NC Division of Medical Assistance
Hospice Services

Medicaid and Health Choice
Clinical Coverage Policy No.: 3D

Amended Date:

DRAFT

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#### Attachment C: Hospice-PCS Coordination Form (DMA-3165)

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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), to deliver 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 aspects to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill beneficiary, family and caregivers. The priority of hospice services is to meet the needs and goals of the hospice beneficiary, family and caregivers to help the terminally ill beneficiary continue with minimal disruption to normal activities while remaining primarily in primary private residence the environment.

The hospice interdisciplinary group (IDG) achieves this by organizing and managing, a comprehensive hospice care plan focused on coordinating care services and administering resources to provide hospice services to beneficiaries, caregivers, and families necessary for the palliation and management of the terminal illness and related conditions.

Only Medicare-certified and licensed hospice agencies are eligible to participate as Medicaid hospice providers. The hospice provider, and the facility and hospital shall have a written contractual agreement for services to be provided in the facility or hospital setting. Hospice participation may limit Medicaid reimbursement of other services for adult beneficiaries. The hospice benefit covers all care pertaining to or resulting from the terminal illness and related conditions.

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 the same as found in 10A NCAC 13 K.0102 (9), GS §131E-201(3) and GS § 131E-176(13a).

1.1.2 Terminal illness

Terminally ill and terminal illness means the same as found in 42 CFR §418.3.
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 eligibility 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.

b. NCHC

An NCHC beneficiary is not eligible for the hospice benefit.

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/provider-manuals.html

EPSDT provider page: http://dma.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

The Division of Medical Assistance (DMA) 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 DMA 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 Part 418, Subpart F, 42 CFR §418.56, 42 CFR §418.114, 42 CFR §418.70, 42 CFR §418.202(i):

a. 42 CFR §418.64 & 42 CFR §418.66 - Nursing services;

b. 42 CFR §418.64 - Medical social services;

c. 42 CFR §418.64 - Physicians’ services;

d. 42 CFR §418.64 - Counseling services (bereavement, dietary, and spiritual);

e. 42 CFR §418.108 - Short-term inpatient care (Refer to Subsection 4.2.3 for NCHC exceptions);

f. 42 CFR §418.66 - Interdisciplinary group, care planning, and coordination of services

Also:

g. 42 CFR §418.106 - Medical appliances and supplies, including drugs and biologicals;

h. 42 CFR §418.76 - Hospice aide and homemaker services;

i. 42 CFR §418.72 - Physical therapy, occupational therapy and speech-language pathology services;

j. 42 CFR §418.78 - Volunteer services; and

k. Any other service that is specified in the beneficiary’s plan of care.

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.
3.2.2 Medicaid Additional Criteria Covered

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

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.

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 shall not require prior approval for Hospice services except prior to the election of the fifth (5th) and each subsequent election period.

Medicaid and NCHC do not require clinical review for Hospice service until after the first (1st) and second (2nd) benefit periods. Prior approval requests and clinical reviews beginning at the third (3rd) benefit period and each subsequent benefit period online through NCTrack's Provider Portal.

Medicaid and NCHC shall not require prior approval for Hospice service except prior to the election for the fifth (5th) and each subsequent election period.

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 Personnel 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 3.3 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. At the first (1st) benefit period the hospice provider (s) shall create a prior approval request and upload the Election Statement (Notice of Election - NOE) within six (6) calendar days after the effective date of the election statement per 42 CFR 418.24(4) online through the NCTracks Provider Portal.

a. The certification of terminal illness in accordance with 42 CFR §418.22 must:

1. be signed by the Hospice Medical Director or the physician member of the hospice interdisciplinary group as well as the beneficiary’s attending physician (MD or DO); and
2. confirm a terminal prognosis of six (6) months or less if the illness runs its normal course.
3. at a minimum consist of:
i. Diagnosis of terminal condition
ii. Other health condition whether related or unrelated to terminal condition; and
iii. Current clinically relevant information supporting all diagnoses.

5.2.2.2 Nursing Facility

Nursing facility or ICF-IID long-term care approval is required for a beneficiary residing or entering the facility. Nursing facility or ICF-IID approval is determined by The DHHS fiscal contractor. The hospice 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 without this approval.

5.2.2.3 Long Term Care

The hospice 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. Hospice Medicaid beneficiaries in nursing or ICF/IID facilities shall meet the same level of care requirements as other Medicaid nursing facility beneficiaries. The beneficiary shall occupy a Medicare-certified bed if in a nursing facility. The hospice agency shall retain a copy of the NC DMA Long Term Care Form FL-2 or IID-2, as applicable, in the Medicaid beneficiary’s records on site at the hospice agency.

5.2.2.4 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 of the following documents online through NCTracks Provider Portal for certification and recertification:

a. NC Medical Hospice Prior Approval Authorization Form (NC DMA-3212);

b. Hospice Certification and Plan of Treatment - Face-To-Face Encounter according to 42 CFR 418.22 (4).
   i. Hospice physician or NP must have face-to-face encounter with hospice patient prior to, but no more than thirty (30) days prior to third benefit period and each thereafter to continue eligibility for hospice benefits;

c. Request and Authorization Form (NCDMA; and

d. Must ensure all health and other records that support the beneficiary has met the specific criteria in Subsection 2.0 of this policy.

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

The Hospice provider(s) shall submit to NC DMA the following:
The provider(s) shall submit to NC DMA the following:

Prior approval requested by the hospice medical director or beneficiary’s attending physician must be submitted to DMA via NC Tracks, using PA Type A-10 Hospice, at least ten (10)-calendar days before the end of the current certification benefit period. In the case of adverse decision, PA may be extended for an additional five (5) days into the next benefit period to ensure due process compliance and permit Maintenance of Service.

Note: The hospice physician or hospice nurse practitioner can act as the beneficiary’s attending physician per beneficiary choice according to 42 CFR 418.52(c)(4).

5.3 Admission to Hospice

The provider of hospice services shall comply with 42 CFR §418.25 Admission to hospice care. The hospice admits a beneficiary patient only on the recommendation of the medical director in consultation with, or with input from, the patient’s attending physician (if any).

The hospice medical director must consider at least the following information to determine that the patient is certified terminally ill:

a. Diagnosis of the terminal condition.

b. Health conditions, related or unrelated to the terminal condition.

5.4 Current clinically information supporting all diagnoses.

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 must obtain written certification of terminal illness for each benefit period.

b. The hospice must obtain the written certification before it submits a claim for payment.

c. Exceptions,

1. If the written certification cannot be obtained within 2 calendar days, after a period begins, then an oral certification within 2 calendar days and the written certification before it submits 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 must have a face-to-face encounter with the patient, 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.

Certification is based on the physician's or medical director's clinical judgment regarding the normal course of the beneficiary's illness. The certification must include the following requirements:

a. The certification must state the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.

b. Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification. Initially, the clinical information may be provided verbally, and must be documented in the medical record and included as part of the hospice's eligibility assessment.

c. The physician must provide a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less as part of the certification and recertification forms.

1. If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician's signature.

2. If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.

3. The narrative shall include a statement directly above the physician's signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or examination of the patient.

4. The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients.

5. The narrative associated with the 3rd benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.

d. The physician or nurse practitioner who performs the face-to-face encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of that visit. The attestation 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.

e. All certifications and recertification’s must be signed and dated by the physician(s), and must include 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 must obtain written certification statement from:
   1. The medical director of the hospice or the physician member of the hospice interdisciplinary group; and
   2. The individual's attending physician, if the individual has an attending physician.

b. For subsequent periods, the only requirement is certification by the medical director of the hospice or the physician member of the hospice interdisciplinary group.”

5.4.4 Maintenance of records

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

The Hospice must make an appropriate entry in the patient's medical record as soon as they receive an oral certification; and file written certifications in the patient’s medical record.

5.5 Initial and Comprehensive Assessment

The provider of hospice services shall comply with 42 CFR §418.54 Condition of participation.

“Initial and comprehensive assessment: The hospice must conduct and document in writing a patient a comprehensive assessment that identifies the patient's need for hospice care services, and the patient'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 must 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, must complete the comprehensive assessment no later than 5 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 patient'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 patient's ability to understand and participate in his or her own care.
   5. Severity of symptoms.
6. **Drug profile.** A review of all the patient’s prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:
   (i) Effectiveness of drug therapy.
   (ii) Drug side effects.
   (iii) Actual or potential drug interactions.
   (iv) Duplicate drug therapy.
   (v) Drug therapy currently associated with laboratory monitoring.

7. **Bereavement.** An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.

8. **Referrals.** The need for referrals and 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 patient's progress related to outcomes, as well as a reassessment of the patient's response to care.

   The assessment update must be completed as frequently as the condition of the patient requires, but no less frequently than every 15 days.

   **e. Patient Beneficiary’s outcome measures.** The comprehensive assessment must include data that allow for measurement of outcomes. The hospice must measure and document data in the same way for all patients. 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 patient. The data for each patient must be used in individual patient 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) election of hospice care.

   a. An individual who meets the eligibility requirement may file an election statement with a hospice.

   b. **Notice of election.** The hospice chosen by the eligible individual must file the Notice of Election (NOE) with its Medicare contractor within 6 (six) calendar days after the effective date of the election statement.

   c. **Consequences of failure to submit a timely notice of election.** When a hospice does not file the required Notice of Election for its Medicare patients within 6 (six) calendar days after the effective date of election, Medicaid will not cover and pay for
**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 individual.** The individual must acknowledge that the identified attending physician was his or her choice.

b. **The individual'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 individual's terminal illness.**

c. **Acknowledgement that certain Medicare services, are waived by the election of Hospice.**

d. **The effective date of the election, 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.**

e. **The signature of the individual.**

**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 will be considered to continue through the initial election (1-2) period and through the subsequent election periods (3- unlimited) without a break in care if the individual:

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 of 42 CFR §418.26.**

**5.6.4 Waiver Duration of election of other benefits.**

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

a. **For the duration of an election of hospice care, an individual waives all rights to Medicare payments for the following services:**

b. **Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice).**
c. Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services:
   1. Provided by the designated hospice;
   2. Provided by another hospice under arrangements made by the designated hospice; and
   3. Provided by the individual’s attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

5.6.5 Re-election of hospice benefits
The provider of hospice services shall comply with 42 CFR § 418.24(e) – re-election of hospice benefits.

If an election has been revoked in accordance with 42 CFR § 418.28, the individual may at any time file an election, in accordance with this section, for any other election period that is still available to the individual.

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 individual (or representative) must 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 include the date the change is to be effective and the date signed by the individual (or representative);

b. The individual (or representative) must 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 statement is signed.

5.7 Duration of Hospice Care Coverage - Election Periods
The provider of hospice services shall comply with 42 CFR § 418.21 Duration of hospice care coverage—Election periods:

a. Subject to the conditions set forth in this part, an individual may elect to receive hospice care during one or more of the following election periods:
   1. An initial 90-day period - Election period 1;
   2. A subsequent 90-day period - Election period 2; or
   3. An unlimited number of subsequent 60-day periods - Election period 3 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 Election Periods

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

5.9 Medicaid Eligibility and Election 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 election 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 election period and enters the next election 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 5.9. The written statement includes 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:

a. Medicaid or NCHC coverage for home health, 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 will 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

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

The hospice shall make the report:

a. initially, within six (6) calendar days of the election of the Medicaid, Medicaid-pending or NCHC hospice benefit and start of care

The agency 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 make reimbursement for room and board charges. Hospice claims are not reimbursed by DHHS without this notification.

The hospice shall make the report:

b. within six (6) calendar days of the start of the second, third, and fourth election period;

c. within six (6) calendar days of the start of care and the start of the second, third, and fourth election periods if the beneficiary resides in a nursing facility, the beneficiary is dually eligible under Medicare and Medicaid, and the hospice agency shall bill Medicaid for room and board charges;

d. if the beneficiary transfers to another hospice agency; or

e. if the beneficiary is discharged from or revokes hospice.

Note: No reporting is required at the beneficiary’s death. Hospice agencies shall coordinate reporting a transfer of hospice care from one agency to another in order to prevent duplication of dates of service and subsequent denial of payment as only one agency can be paid each day. Medicaid-pending hospice reporting shall follow the same processes as all other reporting requirements.

5.13 Hospice Revocations and Discharges

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

5.13.1 Revocations

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. The hospice agency shall promptly report the ending of hospice participation and the effective date of withdrawal to the prior approval unit at the fiscal agent for DMA.

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.

5.13.2 Discharges
The provider of hospice services shall comply with 42 CFR §418.26 Discharge from hospice care. The hospice agency may discharge a beneficiary in accordance with applicable law, rules and regulations, and agency policy. The hospice agency shall complete and submit the NC DMA Hospice Reporting Form (DMA-0004) when a beneficiary revokes, transfers or is otherwise discharged from hospice services. The agency shall promptly report the beneficiary’s revocation or discharge to NC DMA because hospice participation information may affect Medicaid or NCHC payment for other services. The agency may bill for the date of discharge or revocation.

5.13.3 Re-Electing Hospice after Revocation
If a beneficiary wishes to resume hospice, he or she or the representative re-elects hospice for the next election period. The beneficiary is considered to be a new hospice client. A new election statement, plan of care (POC), and physician certification are required. Election periods are counted consecutively regardless of the number of times a beneficiary revokes or re-elects hospice services. Providers must monitor election period numbers in order to determine the need for prior approval. Additionally, a participation report to NC DMA is required, as described in Subsection 5.10.

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
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2. The Patient Protection and Affordable Care Act, Section 2302.
3. The Patient Protection and Affordable Care Act, Section 3132
5. 42 U. S. C. 1302 and 1395hh, Social Security Act (SSA) Sections 1102 and 1871)
6. 42 CFR Part 418, Subpart A—General Provision and Definitions
7. 42 CFR Part 418, Subpart B—Eligibility, Election and Duration of Benefits
8. 42 CFR Part 418, Subpart C—Conditions of Participation: Patient Care
9. 42 CFR §418.64 Condition of participation: Core services.
10. 42 CFR §418.66 Condition of participation: Nursing services—Waiver of requirement that substantially all nursing services be routinely provided directly by a hospice.
11. 42 CFR §418.70 Condition of participation: Furnishing of non-core services.
12. 42 CFR §418.72 Condition of participation: Physical therapy, occupational therapy, and speech-language pathology.
13. 42 CFR §418.74 Waiver of requirement—Physical therapy, occupational therapy, speech-language pathology, and dietary counseling.
14. 42 CFR §418.76 Condition of participation: Hospice aide and homemaker services.
15. 42 CFR §418.78 Conditions of participation—Volunteers.
16. 42 CFR Part 418, Subpart D—Conditions of participation: Organizational Environment
17. 42 CFR Part 418, Subpart F—Covered Services
18. 42 CFR Part 418, Subpart G—Payment for Hospice Care
19. 42 CFR Part 418, Subpart H—Coinsurance

6.2 Provider Certifications

To qualify for enrollment as a Medicaid or NCHC hospice provider, the hospice agency shall obtain Medicare certification and licensure by the Division of Health Service Regulation to provide Medicaid hospice services.

The provider of hospice services shall comply with:
N.C. General Statute (G.S.) Chapter 131E, Article 10 Hospice Licensure Act; and
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 DMA’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. Providers shall comply with these guidelines. Refer to NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

7.3 Coordinating Care

Provider of hospice services 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 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 shall coordinate with other provider(s) any care unrelated to the terminal illness.

The hospice agency 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), the hospice shall contact the CAP case manager. The hospice is responsible for the professional medical oversight of all hospice beneficiaries. CAP services must augment the care provided by the hospice and necessary to meet the beneficiary’s needs. The hospice shall coordinate care with the CAP case manager to prevent duplication of service and to ensure that cost limitations are not exceeded.

Note: CAP participants have a two-letter code in the CAP block of the Medicaid identification (MID) card.

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

The hospice 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 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 individual.

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, including 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 include:
   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 of the requirements and services outlined in clinical coverage policy 2B-1, Nursing Facilities, on DMA’s Web site at http://dma.ncdhhs.gov/.

d. Hospice shall have the responsibility of providing the medications and DME directly related to the terminal illness, with the exception of the DME included in the room and board as referenced above.

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 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.

g. Hospice 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

A beneficiary who is dually eligible for Medicare and Medicaid hospice shall elect both programs simultaneously. Medicare is the primary payer and Medicaid shall reimburse the hospice for nursing facility room and board charges. The hospice shall report the
beneficiary’s hospice participation to NC DMA if the beneficiary is dually eligible under Medicare and nursing facility room and board is submitted to Medicaid for payment. All hospice providers shall follow all reporting requirements.

7.3.2.2 Patient Monthly Liability

The hospice agency assumes responsibility for collecting the Patient Monthly Liability (PML). The agency notifies the local department of social services (DSS) of the beneficiary’s election of hospice, and DSS forwards to the hospice agency notification of the PML amount on the Notification of Eligibility for Medicaid/Amount and Effective Date of Patient’s Liability Form (DMA-5016).

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

7.3.3 Personal Care Services

7.3.3.1 Adult Care Home

Hospice services can 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 shall have a written contractual agreement that describes the services to be provided by each according to 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 has the responsibility for the professional management of the beneficiary’s care. The hospice 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 and the hospice (i.e., room and board, ACH Personal Care Services). The hospice agency 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 Medicaid Personal Care Services (PCS) in accordance with 42 CFR 418.76 (i). Medicaid Personal Care Services shall 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 agency 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 shall be provided with approved and documented coordination of services. Hospice providers are to submit the Hospice-PCS Coordination Form (DMA-3165) (Sample form in Attachment C) via fax to NC DMA within five (5) days of hospice
admission. Refer to the NC DMA website or the NC Tracks Provider Portal for links to this form.

If PCS services are in place prior to hospice:

a. The hospice agency will contact the PCS provider to coordinate the plan of care and scheduling of services.
b. The hospice agency will submit the Hospice-PCS Coordination Form (DMA-3165) to NC DMA within five (5) days of admission.
c. The hospice agency will submit the Hospice Aide Plan of Care to the PCS provider.

If Hospice is in place prior to PCS request:

a. The hospice agency will submit the Hospice-PCS Coordination Form (DMA-3165) to NC DMA to indicate the service gap necessitating the addition of PCS.
b. The hospice physician completes 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 agency will contact the PCS provider to coordinate the plan of care and scheduling of services.
d. The hospice agency will submit the Hospice Aide Plan of Care to the PCS provider.
e. The PCS provider will submit the Online Services Plan from QiReport to the hospice agency.

The hospice aide services must be utilized to the extent that they would be if PCS were not available. NC DMA or its contractors may conduct retrospective reviews of PCS and hospice services. Medicaid payments for personal care services provided to an individual 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 DMA may recover payment for those services.

a. Aide Services

The hospice agency shall coordinate its hospice aide and homemaker services with the Personal Care Services required to meet the beneficiary’s needs. The hospice shall make hospice aide and homemaker services available and adequate in frequency to meet the needs of the hospice beneficiary. "Hospice Aide" means an individual 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.

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

b. Service Coordination and Communication

The hospice agency is responsible for communicating with other providers to ensure that coordination of care occurs. The hospice agency 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 will be documented in each provider’s medical record for the beneficiary.

If the hospice agency determines prior to admission that PCS is in place for the beneficiary, the hospice agency will contact the PCS provider, if known, to discuss the services of the PCS provider that the patient is receiving. This will allow 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 agency will contact the provider immediately after the admission visit to discuss the coordinated plan of care.

c. Plan of Care

The hospice agency and the PCS agency will 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 that are 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 will involve 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 agencies must coordinate visits to ensure separation. The hospice agency and the PCS provider must give education to the aides that if they arrive at the home and the other aide is there they should report this to their respective
agency and leave the home. Any changes in scheduling for either agency will be reported to the other to avoid duplication of services at the same time.

The hospice agency and the PCS provider will 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 in order to process the claim. Refer to clinical coverage policy 9, Outpatient Pharmacy Services on DMA’s website at http://dma.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 agency policy. Services are provided as specified in the plan of care developed and approved by the IDG.

Core services (physician’s services, nursing services, medical social services, and counseling) are routinely provided directly by hospice employees. Other covered services are provided by agency employees or under contractual arrangements. Contractual agreements are in writing and in compliance with 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 Agencies

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

To change agencies during an election period, the beneficiary gives a signed statement to both the current agency and the new agency. The statement indicates the beneficiary’s intent to change agencies, provides the name of the current agency, states the name of the new agency, 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 agency shall cease billing for services.
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on the day prior to the effective date on the notice. The new agency 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 agency may develop a new one.

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

7.7 Electronic Signatures

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

7.8 Routine Home Care (RHC) Rates Policy

In addition, pursuant to the discretion granted to the Secretary under section 1814(i)(6)(D)(i) of the Social Security Act and effective on January 1, 2016; this rule will create two different payment rates for routine home care (RHC) that will result in a higher base payment rate for the first 60 days of hospice care and a reduced base payment rate for days 61 and over of hospice care; and a service intensity add-on (SIA) payment that will result in an add-on payment equal to the Continuous Home Care (CHC) hourly payment rate multiplied by the amount of direct patient care provided by a registered nurse (RN) or social worker provided during the last 7 days of a beneficiary's life, if certain criteria are met. In addition, section 3004(c) of the Affordable Care Act established a quality reporting program for hospices.
8.0 Policy Implementation/Revision Information

Original Effective Date: August 1, 1984

Revision Information:

<table>
<thead>
<tr>
<th>Date</th>
<th>Section Updated</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/01/2006</td>
<td>Sections 2, 3, 5</td>
<td>A special provision related to EPSDT was added.</td>
</tr>
<tr>
<td>04/01/2007</td>
<td>Subsection 7.1.2.1</td>
<td>Removed statement that Medicaid reimburses for co-insurance on hospice-covered drugs and respite days</td>
</tr>
<tr>
<td>04/01/2007</td>
<td>Section 2.6, 3.0, 4.0, 5.0</td>
<td>EPSDT information was revised to clarify exceptions to policy limitations for beneficiaries under 21 years of age</td>
</tr>
<tr>
<td>05/01/2007</td>
<td>Attachment A</td>
<td>Added UB-04 as an accepted claims form.</td>
</tr>
<tr>
<td>08/01/2007</td>
<td>Section 6.0</td>
<td>Changed the name of Division of Facility Services (DFS) to Division of Health Service Regulation (DHSR).</td>
</tr>
<tr>
<td>08/01/2007</td>
<td>Subsection 2.3 and Attachment C</td>
<td>Medicare-AID beneficiaries are not eligible for Medicaid-covered hospice services.</td>
</tr>
<tr>
<td>08/01/2007</td>
<td>Attachment A, letter E</td>
<td>Added revenue code 658.</td>
</tr>
<tr>
<td>12/01/2009</td>
<td>(effective 12/02/2008)</td>
<td>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.</td>
</tr>
<tr>
<td>05/11/2010</td>
<td>Subsection 2.2</td>
<td>Changed reference from Subsection 5.8.2 to Subsection 5.1.2</td>
</tr>
<tr>
<td>06/01/2011</td>
<td>Subsections 1.1.12, 5.7, 7.3.2, 7.3.2.2</td>
<td>Updated information on hospice and long term care to include ICF/MR and related MR-2</td>
</tr>
<tr>
<td>06/01/2011</td>
<td>Subsection 5.4.2, 5.4.3</td>
<td>Refer to Attachment C</td>
</tr>
<tr>
<td>06/01/2011</td>
<td>Subsection 5.4.3</td>
<td>Added information on the Face-to-Face Encounter requirements.</td>
</tr>
<tr>
<td>06/01/2011</td>
<td>Subsection 5.6.2</td>
<td>Added The waiver of curative services is not applicable to beneficiaries under 21 years old. Refer to Subsection 5.6.3.</td>
</tr>
<tr>
<td>06/01/2011</td>
<td>Subsection 5.6.3</td>
<td>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 the complete hospice package having to be provided with the addition of a curative service</td>
</tr>
<tr>
<td>06/01/2011</td>
<td>Subsection 5.6.3</td>
<td>Clarified wording on concurrent care</td>
</tr>
<tr>
<td>06/01/2011</td>
<td>Subsection 7.2</td>
<td>Added Patient Self Determination Act information</td>
</tr>
<tr>
<td>06/01/2011</td>
<td>Attachment A</td>
<td>Updated to standard DMA policy language</td>
</tr>
<tr>
<td>06/01/2011</td>
<td>Attachment C</td>
<td>Added Attachment C</td>
</tr>
<tr>
<td>Date</td>
<td>Section Updated</td>
<td>Change</td>
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<td>------------</td>
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</tr>
<tr>
<td>07/01/2010</td>
<td>Throughout</td>
<td>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.</td>
</tr>
<tr>
<td>11/01/2012</td>
<td>Throughout</td>
<td>Technical changes to merge Medicaid and NCHC current coverage into one policy.</td>
</tr>
<tr>
<td>11/01/2012</td>
<td>Subsections 5.1, 5.2</td>
<td>Addition of prior approval requirement prior to fifth and each subsequent benefit period.</td>
</tr>
<tr>
<td>11/01/2012</td>
<td>Subsection 1.1.10</td>
<td>Clarified that general inpatient care can also be provided in a hospice inpatient facility.</td>
</tr>
<tr>
<td>11/01/2012</td>
<td>Subsection 5.7.2</td>
<td>Added reference to Outpatient Pharmacy policy regarding billing for medications for hospice beneficiaries.</td>
</tr>
<tr>
<td>11/01/2012</td>
<td>Subsection 5.10</td>
<td>Clarification that in the case of a patient transfer between hospice agencies, only one agency can be paid per day.</td>
</tr>
<tr>
<td>11/01/2012</td>
<td>Subsection 7.5</td>
<td>Changes two weeks requirement for plan of care review to 15 calendar days</td>
</tr>
<tr>
<td>11/01/2012</td>
<td>Attachment A</td>
<td>Deleted statement about non-contracting hospice agencies. Changes place of service back to “Not Applicable”</td>
</tr>
<tr>
<td>11/01/2012</td>
<td>Attachment C</td>
<td>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</td>
</tr>
<tr>
<td>07/01/2013</td>
<td>Subsection 5.2</td>
<td>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.”</td>
</tr>
<tr>
<td>07/01/2013</td>
<td>Subsection 5.2</td>
<td>Deleted “Prior approval is requested by the hospice medical director or beneficiary’s attending physician as follows:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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)..&lt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. The physician provides information detailing the complications of the pregnancy (for MPW beneficiaries only), medical necessity for hospice services, the potential impact if the service is not provided, the frequency of visits, and the anticipated duration of services.</td>
</tr>
</tbody>
</table>
|            |                 | c. The completed form is sent to DMA’s designated
<table>
<thead>
<tr>
<th>Date</th>
<th>Section Updated</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/01/2013</td>
<td>Attachment D</td>
<td>Deleted outdated information to reflect current process with fiscal agent.</td>
</tr>
<tr>
<td>10/01/2015</td>
<td>All Sections and Attachments</td>
<td>Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.</td>
</tr>
<tr>
<td>01/01/2016</td>
<td>All Sections and Attachments</td>
<td>Clinical Policy 3D, Hospice Services reorganized, rewritten, and services clarified. These revisions had no effect on scope of coverage.</td>
</tr>
<tr>
<td>06/15/2016</td>
<td>Section 8.0</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>All Sections and Attachments</td>
<td>Clinical Policy 3D, Hospice Services reorganized, rewritten, and services clarified. These revisions had no effect on scope of coverage.</td>
</tr>
<tr>
<td></td>
<td>Section 7.0 Subsection(s) 7.8, 7.8.1, 7.8.2</td>
<td>Incorporated Routine Home Care (RHC) 2-Tier payment structure rates and Service Intensity Add-on rates as a result of the FY2016 Medicare Hospice Final Rule.</td>
</tr>
<tr>
<td></td>
<td>Section 5.0 Subsection 5.1, 5.2, 5.2.2</td>
<td>Modified the clinical review timeframe for 300 days (prior to the 5th certification period) to 180 days (prior to the 3rd certification period).</td>
</tr>
<tr>
<td></td>
<td>Section 5.0 Subsection 5.7</td>
<td>Incorporated the requirement for the electronic submission of the Election Statement (Notice of Election) as a component of the Prior Approval Request for the 1st Certification Period.</td>
</tr>
</tbody>
</table>
Attachment A: Claims-Related Information

Provider(s) shall comply with the, NCTracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, DMA’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)

B. International Classification of Diseases, 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.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>0651</strong> Routine Home Care</td>
<td><strong>Routine Home Care</strong> 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 agency. It is billed by the day and is the agency’s basic per diem rate. This service code is limited to once per day per beneficiary, same or different provider. Routine Home Care is not allowed on the same day as Continuous Home Care or Inpatient Respite Care. The agency should provide and bill the appropriate level of service.</td>
</tr>
</tbody>
</table>
| **0652** Continuous Home Care | **Continuous Home Care** is provided during a medical crisis and is billed by the hour. This level of service is provided when the beneficiary’s physician feels clinically orders 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, adult care home, or nursing facility. The care needed shall be:  
  • continuous care for at least 8 hours of the calendar day (the hours may
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.

Continuous Home Care is not allowed on the same day as Routine Home Care, Inpatient Respite Care or General Inpatient Care. The agency should provide and bill the appropriate level of service.

**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.

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.

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 agency should provide and bill the appropriate level of service.

**General Inpatient Care** is payment made to the hospice for a beneficiary in an acute care hospital. The service is billed by the day as follows:

- 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.

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.

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 agency should provide and bill the appropriate level of service.

| 0235 Incremental Nursing Charge Rate-Hospice | To ensure the end-of-life continuous home care is rendered by the appropriate level of medical staff (RN or SW) when RC0235 is billed with G0300 (LPN) the detail is denied with a message that tells the provider that rendering provider is not authorized to provide service and refer to (new) bulletin article for Hospice Payment Reform. |
| 658 Hospice Nursing Facility Room and Board (Intermediate Level of Care) | Refer to “Hospice Nursing Facility Room and Board,” below. Revenue code 658 is used to bill this service if the beneficiary has been approved for nursing facility care at the intermediate level. |
| 659 Hospice Nursing Facility Room and Board (Skilled Level of Care) | Refer to “Hospice Nursing Facility Room and Board,” below. Revenue code 659 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 |

**Hospice Nursing Facility Room and Board**

Hospice Nursing Facility Room and Board is the charge billed by the hospice agency 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% of the per diem for the individual nursing facility. The amount is reduced by the amount of the PML when applicable. The hospice agency 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.

In addition to RC0235 is used to price details at an hourly rate the same way RC0652 currently pays. (HCPCS Codes currently on file as non-covered are updated under separate
G0299 – Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting; G0300 – Direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting; G0155 - Services Of Clinical Social Worker In Home Health Or Hospice Settings
A value code of 40, 41, or 42, as applicable, in the Value Code 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.

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

Revenue Code 651 unit of service = 1 day
Revenue Code 652 unit of service = 1 hour
Revenue Code 655 unit of service = 1 day
Revenue Code 656 unit of service = 1 day
Revenue Code 658 unit of service = 1 day
Revenue Code 659 unit of service = 1 day
Revenue Code 235 units of service = 1 hour
Per diem rate includes all services provided directly by hospice provider and also 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.
DRAFT

An adult care home under a written agreement with the hospice agency.
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 agency.

G. Co-payments


H. Reimbursement

Providers shall bill their usual and customary charges. For a schedule of rates, see: http://dma.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% 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.

1. Routine Home Care

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

Routine Home Care 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 Final Rule replaces the single RHC per diem rate with two different RHC payment rates:

a. A higher payment rate for the first 60 days of hospice care
b. A reduced payment rate for 61 days and over of hospice care

A 60-day gap in hospice services is required to reset the counter that determines if a patient is qualified for the 1-60 payment category.
Service Intensity Add-On (SIA)
The SIA payment is in addition to the per diem RHC rate when all of the following criteria are met:

- The day is an RHC level of care day
- The day occurs during the last 7 days of the patient’s life, and the patient is discharged expired
- Direct patient care is furnished by a registered nurse (RN) or social worker that day
- The SIA payment will equal the Continuous Home Care (CHC) hourly payment rate, for a minimum of 15 minutes and up to 4 hours total per day

1. Payment change is budget neutral and paid for through a reduction in the RHC rate
2. Going forward, yearly fluctuations in the total size of the add-on will impact the yearly RHC rates
3. New G-codes (HCPCS Codes) will be used to identify RN versus LPN visits and Clinical Social Worker
e. G0299 – Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, Each 15 Minutes.
f. G0300 – Direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting, Each 15 Minutes.
g. G0155 - Services Of Clinical Social Worker In Home Health Or Hospice Settings, Each 15 Minutes.

Note: RC0235 will be used to price details at an hourly rate the same way RC0652 currently pays.

2. Continuous Home Care
Continuous Home Care is provided during a medical crisis, as needed to keep the beneficiary at home and when the beneficiary’s physician believes 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.

3. Inpatient Respite Care
Inpatient Respite Care is short-term care to relieve family members and other unpaid caregivers who care for a beneficiary in a private residence. Respite may be provided only on an occasional basis for up to five (5) consecutive days for each occurrence, as defined by agency policy and based on the needs of the primary caregiver. It is provided in a hospice inpatient facility, a hospital, or nursing facility under arrangement with the hospice agency. The hospital or nursing facility is required to 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.

4. 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 agency. The hospital or nursing facility is required to be in compliance with 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 is a required hospice service but it is not reimbursable.

Drugs and biologicals pertaining to the terminal diagnosis are reimbursed to the hospice as part of the hospice per diem. Medicaid and NCHC shall make direct reimbursement to the pharmacy for drugs used to treat illnesses or conditions not related to the terminal illness.
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 must 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 can be done 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 the seven calendar (7) days after the admission for these beneficiaries. The exceptional circumstance that prevented the face-to-face encounter from being conducted in a timely way 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 (7) days after admission are considered to be 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 include 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 must attest in writing that he or she had a face-to-face encounter with the beneficiary, including 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 way.

2. Attestation Statement for Nurse 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 (6) 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. In the event that 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 include 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. Physicians must briefly synthesize the clinical information supporting the terminal diagnosis, and attest that they 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 include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of six (6) months or less.
### Attachment C: Hospice-PCS Coordination Form (DMA-3165)

**NC Division of Medical Assistance**  
**Notification of Hospice and Personal Care Services (PCS) Coordination Form**

Hospice agencies must notify the NC Division of Medical Assistance (NC DMA) when there is a need for concurrent Hospice and PCS services to be provided to beneficiaries. The purpose of this form is to facilitate care coordination between hospice and PCS agencies. This notification form and supporting documentation must be SUBMITTED to NC DMA within five (5) days of hospice admission or referral to avoid delay of service and reimbursement. Submit these documents via fax to 919-715-9025 to NC DMA Attention: Hospice Consultant.

**Current Status:**
- [ ] Active PCS Recipient  
- [ ] Pending PCS Recipient

**Required Attachments:**
- [ ] Individualized Hospice Plan of Care (e.g., MD order set or 485)  
- [ ] Online Service Plan from PCS provider if current PCS recipient  
- [ ] Individualized Hospice Aide Care Plan  
- [ ] Other Supporting Documentation

**Date of Request:**

<table>
<thead>
<tr>
<th>RECIPIENT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name, First Name, Middle Initial:</td>
</tr>
<tr>
<td>Recipient ID:</td>
</tr>
<tr>
<td>Translator Required? Yes No Language:</td>
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<td>Responsible Party if other than patient:</td>
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<td>Name of person to contact to schedule assessment, if other than the recipient:</td>
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<td>Contact Phone:</td>
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<td>Has this recipient utilized personal care services in the past? Yes No Unknown:</td>
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<th>HOSPICE AGENCY INFORMATION</th>
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<tr>
<td>Name: NPI:</td>
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<td>Phone: Fax:</td>
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<td>Contact Name: Contact Phone:</td>
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<th>PCS AGENCY INFORMATION (if not yet in place, DMA will add when assigned)</th>
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**SERVICE GAP** (Describe needs that require two providers to be involved, e.g., decubitus risk due to immobility, wound care, need for additional personal care due to incontinence/skin care, etc.)

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**NC DMA-3165 (11/2015)**  
**Page 1 of 2**
## ACTIVITIES OF DAILY LIVING:

In the appropriate row/column combination, enter an "H" for services performed by Hospice, "F" for services performed by the family and "P" for services performed by the PCS Provider. "AM" signifies that services are performed before noon, "Mid" signifies Noon-4:00 pm and "PM" signifies 4:00 pm-8:00 pm. * Indicates nurse aide tasks. # Indicates NA II tasks.

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<th>Sunday</th>
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<th>Tuesday</th>
<th>Wednesday</th>
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<td>AM</td>
<td>Mid</td>
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<td># Suctioning</td>
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Beneficiary/Representative Signature / Date / Hospice Representative Signature / Date

### FOR DMA USE ONLY:

- [ ] Accepted Effective Date: ____________________ End Date: ____________________
- [ ] Rejected Reason: ____________________

NC DMA Representative Signature: ____________________ Date: ____________________