities of daily living (IADL).

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibilities and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

a. Medicaid

A beneficiary with Medicaid for Pregnant Women (MPW) is eligible for hospice services only if the terminal illness is pregnancy related. Refer to **Subsection 5.1** for information regarding prior approval for MPW beneficiaries.

A beneficiary who is dually eligible for Medicare and Medicaid hospice shall elect both programs simultaneously. Refer to **Subsection 5.8**.

b. NCHC

None Apply

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if the service is medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/providermanuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover the following hospice services when medically necessary and the criteria and requirements are met according to:

42 CFR §418 – Hospice Care, Subpart C-Conditions of Participation: Patient Care, and Subpart F- Covered Services.

These services must be provided in a manner consistent with acceptable standards of practice:

- a. Nursing services according to 42 CFR §418.202(a);
- b. Medical social services according to 42 CFR §418.202(b);
- c. Physicians' services according to 42 CFR §418.202(c);
- d. Counseling services (bereavement, dietary, and spiritual) services according to

- 42 CFR §418.202(d);
- e. Short-term inpatient care (Refer to **Subsection 4.2.3** for NCHC exceptions) services according to 42 CFR §418.202(e);
 - f. Interdisciplinary group, care planning, and coordination of services according to 42 CFR §418.56;
 - g. Medical appliances and supplies, including drugs and biologicals according to 42 CFR §418.202(f)
 - h. Hospice aide and homemaker services according to 42 CFR §418.202(g);
 - i. Physical therapy, occupational therapy and speech-language pathology services according to 42 CFR §418.202(h);
 - j. Volunteer services according to 42 CFR §418.78; and any other service that is specified in the beneficiary's plan of care as reasonable and necessary for the palliation and management of the patient's terminal illness and related conditions and for which payment may otherwise be made under Medicaid according to 42 CFR §418.202(h)(i).

In addition to the above covered services, Medicaid and NCHC shall cover ambulance transport services when provided in relation to the palliation or management of the beneficiary's terminal illness which occur after the effective date of election.

3.2.2 Medicaid Additional Criteria Covered

In addition to the specific criteria covered in **Subsection 3.2.1** of this policy, if a Medicaid hospice beneficiary becomes a resident of a skilled nursing facility (SNF), nursing facility (NF) or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Medicaid shall cover room and board charge when the Medicare hospice benefit is elected.

3.2.3 NCHC Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid and NCHC shall not cover additional respite care services over and above the per diem amount contracted for hospice services.

Attending and consulting physician services are not considered a hospice service and are covered under the Medicaid and NCHC Physician Services program policies. Refer to NC Medicaid's website <https://medicaid.ncdhhs.gov/>.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

- a. In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, NCHC shall not cover room and board in a nursing facility, skilled nursing facility, ICF/IID facility, or adult care home.
- b. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 1. No services for long-term care.
 2. No nonemergency medical transportation.
 3. No EPSDT.
 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Medicaid and NCHC hospice services require prior approval request but do not require clinical review for Hospice service until after the first (1st) and second (2nd) benefit periods. Request for Hospice service beginning with the third (3rd) and for each subsequent benefit periods must receive prior approval and clinical review. PA request must be submitted online through the NCTracks Provider Portal.

In addition, Medicaid requires Prior Approval (PA) for Hospice services when a beneficiary's physician determines hospice is needed for a Medicaid for Pregnant Women (MPW).

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in Subsection 3.2 of this policy.

5.2.2 Specific

5.2.2.1 First and Second Benefit Periods

The first (1st) benefit period and second benefit period (2nd) are both 90 calendar days. This begins the initial admission to Hospice service based on the original election date for the beneficiary.

Beginning with the first (1st) benefit period, hospice providers must obtain written certification of terminal illness for each benefit period throughout the duration of hospice care to be maintained in the provider file according to 42 CFR §418.22.

At the first (1st) benefit period the hospice provider (s) shall create a prior approval request and upload the Election Statement which notifies NC Medicaid of the beneficiary election of hospice service. The PA request and election statement must be uploaded into NCTracks portal within six calendar days of the effective date of the beneficiary election of hospice service, according to 42 CFR 418.24.

The second (2nd) benefit period requires the entry of a PA request in to NCTracks, however, the election statement is not required at this benefit period

5.2.2.2 Third and Subsequent Benefit Periods

The third (3rd) benefit period and each subsequent benefit period are 60 calendar days. The Hospice provider(s) shall create a prior approval request and upload all the following documents listed below online through the NCTracks Provider Portal for recertification:

- a. NC Medicaid Hospice Prior Approval Authorization Form (DMA-3212);
- b. Hospice Recertification of Terminal Illness;
- c. Physician Plan of Treatment - Order for care and services;
- d. Face-To-Face Encounter
- e. Supporting clinical documentation (i.e. medical history, nurses' IDG notes, etc.), and assessment tools used to measure beneficiary status or decline. Hospice Assessment tool including, but not limited to, Functional Assessment Scales (FAST); Palliative Performance Scales; New York Heart Association Functional Classification Tool (NYHA), Palmetto GBA Local Coverage Determinations.

Note: If above required documentation is not received, the recertification prior approval request is denied.

Prior Approval (PA) requested for hospice services must be submitted on behalf of the medical director or beneficiary's attending physician via NC Track at least ten calendar days before the end of the current benefit period.

Note: The hospice physician, hospice nurse practitioner or physician assistant may act as the beneficiary's attending physician per beneficiary choice according to 42 CFR 418.52(c)(4). Refer to Section 7.8.

5.2.2.3 Nursing Facility

Nursing facility or ICF-IID long-term care approval is required for a beneficiary residing in or entering the facility. Nursing facility or ICF-IID approval is determined by the DHHS fiscal contractor. The hospice provider shall obtain a copy of the approval form (FL-2) or (IID-2) as applicable, to ensure compliance with this guideline. Nursing facility or ICF/IID room and board reimbursement cannot be made to the hospice provider without this approval.

Note: Hospice agencies verify Nursing facility or ICF-IID long-term care approval in NC Tracks to ensure the approval was obtained prior to seeking reimbursement. Hospice providers should provide documentation referencing place of origin verifying the FL-2 or IID-2 in beneficiary medical records.

5.2.2.4 Long Term Care

The hospice provider is responsible for ensuring that the long-term care prior approval process has been completed and that the Medicaid beneficiary is approved for nursing facility or ICF/IID level of care. This process can be completed by the hospice or through arrangement with the facility, hospital discharge planner, physician, or other sources. A hospice Medicaid beneficiary in a nursing or ICF/IID facility shall meet the same level of care requirements as other Medicaid nursing facility beneficiaries. The hospice provider shall retain a copy of the NC Medicaid Long Term Care Form FL-2 or IID-2, as applicable, in the Medicaid beneficiary's records on site at the hospice provider.

Note: Hospice agencies verify the nursing facility or ICF/IID level of care long-term care approval in NC Tracks to ensure the approval was obtained prior to seeking reimbursement. Hospice providers should provide documentation referencing place of origin verifying the FL-2 or IID-2 in beneficiary medical records.

5.3 Admission to Hospice

The provider of hospice services shall comply with 42 CFR §418.25, Admission to hospice care.

The hospice provider admits a beneficiary only on the recommendation of the medical director in consultation with, or with input from, the beneficiary's attending physician (if any). The hospice medical director shall consider at least the following information to determine that the beneficiary is certified terminally ill:

- a. Diagnosis of the terminal condition;
- b. Health conditions, related or unrelated to the terminal condition; and
- c. Current clinically relevant information supporting all diagnoses.

5.4 Certification of Terminal illness

5.4.1 Timing of certification

The provider of hospice services shall comply with 42 CFR §418.22(a), Timing of certification.

- a. The hospice provider shall obtain written certification of terminal illness for each benefit period.
- b. The hospice provider shall obtain the written certification before it submits a claim for payment.
- c. Exceptions.
 1. If the written certification cannot be obtained within two calendar days, after a period begins, then an oral certification must be obtained within two calendar days and the written certification before submitting a claim for payment.
 2. Certifications may be completed no more than 15 calendar days prior to the effective date of election.
 3. Re-certifications may be completed no more than 15 calendar days prior to the start of the subsequent benefit period.
- d. *Face-to-face encounter.* A hospice physician or hospice nurse practitioner shall have a face-to-face encounter with the beneficiary, that must occur prior to, but no more than 30 calendar days prior to, the 3rd benefit period recertification, and every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care.

5.4.2 Content of certification

The provider of hospice services shall comply with 42 CFR §418.22(b), Content of certification.

The physician or nurse practitioner who performs the face-to-face encounter shall attest in writing that he or she had a face-to-face encounter with the beneficiary, reporting the date of that visit. The attestation of the nurse practitioner or the non-certifying hospice physician shall state that the clinical findings of that visit were provided to the certifying physician for use in determining continued eligibility for hospice care. All certifications and recertifications must be signed and dated by the physician(s) and must contain the benefit period dates to which the certification or recertification applies.

5.4.3 Sources of certification

The provider of hospice services shall comply with 42 CFR §418.22(c), Sources of certification.

- a. For the initial 90-day period, the hospice shall obtain a written certification statement from:
 1. The medical director of the hospice or the physician member of the hospice interdisciplinary group (IDG); and
 2. The individual's attending physician, if the individual has an attending physician.
- b. For subsequent periods, only certification by the medical director of the hospice or the physician member of the hospice interdisciplinary group is required.

5.4.4 Maintenance of records.

The provider of hospice services shall comply with 42 CFR §418.22(d)(1)(2), Maintenance of records.

The Hospice shall make an appropriate entry in the beneficiary's medical record as soon as they receive an oral certification, and file written certifications in the beneficiary's medical record.

5.5 Initial and Comprehensive Assessment

The provider of hospice services shall comply with 42 CFR §418.54, Condition of participation. The hospice shall conduct and document in writing a comprehensive assessment that identifies the beneficiary's need for hospice care services, and the beneficiary's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.

a. **Initial assessment:**

The hospice registered nurse shall complete an initial assessment within 48 hours after the election of hospice care.

b. **Timeframe for completion of the comprehensive assessment:**

The hospice interdisciplinary group shall complete the comprehensive assessment no later than five calendar days after the election of hospice care.

c. **Content of the comprehensive assessment:**

The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed to promote the hospice beneficiary's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment must take into consideration the following factors:

1. The nature and condition causing admission (including the presence or lack of objective data and subjective complaints).
2. Complications and risk factors that affect care planning.
3. Functional status, including the beneficiary's ability to understand and participate in his or her own care.
4. Imminence of death.

5. Severity of symptoms.
6. Drug profile is a drug profiling assessment is a review of all the beneficiary's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes the identification of the following:
 - i. Effectiveness of drug therapy;
 - ii. Drug side effects;
 - iii. Actual or potential drug interactions;
 - iv. Duplicate drug therapy; and
 - v. Drug therapy currently associated with laboratory monitoring.
7. Bereavement assessment; is an initial assessment of the needs of the beneficiary's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the beneficiary's death. Information gathered from the bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.
8. Referral; is the review of further evaluation by appropriate health professionals.

d. Update of the comprehensive assessment

The update of the comprehensive assessment must be completed by the hospice interdisciplinary group and must consider changes that have taken place since the initial assessment. It must include information on the beneficiary's progress related to outcomes, as well as a reassessment of the beneficiary's response to care. The assessment update must be completed as frequently as the condition of the beneficiary requires, but no less frequently than every 15 days.

e. Beneficiary's outcome measures

The comprehensive assessment must include data that allows for measurement of outcomes. The hospice provider shall measure and document data in the same way for all beneficiaries. The data must take into consideration aspects of care related to hospice and palliation.

The data must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each beneficiary. The data for each beneficiary must be used in the individual beneficiary care planning and in the coordination of services and must be used in the aggregate for the hospice's quality assessment and performance improvement program.

5.6 Electing the Hospice Benefit

5.6.1 Filing an election statement

The provider of hospice services shall comply with 42 CFR §418.24 (a) Filing an election statement, and upload the election statement into NCTracks as part of the initial PA request for hospice services.

- a. **Submission** of the election statement must be within six calendar days of the effective date, in order to be paid from the beneficiary's date of election into Hospice services. If not submitted within six days of election, Medicaid coverage shall not begin until after the election statement is uploaded into

NCTracks. These days are a provider liability and the provider shall not bill the beneficiary for these non-Medicaid covered days. If beneficiary is physically or mentally incapacitated, his or her representative (as defined in §418.3) may file the election statement.

- b. **Exception to the consequences for filing the Election Statement late may be waived** NC Medicaid determines if a circumstance encountered by a hospice is exceptional and qualifies for waiver. A hospice shall fully document and furnish any requested documentation to NC Medicaid for a determination of exception.

Note: If Medicare is the primary payer, and Medicaid is providing coverage for nursing home room and board the provider shall create a prior approval request in NCTracks and upload the Election Statement into the initial PA for room and board.

5.6.2 Content of election statement

The provider of hospice services shall comply with 42 CFR §418.24 (b), Content of election statement.

The election statement must include the following information:

- a. Identification of the hospice and of the attending physician that will provide care to the beneficiary. The beneficiary shall acknowledge that the identified attending physician was his or her choice;
- b. The beneficiary's acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the beneficiary's terminal illness;
- c. The effective date of the election period, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement;
- d. The signature of the beneficiary or representative; and
- e. Acknowledgement that certain Medicaid services are waived by the election of Hospice.

5.6.3 Duration of election

The provider of hospice services shall comply with 42 CFR §418.24 (c), Duration of election.

An election to receive hospice care is considered to continue through the initial election (1st-2nd) benefit periods and through the subsequent election periods (3rd- unlimited) without a break in care of the beneficiary. If beneficiary:

- a. Remains in the care of a hospice;
- b. Does not revoke the election; and
- c. Is not discharged from the hospice under the provisions according to 42 CFR §418.26.

5.6.4 Waiver of other benefits.

The provider of hospice services shall comply with 42 CFR §418.24 (d), Waiver duration of election other benefits.

In the duration of an election of hospice care, a beneficiary waives all rights to payments for other Medicaid services listed in 42 CFR §418.24 (d).

5.6.5 Re-election of hospice benefits

The provider of hospice services shall comply with 42 CFR §418.24 (e), Reelection of hospice benefits.

If an election has been revoked in accordance with 42 CFR § 418.28, the beneficiary (or his or her representative if the individual is mentally or physically incapacitated) may at any time file an election, in accordance with this section, for any other election period that is still available to the beneficiary.

If the beneficiary wishes to resume hospice, the beneficiary or representative reelects hospice for the next benefit period. The beneficiary is considered a new hospice beneficiary. A new election statement, plan of care (POC), and physician certification are required. Benefit periods are counted consecutively regardless of the number of times a beneficiary revokes or re-elects hospice services.

5.6.6 Changing the attending physician.

The provider of hospice services shall comply with 42 CFR §418.24 (f), Changing the attending physician.

To change the designated attending physician, the beneficiary (or representative) shall file a signed statement with the hospice that states that he or she is changing his or her attending physician.

- a. The statement must identify the new attending physician and contain the date the change is to be effective and the date signed by the beneficiary (or representative).
- b. The beneficiary (or representative) shall acknowledge that the change in the attending physician is due to his or her choice.
- c. The effective date of the change in attending physician cannot be before the date the election statement is signed.

5.7 Duration of Hospice Care Coverage Benefit Periods

The provider of hospice services shall comply with 42 CFR §418.21, Duration of hospice care coverage benefit periods. Subject to the conditions set forth in this part:

- a. A beneficiary shall elect to receive hospice care during one or more of the following benefit periods:
 1. An initial 90-day period - benefit period;
 2. A subsequent 90-day period - benefit period two; or
 3. An unlimited number of subsequent 60-day periods- benefit period three to unlimited.

- b. The periods of care are available in the order listed and may be elected separately at different times.

5.8 Coordinating Medicaid and Medicare Benefit Periods

Medicaid and Medicare benefit periods are identical and run concurrently. When the beneficiary is dually eligible, he or she shall elect the hospice service for both programs simultaneously. Medicare hospice covers payment in full. Medicaid coverage is available only for nursing facility room and board. The benefit period for starting the Medicaid service must mirror the current Medicare benefit status when the coverage does not start concurrently.

Note: The Preadmission Screening Resident Review (PASRR) program is a federal statutory requirement that mandates the review of every beneficiary who applies to or resides in a Medicaid-certified nursing facility, regardless of the source of payment for nursing facility services. Refer to Clinical Coverage Policy 2B-1, *Nursing Facility Services* on NC Medicaid's website at <https://medicaid.ncdhhs.gov/> and according to 42 CFR 483 Subpart C.

5.9 Medicaid Eligibility and Benefit Period Coordination

When a beneficiary becomes ineligible for Medicaid while receiving hospice services or goes into a deductible status, the following apply:

- a. If the beneficiary remained on hospice throughout the ineligible Medicaid period, there is no change in the benefit period status. The hospice charges are applied toward any deductible.
- b. If the beneficiary discontinues hospice coverage when becoming ineligible for Medicaid or NCHC, the situation is handled like a revocation. The beneficiary forfeits any remaining days in the current benefit period and enters the next benefit period if re-electing hospice after Medicaid or NCHC eligibility is restored.

5.10 Waiver of Rights to Other Medicaid or NCHC Covered Services

The provider of hospice services shall comply with 42 CFR §418.24, Election of hospice care.

A Medicaid or NCHC beneficiary who elects the hospice benefit waives the rights to Medicaid or NCHC coverage of other services that replicate the services covered under the hospice benefit. The waiver of curative services is not applicable to beneficiaries under 21 years old. Refer to **Subsection 5.11**. The written statement contains the waiver of coverage for certain Medicaid or NCHC covered services when they are pertinent to treatment of the terminal illness. The waived Medicaid or NCHC services are listed below for beneficiaries 21 and under: (Refer to **Subsection 5.11**):

- a. Medicaid or NCHC coverage for home health, Durable Medical Equipment (DME), and home infusion therapy (HIT) services is not allowed for a hospice beneficiary when the service pertains to the treatment of the terminal illness or related conditions.
- b. Drugs and biologicals pertaining to the terminal diagnosis are reimbursed to the hospice as part of the hospice per diem. Medicaid or NCHC shall make direct reimbursement to the pharmacy for drugs used to treat illnesses or conditions not related to the terminal illness.

5.11 Concurrent Care for Children

Children means Medicaid beneficiaries under 21 years of age, and NCHC beneficiaries age 6 through 18.

Hospice providers shall comply with Sections 1905(o)(1) and 2110(a) (23) of the Social Security Act, and The Patient Protection and Affordable Care Act, Section 2302.

Hospice services are available to children without requiring the waiver of any rights of the child to be provided with, or to have payment made for, services that are related to the cure or treatment of the child's condition for which a diagnosis of terminal illness has been made. Concurrent care is available to the child after the provision of hospice care.

The Patient Protection and Affordable Care Act does not change the criteria for receiving hospice services. The hospice provider shall provide all services covered under the hospice benefit. Concurrent care does not duplicate the services covered in the hospice benefit.

5.12 Reporting Hospice Participation

5.12.1 Dually Eligible

The hospice provider shall report hospice participation for a dually eligible Medicare and Medicaid beneficiary in a nursing facility. Medicare reimbursement is made for the hospice care, and Medicaid shall reimburse room and board charges. Hospice claims are not reimbursed by DHHS without this notification.

5.12.2 Revocations

The hospice provider shall comply with 42 CFR §418.28 Revoking the election of hospice care.

A beneficiary or his or her representative may revoke the hospice election at any time by completing and signing a revocation statement. The statement indicates that the beneficiary revokes the hospice election and the effective date of the revocation. The effective date cannot be earlier than the date the beneficiary signs the revocation statement.

By revoking hospice coverage, a beneficiary:

- a. forfeits any remaining days of coverage in the current benefit period after the revocation date, and
- b. is eligible to resume coverage of the waived benefits effective on the date of revocation.

5.12.3 Discharges and Transfer

The hospice provider shall comply according to 42 CFR §418.26 - Discharge and Transfer from hospice care.

The hospice provider may discharge a beneficiary according to applicable law, rules and regulations, and provider policy. The hospice provider shall complete and upload into NCTracks the NC Medicaid Hospice Reporting Form (DMA0004)

when a beneficiary revokes, transfers or is otherwise discharged from hospice service. The provider shall promptly report the beneficiary's revocation or discharge to NC Medicaid because hospice participation information may affect Medicaid or NCHC payment for other services. The provider shall bill for the date of discharge or revocation.

5.12.4 Hospice Participation Notification

The hospice provider shall report initial hospice participation to NC Medicaid when a beneficiary elects Medicaid or NCHC hospice benefits.

The hospice provider shall submit a PA request:

- a. initially, within six calendar days of the election of the Medicaid, Medicaid pending or NCHC hospice benefit;
- b. within six calendar days of the start of the second and each subsequent benefit period; and
- c. within six calendar days of the start of care, if Medicare is the primary payer, and Medicaid is providing coverage for nursing home room and board.

The hospice provider shall report to NC Medicaid by faxing the NC Medicaid Hospice Reporting Form (DMA-0004) for the following situations:

- a. if the beneficiary is discharged from or revokes hospice;
- b. at the time of the beneficiary's death;
- c. to coordinate reporting a transfer of hospice care from one provider to another to prevent duplication of dates of service and subsequent denial of payment as only one provider can be paid each day; and to notify NC Medicaid of changes in status from Medicaid-Pending to Medicaid-Approved by providing the MID number.

Note: Hospice providers that fail to provide all required documents for prior approval to NC Tracks, may be referred to the Office of Compliance and Program Integrity (OCPI).

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed DHHS Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Note: Only Medicare-certified and licensed hospice agencies are eligible to participate as Medicaid hospice providers.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

- a. Nursing shall comply with NC GS Chapter 90, Article 9 - Nurse Practice Act, Title 21 - Occupational Licensing Boards and Commissions > Chapter 36 - Nursing and agency policy.
- b. Hospice aide shall comply with the qualifications under 42 CFR §418.76.
- c. Provider of hospice services shall comply with the following legal authorities:
 1. Social Security Act (SSA) Section 1905(o). [42 U.S.C. 1396d];1905(o)(1) and 2110(a) (23) of the Social Security Act
 2. The Patient Protection and Affordable Care Act, Section 2302; The Patient Protection and Affordable Care Act, Section 3132
 3. The Patient Self Determination Act of 1990, Sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, P.L.101-508
 4. 42 U. S. C. 1302 and 1395hh, Social Security Act (SSA) Sections 1102 and 1871)
 5. 42 CFR Part 418, Subpart D—Conditions of participation: Organizational Environment
 6. 42 CFR Part 418, Subpart F—Covered Services
 7. 42 CFR Part 418, Subpart G—Payment for Hospice Care
 8. 42 CFR Part 418, Subpart H—Coinsurance
 9. 42 CFR §418.66 Condition of participation: Nursing services—Waiver of requirement that substantially all nursing services be routinely provided directly by a hospice.
 10. 42 CFR §418.70 Condition of participation: Furnishing of non-core services.

6.2 Provider Certifications

To qualify for enrollment as a Medicaid or NCHC hospice provider, the hospice provider shall obtain Medicare certification and licensure to provide Medicaid hospice services.

The provider of hospice services shall comply with:

- a. N.C. General Statute (G.S.) Chapter 131E, Article 10 Hospice Licensure Act; and
- b. 10A NCAC, Chapter 13, SUBCHAPTER 13K – HOSPICE LICENSING RULES.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Patient Self Determination Act

The Patient Self Determination Act of 1990, Sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, P.L.101-508 requires that Medicaid-certified hospitals and other health care providers and organizations give a beneficiary information about their right to make their own health decisions, including the right to accept or refuse medical treatment.

7.3 Coordinating Care

Hospice providers shall comply with 42 CFR §418.56 (e) Condition of participation: Interdisciplinary group, care planning, and coordination of services.

The hospice provider is responsible for the professional management of the beneficiary's medical care. The hospice provider shall assess and coordinate any existing home care services being rendered to a beneficiary electing the hospice benefit. Additionally, to avoid duplication of services, the hospice provider shall coordinate with other provider(s) any care unrelated to the terminal illness.

The hospice provider shall notify the other service provider(s) of the beneficiary's request for hospice services prior to admitting the beneficiary for hospice care. This policy also pertains to Medicare-covered hospice benefits for a dually eligible beneficiary.

7.3.1 Community Alternatives Program

If the Medicaid beneficiary participates in a Community Alternatives Program (CAP/C or CAP/ DA), the hospice shall contact the CAP case manager or care advisors. The hospice is responsible for the professional medical oversight of all hospice beneficiaries. CAP services may augment the care provided by the hospice to meet the beneficiary's needs. Refer to clinical coverage policies 3K-1, *Community Alternatives Program for Children (CAP/C)* and 3K-2, *Community Alternatives Program for Disabled Adults (CAP/DA)* on NC Medicaid's website <https://medicaid.ncdhhs.gov/>. The hospice provider shall coordinate care with the CAP case manager/care advisor to prevent duplication of service.

7.3.2 Providing Care to Medicaid Nursing Facility Residents and Medicaid Residents in an ICF/IID

The provider of hospice services shall comply with:
42 CFR §418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID; 42 CFR §418.100 Condition of Participation: Organization and administration of services; and 42 CFR §418.108 Condition of participation: Short-term inpatient care.

The hospice provider shall assume professional management of the beneficiary's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicaid facility according to 42 CFR §418.100 and 42 CFR §418.108.

The hospice provider shall assess and coordinate the beneficiary's hospice and medical care to facilitate continuity of the care and the facility agrees to provide room and board to the beneficiary.

The agreement must include the following provisions:

- a. Coordination of services in accordance with the plan of care developed by the IDG and indication of the services to be provided by the facility and the services to be provided by the hospice staff;
- b. Indication of the financial arrangements involved, as well as the rate of reimbursement to the nursing facility and the collection of any Patient Monthly Liability (PML) amounts;
- c. The agreement by the facility to provide room and board and related services. Room and board services are:
 1. the performance of personal care services;
 2. assistance in activities of daily living;
 3. socializing activities;
 4. administration of medication;
 5. maintaining the cleanliness of a resident's room;
 6. supervising and assisting in the use of DME and prescribed therapies; and
 7. all the requirements and services outlined in clinical coverage policy 2B1, *Nursing Facilities*, on NC Medicaid's website at <https://medicaid.ncdhhs.gov/>.
- d. A hospice provider shall have the responsibility of providing the medications directly related to the terminal illness; a DME provider shall have the responsibility of providing the medical equipment directly related to the terminal illness;
- e. All other details related to the provision of care and compliance with current North Carolina Rules Governing the Licensure of Hospice;
- f. Process and responsibility for changes to the plan of care. The hospice provider is responsible for approving changes to the plan of care. The hospice shall provide a copy of the plan of care for the facility, and the facility shall allow the hospice access to documentation on the beneficiary's care; and
- g. Hospice provider responsibility for monitoring the care provided to ensure the adequacy of the care provision and to determine the need for any changes.

7.3.2.1 Hospice Reporting and Election Statement for Dually Eligible Nursing Facility Residents

Medicare is the primary payer and Medicaid shall reimburse the hospice for nursing facility room and board charges. The hospice provider shall report the beneficiary's election to participation in hospice. If the beneficiary is dually eligible under Medicare and nursing facility room and board is submitted to Medicaid for payment. The hospice providers shall enter PA into NCTracks and follow all approval reporting requirements. Refer to **Section 5.0 and Subsection 5.12**

7.3.2.2 Patient Monthly Liability (PML)

The hospice provider shall include the collection of PML in the contractual agreement. The nursing facility may act as the hospice provider in collecting the PML if this arrangement is contained in the contractual agreement.

According to 10A NCAC 23E.0210 the Patient Monthly Liability (PML) is the amount the beneficiary is responsible for toward their monthly cost of care. Upon determination of Medicaid eligibility for long term care services by the county Department of Social Services (DSS), the Medicaid provider shall receive notification of the applicant or beneficiary's PML. The DMA-5016, *Notification of Eligibility for Medicaid/Amount and Effective Date of Patient's Liability*, is used to notify nursing facility or institution and the state of the amount and any changes to the PML amount. Nursing facility and hospice providers are required to retain the DMA-5016 for audit purposes. The dates and the amounts on the DMA5016 must match the information on the beneficiary's eligibility detail in NCTracks.

Note: According to 10A NCAC 23E.0210 PATIENT LIABILITY (d)- The county department of social services shall notify the client, the institution and the state of the amount of the monthly liability and any changes or adjustments.

Hospice agencies verify the PML amounts in NC Tracks prior to billing for long term care services. Providers may experience discrepancies with the beneficiary's current eligibility which prevents them from billing for long term care services. The discrepancies may include but are not limited to:

- a. No patient monthly liability listed on the beneficiary's file in NCTracks
- b. No DMA-5016 received by the Hospice provider
- c. Dates or amounts listed on the DMA-5016 do not align with the dates or amounts on the beneficiary's eligibility detail in NCTracks

Nursing facilities and hospice providers experiencing any discrepancies must contact the DSS in the beneficiary's county of residence to have the information corrected.

Those with questions about PML should contact the N.C. Medicaid Contact Center at 1-888-245-0179

7.3.3 Personal Care Services

7.3.3.1 Adult Care Home (ACH)

Hospice services may be provided for a Medicaid beneficiary residing in an adult care home (ACH) when the beneficiary elects the hospice benefit. The ACH and the hospice provider shall have a written contractual agreement that describes the services to be provided by each per the plan of care. The ACH is considered the beneficiary's place of residence and the basic care is provided by the ACH staff.

The hospice provider has the responsibility for the professional management of the beneficiary's care. The hospice provider is responsible for the oversight of the beneficiary's medical care and the monitoring of the care provided by the facility to ensure adequacy of care provision and the need for changes to the services and the plan of care. The plan of care includes the services provided by both the ACH (that is, room and board, ACH Personal Care Services) and the hospice provider (that is, other services related to the terminal illness). The hospice provider is responsible for coordinating all services included in the plan of care. A copy of the hospice plan of care is provided to the ACH.

7.3.3.2 Primary Private Residence

Medicaid-only and dually eligible beneficiaries residing in primary private residences may receive Hospice and State Plan Personal Care Services (PCS) in accordance with 42 CFR 418.76 (i). State Plan Personal Care Services must be used to the extent that the hospice would routinely use the services of a hospice beneficiary's family in implementing a beneficiary's plan of care. The hospice provider shall coordinate its hospice aide and homemaker services with the prior approved personal care services required to meet the beneficiary's needs. Hospice and PCS services are provided with approved and documented coordination of services. Hospice providers are to submit the **Hospice PCS Coordination Form (DMA-3165)** via fax to NC Medicaid within five (5) days of hospice admission. Refer to the NC Medicaid website or the NC Tracks Provider Portal for links to this form.

If PCS services are in place prior to hospice:

- a. The hospice provider contacts the PCS provider to coordinate the plan of care and scheduling of services.
- b. The hospice provider will submit the **Hospice-PCS Coordination Form (DMA-3165)** to NC Medicaid within five days of admission.
- c. The hospice provider will submit the Hospice Aide Plan of Care to the PCS provider.

If Hospice is in place prior to PCS request:

- a. The hospice provider submits the **Hospice-PCS Coordination Form (DMA-3165)** to NC Medicaid to indicate the service gap necessitating the addition of PCS.
- b. The hospice physician shall complete the **Request for Independent Assessment for Personal Care Services (PCS) Attestation of Medical Need (DMA-3051)** and faxes it to the Independent Assessment agency.
- c. Once PCS is authorized, the hospice provider contacts the PCS provider to coordinate the plan of care and scheduling of services.
- d. The hospice provider submits the Hospice Aide Plan of Care to the PCS provider.
- e. The PCS provider submits the Online Services Plan from QiReport to the hospice provider. The hospice providers submit the PCS reports to NC Medicaid for **Medicaid beneficiaries only**.

The hospice aide services must be utilized to the extent that they would be if PCS were not available. NC Medicaid or its contractors may conduct retrospective reviews of PCS and hospice services. Medicaid payments for personal care services provided to a beneficiary also receiving hospice services, regardless of the payment source for hospice services, must be supported by documentation in the medical record of both providers. If duplication of services is found, NC Medicaid may recover payment for those services.

a. Aide Services

The hospice provider shall coordinate its hospice aide and homemaker services with the Personal Care Services required to meet the beneficiary's needs. The hospice provider shall make hospice aide and homemaker services available and adequate in frequency to meet the needs of the hospice beneficiary.

b. Service Coordination and Communication

The hospice provider is responsible for communicating with other providers to ensure that coordination of care occurs. The hospice provider must ensure that a thorough interview process is completed when enrolling a recipient to identify all other Medicaid or other state and/or federally funded program providers of care. This requirement applies to Medicaid beneficiaries as well as the dually eligible Medicare/Medicaid beneficiary. Communication to coordinate care must be documented in each provider's medical record for the beneficiary.

If the hospice provider determines prior to admission that PCS is in place for the beneficiary, the hospice provider contacts the PCS provider, if known, to discuss the services of the PCS provider that the beneficiary is receiving. This allows for better communication with the beneficiary and family during the hospice admission visit to outline the differences in services.

If the PCS provider is not determined prior to admission, hospice provider contacts the provider immediately after the admission visit to discuss the coordinated plan of care.

c. Plan of Care

The hospice provider and the PCS provider agency shall develop a plan of care (POC) in coordination with the beneficiary, the caregiver and each other. The POC must clearly and specifically detail the aide services to be provided along with the frequency of services by each provider to ensure that services are not duplicative, and the beneficiary's daily needs are met.

This process involves coordinating tasks and services as well as the time of day that the beneficiary may receive visits from each provider's aide. Hospice aide and PCS aide hours cannot overlap so the two providers shall coordinate visits to ensure separation. The hospice providers and the PCS provider shall give education to the aides that if they arrive at the home and the other aide is there, they shall report this to their respective providers and leave the home. Any changes in scheduling for either providers must be reported to the other to avoid duplication of services at the same time.

The hospice providers and the PCS provider shall maintain a copy of the plan of care in their respective medical records.

7.3.4 Pharmacy Services

Drugs and biologicals pertaining to the terminal diagnosis are reimbursed to the hospice as part of the hospice per diem. DHHS fiscal contractor shall make direct reimbursement to the pharmacy for drugs used to treat illnesses or conditions not related to the terminal illness. The hospice provider shall supply the diagnosis code for the terminal illness when contacted by the pharmacy. The pharmacy needs this information to process the claim. Refer to clinical coverage policy 9, *Outpatient Pharmacy Services* on NC Medicaid's website at <https://medicaid.ncdhhs.gov/>, for additional information.

7.4 Delivering and Supervising Care

Delivery of care and supervision of the delivery of care must conform to all applicable laws, rules and regulations, the current standard of practice, and the provider policy. Services are provided as specified in the plan of care developed and approved by the IDG.

Hospice services (physician's services, nursing services, medical social services, and counseling) are routinely provided directly by hospice employees. Other covered services are provided by the provider employees or under contractual arrangements. Contractual agreements are in writing according to 10A NCAC 13K and 42 CFR 418.

7.5 Monitoring Care

Members of the hospice IDG shall monitor the beneficiary's condition and initiate changes in the plan of care as needed. The beneficiary's attending physician also participates in this process. The IDG shall complete the review and resulting updates to the plan of care every 15 calendar days to ensure that the beneficiary's needs are met and shall document each review in the beneficiary's health record.

7.6 Changing Providers

A beneficiary may change hospice provider between election periods and once during each election period. A provider change is not a revocation of hospice. When a change occurs during an election period, the beneficiary completes the period with the new provider.

To change provider during an election period, the beneficiary gives a signed statement to the current provider and the new provider. The statement indicates the beneficiary's intent to change provider, the name of the current provider is provided, the new provider name is stated, and identifies the effective date of the change.

The transfer is coordinated with the attending physician and any other care providers to ensure continuity of services. The current or first provider shall cease billing for services on the day prior to the effective date on the notice. The new provider assumes responsibility for the beneficiary's care on the effective date of the change and bills for that date of service. The existing plan of care can be used, or the new provider may develop a new one.

The first provider shall report the transfer to DHHS fiscal contractor. Payment to the new provider depends on a report of the termination of services by the first provider. The new provider shall contact DHHS fiscal contractor to report the admission of the beneficiary to hospice services under the new provider. Both providers shall report the transfer to DHHS fiscal contractor no later than the sixth (6th) day after the date of transfer [day of report plus six previous days].

7.7 Electronic Signatures

N.C. Home Care Licensure Rules provide requirements for accepting electronic signatures for documentation.

7.8 Physician Assistants

Medicare Patient Access to Hospice Act will allow Physician Assistances (PA) to serve as the attending physician to hospice beneficiaries and perform other functions that are otherwise consistent with their scope of practice, beginning January 1, 2019.

8.0 Policy Implementation/Revision Information

Original Effective Date: August 1, 1984

History:

Date	Section or Subsection Amended	Change
	All Sections and Attachment(s)	
12/01/2006	Sections 2, 3, 5	A special provision related to EPSDT was added.
04/01/2007	Subsection 7.1.2.1	Removed statement that Medicaid reimburses for coinsurance on hospice-covered drugs and respite days
04/01/2007	Section 2.6, 3.0, 4.0, and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for beneficiaries under 21 years of age
05/01/2007	Attachment A	Added UB-04 as an accepted claims form.
08/01/2007	Section 6.0	Changed the name of Division of Facility Services (DFS) to Division of Health Service Regulation (DHSR).
08/01/2007	Subsection 2.3 and Attachment C	Medicare-AID beneficiaries are not eligible for Medicaid-covered hospice services.
08/01/2007	Attachment A, letter E	Added revenue code 658.
12/01/2009 (effective 12/02/2008)	Throughout	Updated to include DMA standard statements and incorporate requirements in changes to 42 CFR 418 and CMS Conditions of Participation, issued 10/1/2008, effective 12/2/2008.
05/11/2010	Subsection 2.2	Changed reference from Subsection 5.8.2 to Subsection 5.1.2
07/01/2010	Throughout	Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services.
06/01/2011	Subsections 1.1.12, 5.7, 7.3.2, 7.3.2.2	Updated information on hospice and long-term care to include ICF/MR and related MR-2
06/01/2011	Subsection 5.4.2, 5.4.3	Refer to Attachment C
06/01/2011	Subsection 5.4.3	Added information on the Face-to-Face Encounter requirements.
06/01/2011	Subsection 5.6.2	Added The waiver of curative services is not applicable to beneficiaries under 21 years old. Refer to Subsection 5.6.3.
06/01/2011	Subsection 5.6.3	Added Provision of Hospice Care for Children Under 21 Years Old. Under Provision of Hospice Care for Children Under 21 Years Old added sentence to include

Date	Section or Subsection Amended	Change
		the complete hospice package having to be provided with the addition of a curative service
06/01/2011	Subsection 5.6.3	Clarified wording on concurrent care
06/01/2011	Subsection 7.2	Added Patient Self Determination Act information
06/01/2011	Attachment A	Updated to standard DMA policy language
06/01/2011	Attachment C	Added Attachment C
11/01/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
11/01/2012	Subsections 5.1, 5.2	Addition of prior approval requirement prior to fifth and each subsequent benefit period.
11/01/2012	Subsection 1.1.10	Clarified that general inpatient care can also be provided in a hospice inpatient facility
11/01/2012	Subsection 5.7.2	Added reference to Outpatient Pharmacy policy regarding billing for medications for hospice beneficiaries.
11/01/2012	Subsection 5.10	Clarification that in the case of a patient transfer between hospice agencies, only one agency can be paid per day.
11/01/2012	Subsection 7.5	Changes two weeks' requirement for plan of care review to 15 calendar days
11/01/2012	Attachment A	Deleted statement about non-contracting hospice agencies. Changes place of service back to "Not Applicable"
11/01/2012	Attachment C	Changed language referring to "nurse practitioners" to "Medicare officially recognized non-physician providers" Changes three days' requirement in face to face encounter to seven days
07/01/2013	Subsection 5.2	Added "Prior approval is requested by the hospice medical director or beneficiary's attending physician via NC Tracks, PA Type A-10 Hospice, at least ten days before the end of the current certification period. If prior approval is denied, the beneficiary will be notified of his or her appeal rights."
07/01/2013	Subsection 5.2	Deleted "Prior approval is requested by the hospice medical director or beneficiary's attending physician as follows: <ul style="list-style-type: none"> a. The physician submits the request in writing using the N.C. Medicaid Hospice Prior Approval Authorization Form (NC DMA-3212), which can be obtained from the DMA website (Refer to Attachment D). b. The physician provides information detailing the complications of the pregnancy (for MPW beneficiaries only), medical necessity for hospice

Date	Section or Subsection Amended	Change
		<p>services, the potential impact if the service is not provided, the frequency of visits, and the anticipated duration of services.</p> <p>c. The completed form is sent to DMA’s designated fiscal agent along with the accompanying documentation listed on the form.</p> <p>The prior approval request is submitted by mail at least ten days before the end of the current certification period. The fiscal agent will respond to the hospice provider via fax within five business days. If prior approval is denied, the beneficiary will also receive via mail notification with appeal rights.”</p>
07/01/2013	Attachment D	Deleted outdated information to reflect current process with fiscal agent.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
01/01/2016	All Sections and Attachments	The current policy will allow adult IHC and Residential PCS beneficiary to receive Hospice services and PCS services concurrently when they meet eligibility requirements for both programs. (Refer to note in 01/15/2018 Amendment Section 8.0)
06/15/2016	Section 8.0	Notation for 10/1/2015 regarding ICD-10 update returned to the table. This was inadvertently dropped out during the policy revision process of 01/01/2016. No effect on coverage or scope of policy, so no change made to Amended Date.
01/15/2018	All Sections and Attachments	<i>Clinical Policy 3D, Hospice Services</i> reorganized, rewritten, and services clarified.
01/15/2018	Section 5.0 Subsection 5.1, 5.2, 5.2.2	Modified the clinical review timeframe for 300 days (prior to the 5 th certification period) to 180 days (prior to the 3 rd certification period).
01/15/2018	Section 5.0 Subsection 5.7	Incorporated the requirement for the electronic submission of the Election Statement as a component of the Prior Approval Request for the 1 st Certification Period.
01/15/2018	Attachment A Claims Related Information; Subsection H 1.1 Routine Home Care 1.2 Two Tier Rate 1.3 Service	<p>1.1 Routine Home Care Hospice shall comply with 42 CFR §418.302 Payment procedures for hospice care.</p> <p>1.3 Service Intensity Add-On (SIA) The SIA payment is in addition to the per diem RHC rate when all the following criteria are met: a. The day is an RHC level of care day;</p>

Date	Section or Subsection Amended	Change
	Intensity Add-On (SIA)	<p>b. The day occurs during the last 7 days of the patient’s life; c. The patient is discharged expired; and d. Direct patient care is furnished by a registered nurse (RN) or clinical social worker (SW) qualifying day.</p> <p>The SIA payment is based on the Continuous Home Care (CHC) hourly payment rate multiplied by the amount of direct care provided by an RN or social worker during the last 7 days of life in increments of 15 minutes, up to 4 hours per day. New G-codes will be used to identify the SIA provider (RN or Social Worker) in conjunction with Revenue Code 0235</p> <p>NCTracks does not allows Hospice providers to bill status code 20 to denote the death of Hospice beneficiary. Therefore, valid discharge codes denoting death of the patient for hospice claims were created.</p> <ul style="list-style-type: none"> • 40 (expired at home), • 41 (expired at medical facility), 42 (expired place unknown).
01/15/2018	Section 8	Removed statement from the January 1, 2016 amendment “These revisions had no effect on scope of coverage.” Replaced with, “The current policy will allow adult IHC and Residential PCS beneficiary to receive Hospice services and PCS services concurrently when they meet eligibility requirements for both programs.”
02/01/2018	All Sections and Attachments	Policy posted on this date, with an Amended Date of January 15, 2018
12/01/2019	Section 1.1.2 Hospice care	Added word Social Security
12/01/2019	Section 1.1.5	Clarified wording-changed “and” to “or”
12/01/2019	Subsection 3.2.1 - Specific criteria covered by both Medicaid and NCHC	<ul style="list-style-type: none"> •Removed citations that were not related to Covered Services •Citations are listed is subsection 6.1 Provider Qualifications and Occupational Licensing Entity Regulations
12/01/2019	Subsection 3.2.1 - Specific criteria covered by both Medicaid and	<ul style="list-style-type: none"> •According to 42 CFR §418.202 - Covered services (i) Added verbiage was missing from Citation to complete sentence “as reasonable and necessary for the palliation and management of the patient's terminal illness and

Date	Section or Subsection Amended	Change
	NCHC –(k)	related conditions and for which payment may otherwise be made under Medicaid”.
12/01/2019	Subsection 3.2.1 - Specific criteria covered by both Medicaid and NCHC last paragraph	Completed sentence with the time frame which Medicaid and NCHC ambulance service can occur “which occur after the effective date of election”.
12/01/2019	Section 5.2.2.2	Subsection e (removed “Palliative Performance Scale”) Removed (f) Adding “Hospice Assessment” Tool
12/01/2019	Section 5.2.2.2 Note: section	Removed - “using Type: A10-Hospice” Added wording “or physician assistant” Added- Refer to Section 7.8
12/01/2019	5.2.2.3 Nursing Facility and 5.2.2.4 Long Term Care –	DHB adding to section 5.2.2.3 Nursing Facility “ Note: Hospice agencies verify Nursing facility or ICFIID long-term care approval in NC Tracks to ensure the approval was obtained prior to seeking reimbursement. Hospice providers should provide documentation referencing place of origin verifying the FL-2 in beneficiary medical records. DHB adding to section 5.2.2.4 Long Term Care “ Note: Hospice agencies verify the nursing facility or ICF/IID level of care long-term care approval in NC Tracks to ensure the approval was obtained prior to seeking reimbursement. Hospice providers should provide documentation referencing place of origin verifying the FL-2 or IID-2 in beneficiary medical records”.
12/01/2019	Subsection 5.6.1 Filling an election statement	Verbiage omitted from 42 CFR § 418.28(a). If beneficiary is physically or mentally incapacitated, his or her representative (as defined in §418.3) may file the election statement.

Date	Section or Subsection Amended	Change
12/01/2019	Subsection 5.6.5 Re-election of hospice benefits	Verbiage omitted from 42 CFR § 418.28 “(or his or her representative if the beneficiary is mentally or physically incapacitated)”.
12/01/2019	Subsection 5.12.4- Note: section	<p>Removed – “with each PA entry beginning with the 3rd and subsequent benefit periods”</p> <p>Removed – “the Approval Status Inquiry form or”</p> <p>Clarified wording - DMA providers” to” fax a copy of the NC Tracks Web Submitted Request for HOSPICE Prior Approval Confirmation Page to NC Medicaid “with each PA entry”. “The confirmation page is to be faxed to” 919-715-9025.</p>
12/01/2019	Section 7.3.2.2	<p>Removed - reference to Subsection 5.13</p> <p>DHB adding</p> <p>“According to 10A NCAC 23E.0210PATIENT LIABILITY (d) - The county department of social services shall notify the client, the institution and the state of the amount of the monthly liability and any changes or adjustments.</p> <p>Hospice agencies verify the PML amounts in NC Tracks prior to billing for long term care services. Providers may experience discrepancies with the beneficiary’s current eligibility which prevents them from billing for long term care services.</p> <p>The discrepancies may include but are not limited to:</p> <p style="padding-left: 40px;">No patient monthly liability listed on the beneficiary’s file in NCTracks</p> <p style="padding-left: 40px;">No DMA-5016 received by the provider</p> <p style="padding-left: 40px;">Dates or amounts listed on the DMA-5016 do not align with the dates or amounts on the beneficiary’s eligibility detail in NCTracks</p> <p>Providers experiencing any discrepancies must contact the DSS in the beneficiary’s county of residence to have the information corrected.</p> <p>Those with questions about PML should contact the N.C. Medicaid Contact Center at 1-888-245-0179.</p>

Date	Section or Subsection Amended	Change
12/01/2019	Section 7.3.2.2	Added - "According to 10A NCAC 23E.0210"
12/01/2019	Attachment A: Claims-Related Information Section C. Code -0235	Added: - Modifier: Adding Post-mortem Visits (PM) modifier. Hospice shall report visits and length of visits (rounded to the nearest 15- minute increments), that occur on the date of death, after the patient has expired for nurses, aids, social workers, and therapists who are employed by the hospice. This requirement is applicable for all levels of care (with the exception of GIP provided in a hospice inpatient facility).
12/01/2019	Attachment A: D, Modifiers	Added: Post-Mortem (PM) visits reporting that occur after death and on date of death. Includes hospice-employed nurses, aids, social workers and therapists; regardless of level of care, or site of service. Billing Code appropriate visit revenue code + HCPCS for the discipline + PM Modifier + Units of 15 minutes increments + Charges + Service date. Note: Visits subsequent to date of death are not reported using the PM modifier. Date of date is defined as the date of expiration reported on the official Certificate of Death. Hospice shall report hospice visits that occur before the date of death on a separate claim line from those which occur after the death.
12/01/2019	Attachment A:H, 6	"Medicare" changed to "Medicaid"
12/01/2019	Throughout the 3DHospice Policy	Reference 42 CFR citations by "according to".
12/01/2019	Subsection 5.10	Added "for beneficiaries 21 and under: (Refer to Subsection 5.11)." to the last sentence of the same paragraph. To read - The waived Medicaid or NCHC services are listed below "for beneficiaries 21 and under: (Refer to Subsection 5.11)."
12/01/2019	Subsection 5.6.4	Added "listed in 42 CFR §418.24 (d)" to read: In the duration of an election of hospice care, a beneficiary waives all rights to payments for other Medicaid services listed in 42 CFR §418.24 (d)
12/01/2019	Attachment C:	Removed - Hospice-PCS Coordination Form (DMA3165) from policy
12/01/2019	Attachment A	Updated policy template language: "Unless directed otherwise, Institutional Claims must be billed according

Date	Section or Subsection Amended	Change
		to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines”.
12/01/2019	Table of Contents	Updated policy template language, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.”
08/01/2020	Section 5.12.4	<p>Removed: Note: NC Medicaid requires providers to fax a copy of the NC Tracks Web Submitted Request for HOSPICE Prior Approval Confirmation Page to NC Medicaid with each PA entry. The confirmation page is to be faxed to 919-7159025. NC Medicaid requests that providers include their name and e-mail address on the above form.</p> <p>Added: Note: Hospice providers that fail to provide all required documents for prior approval to NC Tracks, may be referred to the Office of Compliance and Program Integrity (OCPI).</p>
08/01/2020		Policy posted 08/04/2020 with an amended date of 08/01/2020
2/15/2021	Section 5.12.4-final implementation	<p>Removed: Note: NC Medicaid requires providers to fax a copy of the NC Tracks Web Submitted Request for HOSPICE Prior Approval Confirmation Page to NC Medicaid with each PA entry. The confirmation page is to be faxed to 919-7159025. NC Medicaid requests that providers include their name and e-mail address on the above form.</p>

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Revenue Code	Instructions
<p>0651 Routine Home Care</p>	<p>Routine Home Care is the basic level of care that is provided to support the beneficiary. It may be provided in a primary private residence, a hospice residential care facility, or an adult care home. It may also be provided in a nursing facility if the facility has a contractual arrangement with the hospice provider. It is billed by the day and is the provider’s basic per diem rate. This service code is limited to once per day per beneficiary, same or different provider.</p> <p>Routine Home Care is not allowed on the same day as Continuous Home or Inpatient Respite Care. The provider should provide and bill the appropriate level of service.</p>

<p>0652 Continuous Home Care</p>	<p>Continuous Home Care is provided during a medical crisis and is billed by the hour. This level of service is provided when the hospice IDG determines that continuous care, primarily nursing care, is needed. The care is given to achieve palliation or management of acute medical symptoms. It can be provided in the private residence, hospice residential care facility, long term</p>
	<p>care facility, adult care home, or nursing facility. The care needed shall be:</p> <ul style="list-style-type: none"> • continuous care for at least 8 hours of the calendar day (the hours may be split); AND • nursing services by an RN or LPN for at least half of the hours of care in a day. <p>Homemaker and hospice aide services may be used to supplement the nursing care. Continuous Home Care is limited to a maximum of 24 units a day.</p> <p>Continuous Home Care is not allowed on the same day as Routine Home Care, Inpatient Respite Care or General Inpatient Care. The provider shall provide and bill the appropriate level of service.</p>
<p>0655 Inpatient Respite Care</p>	<p>Inpatient Respite Care is short-term care to relieve family members or other unpaid caregivers providing care for the beneficiary in the private residence. It is provided in a hospice inpatient facility or in a hospital or nursing facility under a contractual arrangement. Hospitals or nursing facilities shall meet the special hospice standards for staffing and beneficiary areas.</p> <p>This service can be provided only on an occasional basis for up to five consecutive days at a time. If the beneficiary remains in the facility longer than five days, the extra days are billed at the routine home care rate. The date of discharge is usually billed at the routine home care rate. The inpatient respite rate may be billed if the discharge is due to the beneficiary's death.</p> <p>Inpatient Respite Care counts toward the annual limit on inpatient care. This service code is limited to once per day per beneficiary, same or different provider. Inpatient Respite Care is not allowed on the same day as Routine Home Care, Continuous Home Care or General Inpatient Care. The provider should provide and bill the appropriate level of service.</p>

<p>0656 General Inpatient Care</p>	<p>General Inpatient Care is payment made to the hospice for a beneficiary in an acute care hospital, inpatient facility or skilled nursing facility. The service is billed by the day as follows:</p> <ul style="list-style-type: none">• The number of days that a beneficiary receives general inpatient care is billed, beginning with the date of admission.• The date of discharge is billed at the appropriate rate. If discharge is delayed while a beneficiary awaits nursing facility placement, the general inpatient rate can be billed for up to three days. Bill any subsequent days as if the beneficiary is in a nursing facility; that is, the routine home care rate plus the appropriate long-term-care rate to cover room and board. If a beneficiary is discharged as deceased, bill the general inpatient rate for the date of discharge. <p>If the beneficiary is hospitalized for a condition not related to the terminal illness, the hospital bills Medicaid for the beneficiary's inpatient care. Additionally, the hospice bills the routine home care rate during the inpatient stay.</p>
	<p>General Inpatient Care counts toward the annual limit on inpatient care. This service code is limited to once per day per beneficiary, same or different provider. General Inpatient Care is not allowed on the same day Continuous Home Care, Inpatient Respite Care or General Inpatient Care: The provider should provide and bill the appropriate level of service.</p>

<p>0235 Incremental Nursing Charge Rate-Hospice- Service Intensity Add-On (SIA)</p>	<p>The SIA payment is in addition to the per diem for Routine Home Care (RHC) rate when all the following criteria are met:</p> <ul style="list-style-type: none"> • The day is an RHC level of care day; • The day occurs during the last 7 (seven) days of the beneficiary’s life; • The beneficiary is discharged as expired; and • Direct patient care is furnished by a registered nurse (RN) or social worker (SW) that day <p>The SIA payment is based on the Continuous Home Care (CHC) hourly payment rate multiplied by the amount of direct care provided by an RN or social worker during the last 7 days of life in increments of 15 minutes, up to 4 hours per day. New G-codes will be used to identify the SIA provider (RN or Social Worker) in conjunction with Revenue Code 0235. When end-of-life continuous home care is rendered by the appropriate level of medical staff (RN- G0299 or SW- G0155) with code RC0235 the claim will process for authorized provider services.</p> <p>Note: If G-code is incorrect or missing, the claim will be denied with a message that indicates the staff level of care is not authorized to provide care. SIA payment will only apply to visits that occur prior to death. Visit reported with the PM modifier will not receive an SIA payment. Per CMS policy, if the social worker provided comfort and grief counseling to the beneficiary’s family, the social worker time would be reported with the PM modifier.</p> <p>Modifier: Adding Post-mortem Visits (PM) modifier. Hospice shall report visits and length of visits (rounded to the nearest 15- minute increments), that occur on the date of death, after the patient has expired for nurses, aides, social workers, and therapists who are employed by the hospice. This requirement is applicable for all levels of care (with the exception of GIP provided in a hospice inpatient facility).</p>
<p>0658 Hospice Nursing Facility Room and Board (Intermediate Level of Care)</p>	<p>Refer to “Hospice Nursing Facility Room and Board,” below. Revenue code 0658 is used to bill this service if the beneficiary has been approved for nursing facility care at the intermediate level.</p>
<p>0659 Hospice Nursing Facility Room and Board (Skilled Level of Care)</p>	<p>Refer to “Hospice Nursing Facility Room and Board,” below. Revenue code 0659 is used to bill this service if the beneficiary has been approved for nursing facility care at the skilled level or the approval was granted after May 31, 2004</p>

Hospice Nursing Facility Room and Board

Hospice Nursing Facility Room and Board is the charge billed by the hospice provider for a beneficiary residing in a nursing facility or ICF/IID. It is billed in addition to routine home care or continuous home care, as applicable.

Medicaid reimbursement to the hospice is based on 95 percent of the per diem for the individual nursing facility. The amount is reduced by the amount of the PML when applicable. The hospice provider reimburses the nursing facility at the negotiated rate determined by the contractual agreement.

To bill for nursing facility room and board, enter the National Provider Identifier (NPI) number for the nursing facility where the beneficiary resides in the Attending Provider field of the UB-04 form or 837I transaction. The NPI number entered and the revenue code used correspond to the current level of care for the beneficiary, as determined by the FL-2 approval. Use RC 658 for intermediate level of care and RC 659 for skilled level of care.

Type of Bill

081X Hospice—Non-hospital based

082XHospice—Hospital based

Note: The fourth digit in the Bill Type is the Frequency Code 0–5. Refer to the Medicare Claims Processing Manual Chapter 11 - Processing Hospice Claims for the description of applicable code.

Value Code

Hospices billing routine home care, continuous home care, inpatient respite care, or general inpatient care (Revenue Codes 651, 652, 655, or 656) are required to enter the following information on the UB-04 form or 837I transaction:

- a. A value code of 61 or 68, as applicable, in the Value Code field.
- b. the ZIP code for the location where the service was rendered in the Facility Location field.
- c. the applicable Core-Based Statistical Area (CBSA) for the location where the care was provided (such as the beneficiary's residence, nursing home, assisted living facility, hospital unit) in the Value Code Amount field.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions for Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Providers shall follow applicable modifier guidelines.

Post-Mortem Visits (**PM**): Visits reporting that occur on the date of death and after the patient has expired. Includes Hospice-employed nurses, aides, social workers and therapists; regardless of level of care, or site of service.

Billing

Code appropriate visit revenue code + HCPCS for the discipline + PM Modifier + Units of 15 minutes increments + Charges + Service date.

Note: Visits subsequent to date of death are not reported using the PM modifier. Date of date is defined as the date of expiration reported on the official Certificate of Death. Hospice shall report hospice visits that occur before the date of death on a separate claim line from those which occur after date of death.

E. Billing Units

The provider shall report the appropriate procedure code(s) used which determines the billing unit(s).

- Revenue Code 0651 unit of service = 1 day
- Revenue Code 0652 unit of service = 1 hour
- Revenue Code 0655 unit of service = 1 day
- Revenue Code 0656 unit of service = 1 day
- Revenue Code 0658 unit of service = 1 day
- Revenue Code 0659 unit of service = 1 day
- Revenue Code 0235 units of service = 15-minute increments up to 4 hours total per day

Per diem rate includes all services provided directly by hospice provider and services provided indirectly through subcontracting arrangements with other providers including all areas listed under coverage.

F. Place of Service

Not applicable for institutional claims.

- The beneficiary's primary private residence.
- An adult care home under a written agreement with the hospice provider.
- A hospice residential care facility or hospice inpatient unit.
- A hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) under a written agreement with the hospice provider.

G. Co-payments

For Medicaid refer to Medicaid State Plan: <https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

For NCHC refer to NCHC State Plan:
<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

H. Reimbursement

Providers shall bill their usual and customary charges.
For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>.

Payment rates for hospice services are equivalent to Medicare hospice rates, and Medicare methodology is followed. For Medicaid, only, the hospice reimbursement rate for nursing facility room and board is 95 percent of the nursing facility rate.

The reimbursement rate for routine home care, continuous home care, inpatient respite care, and general inpatient care (Revenue Codes 651, 652, 655, or 656) is dependent on the beneficiary's location by Core-Based Statistical Areas (CBSA) on the date of service. Level of Care Categories.

Each day of the beneficiary's hospice coverage is classified at one (1) of four (4) levels of care. The Medicaid reimbursement for the service is made at a per diem rate based on the level of care and the location at which the service is furnished to the beneficiary.

Payment amounts are determined within each of the following categories.

Routine Home Care

Hospice shall comply with 42 CFR §418.302 Payment procedures for hospice care.

Routine Home Care (RHC) is the basic level of care provided to support a hospice beneficiary. It is provided in a primary private residence, a hospice residential care facility, a nursing facility, or an adult care home. When the care is provided in a nursing facility or adult care home, the hospice and the facility shall have a written contractual agreement for the services to be provided in the facility.

Two Tier Rate

The FY2016 Medicare Hospice Payment Reform, 42 CFR 418, replaces the single RHC per diem rate with two different RHC payment rates:

- a. A higher payment rate for the first 60 days (Tier 1) of hospice care; and
- b. A reduced payment rate for 61 days (Tier 2) and over of hospice care

A 60-day gap in hospice services is required to reset the counter that determines if a beneficiary is qualified for the Tier 1 (day one) through sixty (60) days) payment rate when remitted back in to Hospice.

Service Intensity Add-On (SIA)

The FY 2016 Medicare Hospice Payment Reform, 42 CFR 418, also implemented a Service Intensity Add-On (SIA) payment. The SIA payment is in addition to the per diem RHC rate when all the following criteria are met:

- a. The day is an RHC level of care day;
- b. The service day occurs during the last 7 days of the patient's life;
- c. The patient is discharged expired; and
- d. Direct patient care is furnished by a registered nurse (RN) or social worker (SW) on the qualifying day.

The SIA payment is based on the Continuous Home Care (CHC) hourly payment rate multiplied by the amount of direct care provided by registered nurse (RN) or social worker (SW) during the last 7-days of life in increments of 15 minutes, up to 4 hours per day.

New G-codes will be used to identify the SIA provider (RN or Social Worker). Although LPN are not able to provide services which received SIA payment, G-code has been added for the skill level.

HCPCS Code(s)	Description
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15-minute increment up to 4 hours per day.
G0300	Direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting, each 15-minute increment up to 4 hours per day.
G0155	Services of a clinical social worker (SW) in Home Health or Hospice Settings, each 15-minute increment up to 4 hours per day.

Note: NCTracks no longer allows Hospice providers to bill status code 20 to denote the death of Hospice beneficiary. Guidance from Chapter 11 Medicare Claim Processing Manual specifically states that status of 20 is no longer used on Hospice Claims and these claims using status of 20 will deny.

Therefore, valid discharge codes denoting death of the patient for hospice claims were created.

Discharge Code(s)	Continuous Home Care	Description
40		Expired at Home
41		Expired at Medical Facility
42		Expired Place Unknown

Continuous Home

Care is provided during a medical crisis, as needed to keep the beneficiary at home and when the hospice IDG determines that continuous care, primarily nursing care, is needed to achieve palliation or management of acute medical symptoms. The care must be needed for a minimum of eight (8) hours of the calendar day. The hours may be split into two or more periods during the day. An RN or LPN shall provide nursing services for at least half of the hours of care in a day. Homemaker and home health aide services may be used to supplement the nursing care for the remaining hours. It can be provided in the private residence, hospice residential care facility, long term care facility, adult care home, or nursing facility.

Inpatient Respite Care

Inpatient Respite care is short-term inpatient care provided to the beneficiary only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may only be provided in a Medicare participating hospital or hospice inpatient facility, or a Medicare or Medicaid participating nursing facility. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care provided for more than five consecutive days at a time must be billed as routine home care for day 6 and beyond, and the patient may be liable for room and board charges for day six and beyond. See §40.1.5 for additional information. The hospital or nursing facility shall meet the special hospice standards for staffing and patient care areas as specified in 10A NCAC 13K and 42 CFR 418. For a detailed explanation on determining annual limitations as it relates to inpatient care, refer to 42 CFR 418.

General Inpatient Care

General Inpatient Care is for the management of symptoms or to perform procedures for pain control that cannot be performed in other settings. The care is provided in a hospice inpatient facility, a hospital, or a nursing facility under arrangement with the hospice provider. The hospital or nursing facility shall follow the special hospice standards for staffing and patient care areas as specified in 10A NCAC 13K and 42 CFR 418.108. For a detailed explanation on determining annual limitations on payments to inpatient care, refer to 42 CFR 418.

Bereavement Counseling

Bereavement counseling consists of counseling services provided to the beneficiary's family before and after the individual's death. Bereavement counseling is a required hospice service, provided for a period up to one year following the beneficiary's death. It is not separately reimbursable. Bereavement specifics are found in Pub. 100-07, State Operations Manual, Appendix M, 42 CFR 418.64(d)(1), L596

Special Modalities

Drugs and biologicals pertaining to the terminal diagnosis are reimbursed to the hospice as part of the hospice per diem. Medicaid and NCHC shall directly reimburse the pharmacy for drugs used to treat illnesses or conditions not related to the terminal illness.

A hospice may use chemotherapy, radiation therapy, and other modalities for palliative purposes if it determines that these services are needed. This determination is based on the patient's condition and the individual hospice's care-giving philosophy. No additional Medicaid payment may be made regardless of the cost of the services.

Attachment B: Physician Face-to-Face Encounter and Certification of Terminal Illness

A physician face-to-face encounter is required for all Medicaid and NCHC hospice beneficiaries at the third (3rd) election period and at all subsequent election periods, prior to recertification of terminal illness in accordance with the Patient Protection and Affordable Care Act, Section 3132. The physician shall provide a written attestation that the encounter occurred.

A. Timeframe Requirements

The Affordable Care Act, Section 3132 outlines specific timeframes for the face-to-face contact to occur. Failure to meet the face-to-face encounter requirements and time frames results in a failure by the hospice to meet the beneficiary's recertification of terminal illness eligibility requirement and the beneficiary would cease to be eligible for the hospice benefit.

1. Timeframe of the Encounter

- a. The encounter must occur no more than 30 calendar days prior to the start of the third election period, and no more than 30 calendar days prior to every subsequent election period thereafter.
- b. The encounter must be rendered by the hospice physician or Medicare-officially recognized provider.

2. Timeframe Exceptions

- a. Exceptions to timeframe guidelines are permitted for admission of a new hospice beneficiary in the third or later election period. Exceptional circumstances may prevent a face-to-face encounter prior to the start of the election period in cases where a hospice newly admits a Medicaid or NCHC beneficiary who is in the third or later election period. The face-to-face encounter must occur no later than seven calendar days after the admission for these beneficiaries. The exceptional circumstance that prevented the face-to-face encounter from being conducted in a timely manner must be documented in the beneficiary's health record.
- b. Exceptions to the timeframe are permitted when the hospice may be unaware that the patient is in the third election period. In such documented cases, a face-to-face encounter which occurs within seven days after admission will be considered timely. The hospice agency shall document the circumstances for the exception.

B. Physician and Non-Physician Practitioners Allowed To Provide The Face-to-Face Encounter

The hospice medical director or hospice physician shall be responsible for providing and documenting the encounter, as follows:

1. A hospice physician is described as a physician who is employed by the hospice or working under contract with the hospice.
2. Non-physician practitioners allowed to provide the face-to-face encounter are those officially recognized by Medicare.

C. Documentation Requirements

1. Face-to-Face Encounter

A hospice physician or other Medicare-recognized provider who performs the encounter shall attest in writing that he or she had a face-to-face encounter with the beneficiary, documenting the date of the encounter. Note the following:

- a. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled.
- b. Documentation is required for any exceptional circumstance that prevented the face-to-face encounter from being conducted in a timely manner.

2. Attestation Statement for Non-Physician Practitioner

- a. Where a Medicare-recognized non-physician provider performed the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the beneficiary continues to have a life expectancy of six months or less, should the illness run its normal course.
- b. Medicare-recognized non-physician hospice providers may conduct face-to-face encounters as described in as part of the certification process but are still prohibited by statute from certifying the terminal illness. If a beneficiary's attending physician is a Medicare recognized non-physician provider, the hospice medical director or physician designee may certify or recertify the terminal illness.

D. Certification and Recertification of Terminal Illness

The certifications or recertification must contain a brief narrative describing the clinical basis for the beneficiary's terminal prognosis. The hospice shall retain all certification statements and attestations of face-to-face encounters. Note the following:

1. The certification or recertification must contain the following:
 - a. Physician shall briefly synthesize the clinical information supporting the terminal diagnosis and attest that he or she composed the narrative after reviewing the clinical information, and where applicable, examining the beneficiary. The narrative must reflect the beneficiary's individual clinical circumstances.
 - b. The certification or recertification must include the election period dates to which it applies and be signed and dated by the certifying or recertifying physician.
 - c. Initial certifications may be prepared no more than 15 calendar days prior to the effective date of election.
 - d. Recertification may be prepared no more than 15 calendar days prior to the start of the subsequent election period.
2. Narratives associated with the third and later election period must also contain an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of six months or less.