Hospice

The Hospice program is designed to provide support and comfort for Medicaid-eligible recipients who have a terminal illness and have decided to receive end of life care. Nursing services, physician services, and drugs and biologicals must be routinely available on a 24-hour basis; all other covered services must be available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions.

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

Covered Services

- Physical therapy, occupational therapy, respiratory therapy and speech-language pathology are Medicaid covered benefits when they are provided for the purpose of symptom control, or to enable the patient to maintain activities of daily living and basic functional skills.
- Counseling services are available to both the individual and the family and are part of the per diem rate and the recipient's plan of care. Bereavement counseling for the client's family and significant others is available for up to one year after the patient's death and is not reimbursable.
- Medicaid provides coverage for equipment provided by the hospice for use in the patient's home pursuant to the Plan of Care (POC).

Services included in the hospice benefit plan are:

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

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

Non-Covered Services

No reimbursement is provided for curative services for adults.

Prior Authorization (PA)

Effective with dates of service on or after March 1, 2017, prior authorization (PA) is required for Hospice services. The hospice agency will not be reimbursed for hospice services unless all signed paperwork has been submitted to Nevada Medicaid and PA has been obtained. It is the responsibility of the hospice provider to ensure that PA is obtained for services unrelated to the hospice benefit. To request PA and upload required documents, please use the Provider Web Portal. Faxes are no longer accepted.

Authorization requests for admission to Hospice Services must be submitted as soon as possible, but not more than eight business days following admission. Please note if the authorization request is submitted after admission, the Hospice provider is assuming responsibility for program costs if the authorization request is denied. PA only approves the

existence of medical necessity, not recipient eligibility. PA for medical necessity is not required for dual eligible (Medicare/Medicaid eligible) recipients.

Hospice forms FA-92 or FA-93, and FA-94 must be submitted with FA-95 (the prior authorization request). For extended hospice services past 12 months, FA-96 must be submitted with FA-95. See page 3 of this billing guide for information regarding Hospice forms.

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

Billing Instructions

- PT 64 must bill using revenue codes only. Effective October 2, 2017, PT 64 does not bill with procedure codes or revenue/procedure code combinations.
- PT 64 bills the following revenue codes for hospice services:

Revenue Code	Description	Codes Replaced
0551	Service Intensity Add-On for the last 7 Days of Life (RN, LPN, Social Worker)	Replaces codes G0155, G0299 and G0300
0650	Routine Hospice Care Days 1-60	Replaces code Q5001 with the U2 Modifier
0651	Routine Hospice Care Days 61+	Replaces code Q5001
0652	Continuous Home Care	
0655	Inpatient Respite Care	
0656	General Inpatient Care	

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

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

Effective on claims with dates of service on or after January 1, 2016, a dual rate has been established for Routine Home Care (RHC) hospice services provided by provider type (PT) 64 (Hospice), which pays a higher base rate for the first 60 days of hospice care and a reduced base rate for days thereafter. An add-on payment has been established for services provided by a registered nurse or social worker during the last seven days of a recipient's life.

Special Billing Instructions for Routine Home Care (RHC):

- Use revenue code 0650 (Hospice Service-Routine-Home Care) for routine home day care for the first 60 days (RHC).
    - Please note: If a recipient is discharged and re-admitted within 60 days of that discharge, then the day count would start back to the discharge day. Calculation example: If the recipient was on hospice for only five days, does not receive hospice care for 50 days and is then re-admitted, the provider has 55 more days of the higher RHC rate. If a recipient is discharged and does not have hospice services for at least 60 days in a row and is re-admitted, the provider starts all over with the 60-day higher rate.
- Use revenue code 0651 Routine Hospice Care for routine home day care for days 61+.
- Bill Registered Nurse (RN) Licensed Practical Nurse (LPN), Social Worker (SW) services for the last seven days of a recipient's life with revenue code 0551.

Hospice

Ordering, Prescribing or Referring (OPR) Provider Requirements

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

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

Reminders for providers who submit institutional claims:

- If your provider type requires the attending physician to be listed on the Institutional claim, that attending physician must be enrolled with Nevada Medicaid.
- If the service was ordered, prescribed or referred by another provider, the NPI of the OPR provider is required to be listed on the claim form. The OPR provider must be enrolled in Nevada Medicaid.
- If the attending physician is the same as the OPR provider, leave the OPR field blank.
- The attending and OPR NPI must be for an individual provider (not an organization or group).
- For detailed claim completion information, refer to the 837I FFS Companion Guide located at: https://www.medicaid.nv.gov/providers/edi.aspx and the Electronic Verification System (EVS) User Manual Chapter 3 located at: https://www.medicaid.nv.gov/providers/evsusermanual.aspx

Notes

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

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

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

Hospice Forms

Forms have been created for standardization and uniformity of the Hospice Program. All fields on the forms are required to be filled in and the physician signature must be included. Nevada Medicaid Hospice forms without the physician signature will not be accepted.

- Nevada Medicaid Hospice Program Action Form (**FA-91**) (for hospice discharge, change of hospice provider or revocation of hospice services)

Hospice

- Nevada Medicaid Hospice Program Election Notice - Adults (**FA-92**) or Nevada Medicaid Hospice Program Election Notice - Pediatrics (**FA-93**)
- Nevada Medicaid Hospice Program Physician Certification of Terminal Illness (**FA-94**)
- Hospice Prior Authorization Request (**FA-95**)
- Nevada Medicaid Hospice Extended Care Physician Review Form **(FA-96)**

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