



HOSPICE SERVICES

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This provider manual outlines policy and claims submission guidelines for claims submitted to the North Dakota Health Enterprise MMIS.

This document covers services provided by hospice providers that are certified to participate in the Medicare program, licensed and enrolled with ND Medicaid.

HOSPICE ELECTION

A hospice election must be submitted for a member who is eligible for hospice care and who wishes to elect hospice.

HOSPICE CARE ELIGIBILITY REQUIREMENTS

A member must be certified as terminally ill to be eligible for coverage of hospice care. Hospice care may continue until a member is no longer certified as terminally ill or until the member or representative revokes the election of hospice.

A member may live in a home in the community or in a long-term care facility while receiving hospice services. A long-term care facility is a nursing facility, swing bed facility or intermediate care facility for the intellectually disabled.

A dually eligible member must elect or revoke hospice care simultaneously under both the Medicare and the Medicaid programs.

PHYSICIAN CERTIFICATION

A written certification statement signed by the medical director of the hospice or a physician member of the hospice interdisciplinary group and the member's attending physician, if the member has one, should be obtained within two calendar days after hospice care is initiated. If the hospice does not obtain a written certification within two calendar days after hospice care is initiated, a verbal certification must be obtained within the two calendar days and a written certification must then be obtained no later than eight days after care is initiated if a verbal certification was provided.

If the certification requirements are not met, no payment can be made for hospice care provided prior to the date of any subsequent certification. The certification statement must include a statement indicating the member's medical prognosis is a life expectancy of six months or less.

COVERED SERVICES

The hospice must provide the services listed below. Core services must routinely be provided directly by hospice employees. The hospice may contract for supplemental services during periods of peak patient load or for extraordinary circumstances. All services must be performed by appropriately qualified personnel.

1. Core Services
 - a. Nursing services provided by or under the supervision of a registered nurse.
 - b. Social services provided by a social worker under the direction of a physician.
 - c. Services performed by a physician, dentist, optometrist, or chiropractor.
 - d. Counseling services provided to the member and family members or other persons caring for the member at the member's home to assist in minimizing the stress and problems that arise from the terminal illness, related conditions, and the dying process.
2. Supplemental Services
 - a. Inpatient hospice care including procedures necessary for pain control and acute or chronic symptom management.
 - b. Inpatient respite care.
 - c. Medical equipment supplies and drugs. Medical equipment including self-help and personal comfort items related to the palliation or management of the member's terminal illness must be provided by the hospice for use in the member's home. Medical supplies include supplies specified in the written plan of care. Drugs include those used to relieve pain and control symptoms for the member's terminal illness.
 - d. Home health aid services and homemaker services which include personal care services and household services, such as changing a bed, light cleaning and laundering, necessary to maintain a safe and sanitary environment in areas of the home used by the member. Aide services must be provided under the supervision of a registered nurse.
 - e. Physical therapy, occupational therapy, and speech and language pathology services provided for symptom control or to maintain activities of daily living and basic functional skills.

INPATIENT HOSPICE CARE

A member may need care as an inpatient on a short-term basis during a period of crisis. To meet this need, the hospice or facility under contract to provide inpatient hospice care must provide 24-hour nursing services. Nursing services must be sufficient to meet the total nursing needs and be consistent with the member's plan of care. The inpatient facility must provide treatments, medications, and diet as prescribed, and keep the member comfortable, clean, well groomed, and protected from accident, injury, and infection. The inpatient facility must employ a registered nurse on each shift to provide nursing care.

INPATIENT RESPITE CARE

Inpatient respite care may be provided on an occasional basis to give the member's family or caregiver a break from the full-time responsibility of providing care. Payment for inpatient respite care may not exceed five consecutive days of inpatient respite care at a time.

BEREAVEMENT COUNSELING

The hospice must make bereavement services available to the member's family for at least one year after the member's death. Family includes persons related to the member or those considered by the member to be family because of close association. No payment is made for bereavement counseling.

REIMBURSEMENT FOR PHYSICIAN SERVICES

The daily rates paid for hospice care include payment for the administrative and general supervisory activities performed by the medical director or a physician member of the interdisciplinary team. These activities include participation in establishment of care plans, supervision of care and service, periodic review and updating of care plans, and establishment of governing policies. The cost of these activities may not be billed separately.

The hospice may be paid at the current Medicaid rate for physician services provided for purposes other than those listed above if the physician is an employee of the hospice or provides services under arrangement with the hospice. Payment is not available for donated physician services.

Payment may be made for personal professional services provided by a member's attending physician, if the physician is not an employee of the hospice, not providing services under arrangement with the hospice, or does not volunteer services to the hospice. Costs for services other than personal professional services, such as lab or x-

ray, may not be included on the attending physician's bill and may not be billed separately.

ROOM AND BOARD PAYMENT FOR MEMBER IN LONG-TERM CARE FACILITY

When hospice care is furnished to a member residing in a long-term care facility, payment to the long-term care facility by ND Medicaid is no longer available, and the hospice is responsible for paying for room and board furnished by the long-term care facility. The hospice is responsible for including the room and board charges on the claim for the amount equal to the Medicaid rate payable to the long-term care facility at the time the services are provided. The hospice may not negotiate a room and board rate with the long-term care facility with the exception of payment for private room accommodations. No additional payment will be made to the hospice for negotiated private room rates.

If a member has a recipient liability, the amount will be shown on a remittance advice. The hospice is responsible for collection of this amount from the member. The hospice may make arrangements with the long-term care facility to collect the recipient liability. ND Medicaid will not reimburse the hospice for any uncollected recipient liability.

A hospice claim must be submitted for all individuals electing hospice who reside in a long-term care facility even if no payment is due from ND Medicaid and payment is made entirely by Medicare, insurance, or any other payment source.

BILLING GUIDELINES

Hospice agencies must bill for services using the North Dakota Web Portal using the electronic claims submission web pages or Electronic Data Exchange transaction. The claim must include a valid National Provider Identification number (NPI) and taxonomy code.

Claims must be submitted to ND Medicaid using the applicable *Bill Type* **811-828**.

The bill type frequency must coincide with the status code billed.

Claims must be submitted to ND Medicaid using the following *Revenue Codes* when billing for:

Revenue Code 651	Routine Home Care
Revenue Code 652	Continuous Home Care
Revenue Code 655	Inpatient Respite Care
Revenue Code 656	General Inpatient Care
Revenue Code 657	Hospice Physician Services
Revenue Code 659	Room and Board Days

The hospice provider will be reimbursed at one of four predetermined rates for each day a member is under the care of the hospice. The four rates exclude payment for physician services that are separately paid.

The hospice provider will be reimbursed an amount applicable to the type and intensity of services provided each day to the member. The four levels of care into which each day of care is classified are:

- Routine Home Care – This level of care is used for each day the member is under the care of the hospice and the member is not classified at another level of care. This level of care is paid without regard to the volume or intensity of services provided.
- Continuous Home Care – This level of care is used for each day the member receives nursing services on a continuous basis during a period of crisis in the member's home. The hospice is paid an hourly rate for every hour or part of an hour of continuous care furnished up to a maximum of 24 hours a day.
- Inpatient Respite Care – This level of care is for each day a member is in an inpatient facility and receiving respite care. Payment for inpatient respite care is limited to 5 consecutive days beginning with the day of admission, but excluding the day of discharge. Any inpatient respite care days in excess of 5 consecutive days must be billed as routine home care. Inpatient respite care may not be paid when a member resides in a long-term care facility.
- General Inpatient Care – This level of care is for each day the member receives inpatient hospice care in an inpatient facility for control of pain or management of acute or chronic symptoms that can't be managed in the home. The day of admission to the facility is general inpatient care and the day of discharge is not general inpatient care, unless the member is discharged deceased. Payment for general inpatient care may not be made to a long-term care facility when that facility is considered the resident's home; however, payment for general inpatient care can be made to another long-term care facility.

Payment for inpatient care days will be limited according to the number of days of inpatient care furnished to Medicaid members by the hospice in a year. The maximum number of payable inpatient respite and general inpatient days may not exceed twenty percent of the total number of days of hospice care provided to all Medicaid members by the hospice. If the maximum number of days exceeds twenty percent of total days, an adjustment will be made to pay the excess days at the routine home care rate, and the difference will be recovered from the hospice provider. The limitation on inpatient care days does not apply to members diagnosed with acquired immunodeficiency syndrome (AIDS).