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Section 1: Introduction

Overview

This manual provides a comprehensive, single-source document that outlines key policies and procedures associated with the Indiana Health Coverage Programs (IHCP) Hospice Program. The manual does not address more general aspects of IHCP policy, such as those that describe IHCP member eligibility, third-party liability (TPL), medical policy, prior authorization (PA), utilization review, and case mix. Refer to the IHCP Provider Manual for a discussion of these general topics. The IHCP Provider Manual is available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/manuals.htm.

This manual is divided into nine main sections and three appendices as described in Table 1.1.

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<td>Provider Enrollment</td>
<td>Describes the conditions of provider participation and provider enrollment procedures with special attention to Medicare provider certification requirements, State hospice licensure, service location issues, and institutional policies Provider Enrollment Application IHCP Hospital and Facility Provider Application and Maintenance Form</td>
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<td>Describes the target groups by population category Prognosis is terminal within six months Medicaid Physician Certification State Form 48736 (R/12-02)/OMPP 0006 (HF-3)</td>
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<td>Election, Discharge, and Revocation</td>
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### Section 6

**Hospice Authorization Process**  
Describes the procedures and policies that determine the overall framework of a member’s hospice services, with an emphasis placed on the informational requirements associated with the benefit periods and on the authorization process for services unrelated to the terminal illness of the member.  
Plan of care for one benefit period at a time  
*Medicaid Hospice Plan of Care State Form 48731 (R2/11-04)/OMPP 0011 (HF-4)*

**Level of Care:**  
Hospice is allowed to manage levels of service within benefit period established by hospice authorization  
- Routine home  
- Continuous home  
- Inpatient respite  
- General inpatient

**Location of Care:**  
- Private home  
- Institutional setting

### Section 7

**Reimbursement**  
Describes how providers are reimbursed for the provision of hospice services and lists the revenue codes associated with the various levels of service and care.  
*UB-04*  
Provider bills using one of 11 revenue codes

### Section 8

**IHCP Recoupment**  
Describes how the IHCP recoups overpayments from hospice and nonhospice providers  
IHCP recoupment of overpayments to nursing homes for room and board for service dates resident is on hospice

### Section 9

**Hospice Care in Nursing Facilities**  
Describes care and reimbursement issues specific to hospice care in nursing facilities  
Level of Care, Reimbursement and Coverage Issues for Hospice Care in Nursing Homes

### Appendix A

**Forms**  
Provides Web links to access relevant forms

### Appendix B

**Hospice-Related Bulletins, Banner Pages, and Newsletters**  
Provides Web links of relevant provider communications

### Appendix C

**Common Error Codes**  
Most common Medicaid and hospice claims denials
Section 2: IHCP Hospice Program Overview

Overview

This section provides an overview of the Medicaid Hospice Program with regard to hospice-covered services and hospice levels of care. Hospice reimbursement and billing information is available in Section 7: Reimbursement. Section 9:

Indiana State statute legislatively mandated that the Office of Medicaid Policy and Planning (OMPP) implement a Medicaid hospice benefit with a start date of July 1, 1997. State statute requires the Medicaid hospice benefit mirror the Medicare Hospice Program with regard to hospice covered services and reimbursement methodology.

Medicare Conditions of Participation for Hospice Care

Indiana State statute requires a hospice provider to be Medicare-certified as a hospice prior to enrollment in the Indiana Health Coverage Programs (IHCP) as a Medicaid hospice provider. The IHCP further requires a hospice to be licensed by the Indiana State Department of Health (ISDH) as a requisite to enrollment as a Medicaid hospice provider. As such, the IHCP expects hospice providers to comply with the Medicare Conditions for Participation for Hospice Care under 42 CFR Part 418. Providers may view the federal hospice regulations at http://www.in.gov/isdh/regsvcs/acc/lawrules/.

Covered Services within the IHCP Hospice Per Diem

According to 405 IAC 5-34-8, services covered within the IHCP hospice per diem reimbursement rates include the following:

- Nursing care provided by or under the supervision of a registered nurse
- Medical social services provided by a social worker who has a bachelor’s degree or higher, and who is working under the supervision of a physician
- Physician services provided by the medical director or physician member of the interdisciplinary team characterized as follows:
  - General supervisory services, participation in the establishment of the plan of care, supervision of the plan of care, periodic review, and establishment of governing policies (for example, services covered by hospice per diem revenue codes 651, 652, 653, 654, and 655)
  - Direct care patient services (covered by fee-for-service revenue code 657)
- Counseling services provided to the member and the member’s family or other person caring for the member
- Short-term inpatient care provided in a hospice inpatient unit, participating hospital, or nursing home subject to the limitations in 405 IAC 1-16-3
- Medical appliances and supplies, including palliative drugs, related to the palliation or management of the member’s terminal illness
- Home health services furnished by qualified aides that meet the skills, attitude, and training of home health aide under the Medicare Home Health Benefit at 42 CFR Section 484.36 Condition of
Participation—Home Health Aide. Effective December 2, 2008, the Medicare hospice conditions of participation at 418.76 reflect the training, supervision, and duties of the hospice aide.

- Homemaker services that assist in providing a safe and healthy environment. The hospice must ensure that the instructions for homemaker services are noted in the hospice plan of care, and the proper supervision and proper reporting and documentation requirements are also met as required in the Medicare Conditions of Participation at 42 CFR 418.76.
- Physical therapy, occupational therapy, and speech-language pathology services provided for purposes of symptom control
- Inpatient respite care, subject to the limitations in 405 IAC 1-16-2
- Room and board (for dually eligible Medicare/IHCP hospice members) residing in long-term care (LTC) facilities, as described in 405 IAC 1-16-4
- Room and board for IHCP-only hospice members who reside in LTC facilities as covered by hospice per diem revenue codes 653 or 654, as described in 405 IAC 1-16-4.
- Any other item or service specified in the member’s hospice plan of care, if the item or service is a covered service under the Medicare program

The IHCP Hospice Program mirrors the Medicare Hospice Program in defining hospice core services from hospice noncore services.

- Hospice core services are those covered services in the Medicare and IHCP hospice per diem that must be provided directly to the hospice patient by hospice employees. Hospice core services include hospice physician services, hospice nursing services, hospice medical social work services, and hospice counseling services (including bereavement, dietary, spiritual, and other counseling).
- Hospice noncore services are those services in the Medicare or IHCP hospice per diem not identified as hospice core services in the preceding bullet point. Hospice providers may contract other healthcare professionals to provide hospice noncore services. However, the hospice must still retain oversight as the manager of the member’s hospice care.
- Physician services represent another distinct service category. However, these services are reimbursed on a fee-for-service (FFS) basis and are therefore not affected by the location of care category. For additional information, refer to Section 7: Reimbursement.
- Hospice providers must ensure that the hospice agency is not involved with another healthcare provider who submits claims for any services not reimbursable under Medicare or IHCP programs based on the following program guidelines:
  - Standard Medicare or IHCP benefits for treatment of the terminal illness
  - Treatment by another hospice not arranged for by the patient’s hospice
  - Care from another provider that duplicates care the hospice is required to furnish. The hospice provider must work with other nonhospice providers to coordinate care and ensure appropriate billing if these situations occur.

**Comparison Chart of IHCP Hospice Covered Services and Medicare Hospice Covered Services**

This section demonstrates to hospice providers how the IHCP hospice per diem mirrors the services covered under the Medicare Hospice Program as described in the Medicare Conditions of Participation for Hospice Care. Hospice providers are reminded that federal regulations about hospice care can be found in 42 CFR Part 418. Providers can refer to these regulations for a more thorough review of the Medicare Conditions of Participation for Hospice Care.
Hospice providers are reminded that any case-specific issues about the development of a plan of care for a Medicare beneficiary must be directed to the agency’s Part A Medicare Administrative Contractors (MACs).

Table 2.1 – Hospice Service Regulations

<table>
<thead>
<tr>
<th>Hospice Service</th>
<th>State Regulations</th>
<th>Federal Regulations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>405 IAC 5-34-8 (1)</td>
<td>42 CFR Section 418.82</td>
</tr>
<tr>
<td>Medical social services</td>
<td>405 IAC 5-34-8 (2)</td>
<td>42 CFR Section 418.84</td>
</tr>
<tr>
<td>Physician services</td>
<td>405 IAC 5-34-8 (3)</td>
<td>42 CFR Section 418.86</td>
</tr>
<tr>
<td>Counseling services</td>
<td>405 IAC 5-34-8 (4)</td>
<td>42 CFR Section 418.88</td>
</tr>
<tr>
<td>Short-term inpatient care</td>
<td>405 IAC 5-34-8 (5)</td>
<td>42 CFR Section 418.98 (a) and (c)</td>
</tr>
<tr>
<td>Medical appliances and supplies</td>
<td>405 IAC 5-34-8 (6)</td>
<td>42 CFR Section 418.96</td>
</tr>
<tr>
<td>Hospice aide (Home health aide services)</td>
<td>405 IAC 5-34-8 (7)</td>
<td>42 CFR Section 418.76</td>
</tr>
<tr>
<td>Homemaker services</td>
<td>405 IAC 5-34-8 (8)</td>
<td>42 CFR Section 418.76</td>
</tr>
<tr>
<td>Physical therapy, occupational therapy</td>
<td>405 IAC 5-34-8 (9)</td>
<td>42 CFR Section 418.92</td>
</tr>
<tr>
<td>Inpatient respite care</td>
<td>405 IAC 5-34-8 (10)</td>
<td>42 CFR Section 418 (b) (2)</td>
</tr>
<tr>
<td>Room and board for dually eligible Medicare/IHCP hospice members residing in a nursing facility (NF)</td>
<td>405 IAC 5-34-8 (11)</td>
<td>The Medicare program does not provide payment for room and board</td>
</tr>
<tr>
<td>Any other item or service specified in the hospice plan of care, if the item or service is a Medicare covered service</td>
<td>405 IAC 5-34-8 (12)</td>
<td></td>
</tr>
</tbody>
</table>

**Hospice Levels of Care**

These covered services are delivered and reimbursed at one of four levels. The use is determined by the hospice provider within the context of overall use and reimbursement limitations described in [Section 7: Reimbursement](#).

The hospice levels of care (LOCs) include the following:

- Routine home hospice care
- Continuous home hospice care
- Inpatient respite hospice care
- General inpatient hospice care

Some case-specific questions have been posed to the IHCP and ISDH regarding some of the hospice LOCs that are not noted in [Section 6: Hospice Authorization Process](#). Therefore, this information is noted in this section.
Continuous Home Hospice Care

There are ongoing questions about the continuous home care rate under Medicare and IHCP hospice benefits. To provide additional information about this LOC, the following information was presented by Palmetto Government Benefits Administrators (GBA), the Part A MAC for Indiana, at a May 2003 conference:

- Hospice providers should follow the parameters outlined in Transmittal A-03-16 dated February 28, 2003, and effective April 1, 2003.
- This LOC can be provided during a period of crisis to maintain the individual at home.
- A period of crisis is defined as a time in which the patient requires predominantly nursing care to achieve palliation or management of acute medical symptoms.
- If a caregiver has been providing a skilled LOC and becomes unable to or unwilling to continue providing the care, this may precipitate a period of crisis because the skills of a nurse may be required to replace the services that had been provided by the caregiver.
- The hospice must provide a minimum of eight hours of care during a 24-hour day.
- The 24-hour day begins and ends at midnight.
- The care need not be continuous.
- When fewer than eight hours of care are provided, the care is reimbursed at the routine home care rate.
- Nursing care provided by a registered nurse (RN) or licensed practical nurse (LPN) can be provided for more than half of the period of care.
- Home health aides may supplement the nursing care in the total continuous care hours.
- All hours must be counted. Aide hours cannot be discounted.
- The documentation should clearly indicate the nature of the medical crisis and the need for skilled intervention and illustrate hourly and daily what level of staffing and the services that were provided.

Hospice providers may also refer to transmittals released by Palmetto GBA regarding education about the medical acuity level that warrants continuous home hospice care and the required documentation to support billing this hospice LOC. Educational articles may be viewed on the Palmetto GBA Web site at http://www.palmettogba.com > Regional Home Health & Hospice Intermediary > Articles > Hospice.

Inpatient Respite Hospice Care

The purpose of inpatient respite hospice care is to ensure that the primary caregiver(s) receive respite services. Inpatient respite hospice care may be provided in a nursing facility that meets the parameters in 42 CFR Part 418.110 (b) and (f).

Effective December 2, 2008, the Centers for Medicare & Medicaid Services’ (CMS’) hospice final rules state that the care needs of a respite patient are equivalent to those of the patient in his or her home and, therefore, may not necessitate registered nursing care on a 24-hour basis. Rather, staffing for a facility solely providing the respite level of care to hospice patients should be based on each patient’s care needs. The requirements for respite care can be 42 CFR 418(b)(2).

General Inpatient Hospice Care

Federal hospice regulations at 42 CFR 418.110 et. seq. inpatient care specifies the conditions of participation (COP) for general inpatient care and should be reviewed in their entirety. All COP requirements must be met whether or not a hospice provides general inpatient care in their own...
inpatient unit or by arrangement with another entity. Unless the nursing facility is a skilled nursing facility (SNF) in a hospital setting, most nursing facilities do not meet the skilled nursing requirement for this level of care. Specifically, the nursing facility must provide 24-hour RN coverage, and the RN at the nursing facility must be capable of providing the pain management required for this LOC. The presence of an RN 24 hours at the nursing facility is not sufficient to meet the requirements at 42 CFR 418.100 et. seq.

**Location of Routine or Continuous Home Hospice Care**

Routine and continuous home hospice care may be provided in a member’s home. The CMS has defined a patient’s home as the following:

- Member’s private residence
- Member’s apartment or condominium
- Family member’s residence where patient resides
- Hospice residence
- Assisted living
- Adult foster care
- Residential care facility
- Nursing home
- Intermediate care facility for the mentally retarded (ICF-MR)
- Trailer or houseboat

This section addresses some case-specific reminders regarding the provision of routine or continuous hospice care in hospice residences, assisted living, residential care facilities, nursing home, and ICF/MR.

OBRA 89 requires that dually eligible Medicare/Medicaid members residing in nursing facilities must elect, revoke, be discharged, and change hospice providers under both programs, because Medicaid is required to pay the hospice a pass thru payment for room and board. Therefore, the hospice is required to submit paperwork to ADVANTAGE Health Solutions to identify the member as hospice.

For Medicare beneficiaries residing in any of these other settings, the hospice provider is not required to submit paperwork to ADVANTAGE Health Solutions. Providers are required to coordinate care but IHCP hospice authorization is not required. The Medicare provider bills Medicare for the hospice services and the nonhospice provider continues to bill Medicaid following specific billing instructions under the Medicaid program.

**Hospice Residence**

Hospice providers may have hospice residences where members may receive routine or continuous hospice care and pay the hospice room and board or they may have hospice inpatient units where the member may receive routine, continuous, or general inpatient hospice care. It is important that the hospice medical chart reflect and support the appropriate hospice level of care rendered in either location.
**Assisted Living Facilities**

Assisted living facilities are not required to be licensed in the state of Indiana. Residential care facilities are licensed under IC 16-28 and may provide minimal care to residents. ISDH regulations for residential rules are found at: [http://www.in.gov/isdh/20227.htm](http://www.in.gov/isdh/20227.htm).

The hospice should provide all hospice services to the patient as if the services were being provided in a patient’s home. If the hospice is working with a licensed residential care facility, refer to the criteria in the Hospice Conditions of Participation for Written Agreement found at 42 CFR Section 418.56(b)(1)(2)(3)(4)(5) and (6). The type of staff available at the licensed residential care facility should be verified if they are to administer medications.

Case-specific survey questions regarding hospice care should be directed to the ISDH Acute Care Unit at (317) 233-7474. Case-specific issues regarding assisted living and residential care facilities should be directed to the ISDH Long Term Care Unit at (317) 233-7442.

IHCP hospice authorization is not required for dually eligible members residing in assisted facilities or receiving assisted living services under the aged and disabled waiver. Reimbursement requires the hospice to bill Medicare or Medicaid for the hospice per diem. The unlicensed assisted living facility is reimbursed by the member for room and board.

**Residential Care Facility Providing Residential Care Assistance Program Services**

Residential care facilities are licensed and may provide minimal care to residents. If the hospice is working with a licensed residential care facility, refer to the criteria related in the Hospice Conditions of Participation for Written Agreement found at 42 CFR Section 418.56(b)(1)(2)(3)(4)(5) and (6).

The Family and Social Services Administration (FSSA), Division of Aging (DA), administers the Residential Care Assistance Program (RCAP). An individual who does not meet IHCP NF LOC may be eligible for the RCAP. The RCAP rate pays for room and board, laundry, and minimal administrative direction. The RCAP rate does not include a skilled nurse component. County homes and residential care facilities that agree to participate in the RCAP are provided an RCAP rate. For more information about the RCAP or a current listing of facilities participating in RCAP, contact the program coordinator within the Family and Social Services Administration Division of Aging at (317) 234-2944 or 1-888-673-0002.

IHCP-eligible individuals enrolled in RCAP can elect the IHCP hospice benefit if they reside in a residential care facility. However, the IHCP does not pay additional room and board for these individuals. It is important to know that individuals enrolled in RCAP who reside in county homes are not eligible for the hospice program as the resident’s aid category of Aid to Residents in County Homes (ARCH) makes them ineligible for the hospice program.

**Nursing Home**

Refer to Section 7: Reimbursement of this manual for a detailed overview regarding coordination of care and reimbursement issues.

**Intermediate Care Facility for the Mentally Retarded**

The hospice must have a coordinated plan of care with the intermediate care facility for the mentally retarded (ICF/MR) in which respective responsibilities are outlined. The hospice needs to ensure that
the hospice provides core services for the ICF/MR resident and has a coordinated plan of care with the ICF/MR. The type of staff available at the ICF/MR should be verified if they are to administer medications.

Case-specific survey questions regarding hospice care should be directed to the ISDH Acute Care Unit at (317) 233-7474. Case-specific issues regarding assisted living and ICF/MRs should be directed to the ISDH Long Term Care Unit at (317) 233-7442.

For reimbursement, the hospice should bill Medicare or Medicaid for the hospice per diem, and the ICF/MR should continue to bill Medicaid for the ICF/MR per diem.

**Location of Hospice Inpatient Care**

Hospice short-term inpatient care is offered under the hospice respite LOC or hospice general inpatient care. Providers should refer to 42 CFR 418.110 et. seq. for regulations regarding inpatient hospice care. Hospice inpatient care may be offered in any of the following settings:

- Hospice inpatient facility or unit
- Hospital
- SNF
- NF-hospice respite only

The following chart specifies the requirements that a hospice must follow when general inpatient hospice care is provided directly or under arrangement.

<table>
<thead>
<tr>
<th>Inpatient Care Provided Directly</th>
<th>Inpatient Care Provided Under Arrangement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice owns the facility that must meet the requirements outlined in 42 CFR 418.110 et. seq.</td>
<td>Medicare-certified hospital that must meet the requirements outlined in 42 CFR 418.110 et. seq.</td>
</tr>
<tr>
<td>Hospice leases space in a facility that must meet the requirements outlined in 42 CFR 418.110 et. seq.</td>
<td>Medicare-certified SNF that must meet the requirements outlined in 42 CFR 418.110 et. seq.</td>
</tr>
<tr>
<td>Space in a Medicare hospital or SNF/NF that must meet the requirements outlined in 42 CFR 418.110 et. seq.</td>
<td>Medicare-certified hospice that must meet the requirements outlined in 42 CFR 418.110 et. seq.</td>
</tr>
<tr>
<td>Because hospice provides inpatient care directly, a written agreement is not required under 42 CFR 418.100(e).</td>
<td>Hospice must have a written agreement with the contracted facility that meets the requirements of 42 CFR 418.100(e).</td>
</tr>
</tbody>
</table>

**Hospice Provider’s Contractual Responsibilities as the Professional Manager of the Member’s Hospice Care**

Federal regulations at 42 CFR Section 418.56 specify that the hospice provider is the professional manager of the hospice member’s hospice care. As such, the hospice provider’s responsibilities include coordinating the plan of care and ensuring that the plan of care is consistent with the hospice philosophy of care.
If the hospice patient requires care from another healthcare professional, outpatient clinic, or inpatient clinic for treatment of the terminal illness or related conditions, it is the responsibility of the hospice to obtain a contract with that healthcare professional or other healthcare provider for the arranged services. The contract must contain the minimum criteria as stated in 42 CFR Section 418.100(e) and specify that it is the responsibility of the hospice to pay the contracted provider for the arranged services. The hospice provider must also ensure that the contracted provider understands that it is inappropriate for the contracted provider to bill Medicare or the IHCP directly for the contracted services because the hospice provider reimburses the contracted provider directly.

The hospice provider must not, under any circumstance, delegate hospice core services to a healthcare professional or another hospice provider. A hospice provider must not permit another healthcare professional to provide hospice noncore services without a contract. The contract ensures that the hospice is identified as the manager of the individual’s hospice care to both parties and provides a mechanism to establish each party’s responsibilities and to specify the rate of payment.

Clariﬁcations from the State Survey Agency

The following section provides clariﬁcation that the ISDH has previously shared with hospice providers. The IHCP is including this section for the beneﬁt and ease of reference of hospice providers.

End-Stage Renal Disease and Hospice Clarification from CMS to Surveyors

The question was posed whether a hospice may accept a patient who is on dialysis and continues to receive dialysis. If the end-stage renal disease (ESRD) patient is admitted to hospice with a non-ESRD primary diagnosis, such as chronic obstructive pulmonary disease (COPD) or Alzheimer’s, the patient may continue to receive dialysis treatments during the hospice stay.

The following response is from a representative in the Center for Medicare Management (CMM) regarding ESRD as an admitting diagnosis to hospice: See Section 230.1 (I) of the Medicare Hospice Manual. This section states that any other item of service, which is included in the plan of care and for which payment may be otherwise made by Medicare, is a covered hospice service under the Medicare hospice benefit. If the hospice is responsible for providing all services indicated in the plan of care as necessary for the palliation and management of the terminal illness, then it is a covered hospice service. However, there is no additional payment made. Most hospices have across-the-board admission policies that say that they do not accept patients who still want to receive dialysis, which they can do as long as they do not discriminate against Medicare patients.

The following is the section from the Medicare Hospice Manual from which the interpretation is taken:

230.1 ELIGIBILITY AND COVERAGE 06-03

230.1 Covered Services—All services must be performed by appropriately qualiﬁed personnel, but it is the nature of the service, rather than the qualiﬁcation of the person who provides it, that determines the coverage category of the service. The following services are covered services:

“Medical Appliances and Supplies, Including Drugs and Biologicals”—Only drugs as deﬁned in Section 1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual’s terminal illness are covered. Appliances include covered durable medical equipment as described in 42 CFR 410.38 as well as other self-help and personal comfort items related to the palliation or management of the patient’s terminal illness. Equipment is provided by the hospice for use in the patient’s home while he or she is
under hospice care. Medical supplies include those that are part of the written plan of care.

“Other Items and Services”—Any other item or service which is included in the plan of care and for which payment may otherwise be made under Medicare, in accordance with Title XVIII of the Social Security Act, is a covered service under the Medicare hospice benefit. The hospice is responsible for providing any and all services indicated in the plan of care as necessary for the palliation and management of the terminal illness and related conditions.”
Basic Enrollment Requirements

Hospice provider participation in the Indiana Health Coverage Programs (IHCP) Hospice Program requires submission of the following documentation:

- The IHCP Hospital and Facility Provider Application and Maintenance Form must be completed even when a provider currently participates as an IHCP provider of another type of service. The hospice provider must have obtained a National Provider Identifier (NPI) prior to completing the IHCP Hospital and Facility Provider Application and Maintenance Form.
- A copy of the provider’s Medicare Hospice Certification Letter from the Centers for Medicare & Medicaid Services (CMS) for each hospice office location.
- A copy of a Certification and Transmittal (C&T) sent to HP from the Indiana State Department of Health (ISDH) for each hospice office location.

Provider Enrollment Application and Agreement

The IHCP Hospital and Facility Provider Application and Maintenance Form, which includes the provider agreement, is available from the HP Provider Enrollment Unit. Contact the HP Provider Enrollment Unit at the following address and telephone number:

HP Provider Enrollment Unit
P. O. Box 7263
Indianapolis, IN 46207-7263
1-877-707-5750

The IHCP Hospital and Facility Provider Application and Maintenance Form is available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/ProviderServices/provider_enroll.asp.

Medicare Hospice Certification and State Hospice Licensure

Indiana State Licensure of Hospices

Medicare hospice certification confirms that the provider meets all Title XVIII standards for Medicare hospice participation. Per the requirements outlined in 405 IAC 5-34-3 (b) and (c), a hospice provider must be certified as a hospice provider in the Medicare program to be enrolled as an IHCP hospice provider. A copy of the provider’s Medicare Hospice Certification Letter from the CMS must be submitted with the IHCP Hospital and Facility Provider Application and Maintenance Form. A hospice provider that operates at more than one location must provide a copy of the Medicare certification letter from CMS demonstrating that the regional office has approved each additional office location to be Medicare-certified as a satellite office of the home office location or as a separate hospice with a unique Medicare provider number. The provider must also comply with all state and federal requirements for Medicaid and Medicare providers. Furthermore, the hospice and all hospice employees with skill sets that require an Indiana state license must be licensed in accordance with federal, state, and local laws and regulations as required under federal regulations at 42 CFR 418.72 and Indiana state hospice licensure at IC 16-25-3.
The following sections provide further information about Indiana state licensure of hospices, the application process for a hospice license, and the regulatory process.

Pursuant to IC 16-25-1.1 et seq, effective July 1, 1999, any hospital, home health agency that operates a distinct hospice program, or person who operates a hospice program in the state of Indiana must be licensed by the ISDH. Such license issued or approval granted authorizes the owner or operator of a hospice program to provide hospice services.

**Application Process for a Hospice License**

A provider must submit an application for a hospice license or approval to operate a hospice program on a form prescribed by the ISDH, to include any documentation requested on such form. Such license or approval to operate must be renewed annually. Applications must include the license fee to be paid with the initial application and annually thereafter with application for renewal. Each application must include the following:

- A single disclosure document, which includes the components outlined in IC 16-25-7, prepared by the hospice program and updated, as necessary, and used for presentation to each potential patient of the hospice program
- A copy of the administrator’s or director's completed criminal history report, pursuant to IC 16-25-6
- A copy of the medical director's license and resume
- A copy of the patient or family care coordinator's license and resume
- A copy of the Certificate of Incorporation signed by the Indiana secretary of state for all Indiana corporations; or, if the applicant is an out-of-state corporation, a copy of the Certificate of Authority signed by the Indiana secretary of state
- A list of each home health aide, employed, contracted, or used (including volunteers) by the applicant at the time of the application, including date of hire, pursuant to IC 16-25-6
- Copies of completed criminal history reports for each home health aide listed by the applicant
- A list of each volunteer used by the provider at the time of the application, including date of hire, pursuant to IC 16-25-6
- Copies of completed criminal history reports for each volunteer listed by the applicant, pursuant to IC 16-25-6
- Documentation by the provider of the inquiry to the State Nurse Aide Registry about each home health aide listed on the application

**Regulatory Process**

The hospice program must meet the minimum standards for certification under the Medicare program and comply with the regulations for hospices under 42 CFR 418.1 et seq. IC 16-25-5-1 to obtain a license of approval to operate a hospice program pursuant to IC 16-25-3. These regulations require the ISDH to determine compliance with this article by conducting an initial survey of each hospice program licensed or approved under IC 16-25-3 prior to September 1, 2000. After conducting the required initial surveys, the ISDH makes a recommendation to the Indiana General Assembly about the suggested frequency of hospice licensure surveys.

Hospice providers must comply with all state and federal requirements for Medicaid and Medicare providers in addition to the requirements in this section. The hospice and all hospice employees must be licensed and comply with all applicable federal, state, and local laws and regulations as required under federal regulations stated in 42 CFR 418.72.
Hospice providers may refer to the IHCP provider bulletin BT200331 for more detailed information about the Medicare certification process and state hospice licensure and how these two requirements impact the IHCP provider enrollment process. See Appendix B for a complete list of referenced IHCP banner pages, bulletins, and newsletters.

IHCP Hospice Provider Number

A unique IHCP hospice provider number is issued when a completed IHCP Hospital and Facility Provider Application and Maintenance Form and a copy of the provider’s Medicare Hospice Certification Letter is received by the HP Provider Enrollment Unit and entered into IndianaAIM.

The IHCP-enrolled hospice provider must use the Legacy Provider Identifier (LPI) or NPI when submitting paper IHCP hospice authorization forms to ADVANTAGE Health Solutions-FFS. Hospice providers are also reminded that all IHCP providers are required to use the NPI; therefore, hospice providers must only submit claims with the NPI. At this time, hospice providers should check the status of any prior authorization using the NPI on Web interChange, because Web interChange will not take LPI. The IHCP eligibility verification systems are set up to be able to read which NPI corresponds to a particular LPI.

Non-Medicare Certified Hospice Providers

Indiana providers that do not meet Title XVIII standards for Medicare hospice participation are required to obtain this certification before attempting to enroll in the IHCP Hospice Program. Providers should contact the Acute Care Services Division of the ISDH to obtain certification.

Inquiries about Medicare hospice certification and Indiana state hospice licensure should be directed to the following address:

Acute Care Services
Indiana State Department of Health
2 N. Meridian St., Section 4A
Indianapolis, IN 46204
(317) 233-7474

Out-of-state providers, as described in the following section, should first contact the relevant Medicare hospice certification authority in their state about Medicare certification and the Acute Care Services Unit of the ISDH about Indiana hospice licensure requirements.

The ISDH has informed the Office of Medicaid Policy and Planning (OMPP) that Indiana law does not permit the ISDH to enter into reciprocal agreements with other state agencies concerning state hospice licensure. Therefore, the ISDH cannot accept any other state hospice license as satisfying Indiana licensing requirements. The impact this has for providers located in designated areas outlined in 405 IAC 5-5-2(a) is outlined in the following section.

Providers Located in Out-of-State Designated Cities

Out-of-state hospice providers can provide services to Indiana residents only if they are located in a designated out-of-state city as listed in 405 IAC 5-5-2(a) and also have a valid IHCP hospice provider number per the requirements outlined in 405 IAC 5-34-2 and 405 IAC 5-34-3. Hospice providers located in out-of-state designated cities must obtain an Indiana state hospice license because the ISDH does not recognize reciprocity of hospice licenses from other state survey agencies.
The following is taken directly from 405 IAC 5-5-2(a):

Sec. 2. (a) The services listed in section 1 of this rule require prior authorization except as follows:

1. Emergency services provided out-of-state are exempt from prior authorization; however, continuation of inpatient treatment and hospitalization is subject to the prior authorization requirements of Indiana.

2. Recipients of the adoption assistance program placed outside of Indiana will receive approval for all routine medical and dental care provided out-of-state.

3. Recipients may obtain services listed in section 1 of this rule in the following designated out-of-state cities subject to the prior authorization requirements for in-state services set out in this article:

   A) Louisville, Kentucky
   B) Cincinnati, Ohio
   C) Harrison, Ohio
   D) Hamilton, Ohio
   E) Oxford, Ohio
   F) Sturgis, Michigan
   G) Watseka, Illinois
   H) Danville, Illinois
   I) Owensboro, Kentucky

4. Recipients may obtain services in Chicago, Illinois, subject to all of the following conditions:

   A) The recipient’s physician determines the service is medically necessary.
   B) Transportation to an appropriate Indiana facility would cause undue hardship to the patient or the patient’s family.
   C) The service is not available in the immediate area.
   D) The recipient’s physician complies with all of the criteria set forth in this article, in accordance with the state plan and 42 CFR 456.3.

In such situations, the following rules apply:

- Routine home and continuous home hospice services can be provided to members who reside in Indiana in their own home or in an Indiana nursing facility (NF).
- Respite and inpatient hospice services can be provided in the out-of-state provider's facility if the provider has an IHCP hospice provider number. This includes NFs that enroll as IHCP hospice providers.
- Routine and continuous hospice services cannot be provided to an Indiana resident in an NF that is located outside the state of Indiana, even if the NF is in an out-of-state designated city listed in 405 IAC 5-5-2 (a).

Indiana law does not permit the ISDH to enter reciprocal agreements with other state agencies concerning State hospice licensure. Therefore, the ISDH cannot accept any other state hospice license (Ohio, Illinois, Michigan, or Kentucky) as satisfying Indiana licensing requirements. Because the ISDH does not have the legal authority to cross state lines to survey out-of-state hospice providers, out-of-state hospice providers in designated areas need to take the following steps to obtain an Indiana State hospice license and approval:

- Open a fully operational, fully staffed hospice office location in Indiana that complies with all the federal Conditions of Participation for Hospice Care in 42 CFR Part 418, Hospice Care.
- Contact the ISDH Acute Care Division to obtain information about the application process to obtain a State hospice license or approval.
- Contact the ISDH Acute Care Division to obtain an application for Medicare certification for the Indiana hospice office license. If the hospice decides to have the state survey agency of the parent
office perform the Medicare certification survey, the hospice should provide the ISDH Acute Care Division with a copy of that Medicare Hospice Certification Letter.

ISDH cannot enter into reciprocal agreements with other state survey agencies, which impacts the current enrollment requirements for out-of-state hospice providers in designated cities as listed in 405 IAC 5-34-3.

**Medicare-Certified Hospice Providers**

Providers that already meet standards for Medicare hospice participation and are licensed to provide hospice care in Indiana can enroll directly as IHCP hospice providers by completing an IHCP Hospital and Facility Provider Application and Maintenance Form. In addition, HP must also have a C&T sent directly to HP from the ISDH. Verification of a current Indiana state hospice license or approval is also required with the IHCP Hospital and Facility Provider Application and Maintenance Form.

A hospice provider entitled to reimbursement by the IHCP is defined as a public or private organization, or subdivision of either, that is primarily engaged in providing care to terminally ill individuals and their families. The organization is certified under Medicare Conditions of Participation for Hospice Care after completing State hospice licensure requirements, and has a valid IHCP provider agreement indicating intent to provide hospice services.

**Institutional Requirements**

As with enrollment in other IHCP services, hospice enrollment is associated with established policies for service delivery, record maintenance, disclosure of information, reimbursement, Surveillance and Utilization Review (SUR), licensing, termination of participation, and appeal rights. These established policies are found in the IHCP Provider Manual available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/manuals.htm.

In addition to these established policies, IHCP hospice providers must meet the following requirements for the hospice interdisciplinary group and delivery of hospice services to the hospice member.

**Interdisciplinary Group**

The hospice provider must designate an interdisciplinary group comprising individuals who are employees of the hospice and who provide or supervise care and services offered by the hospice provider. At a minimum, this group must include the following:

- A medical director, who must be a doctor of medicine or osteopathy
- A registered nurse
- A social worker
- A pastoral or other counselor

This interdisciplinary group is responsible for the following:

- Participate in the establishment of the plan of care
- Provide or supervise hospice care and services
- Review and update the plan of care
- Establish policies governing the day-to-day provision of care and services
State hospice licensure requires hospice providers to comply with Medicare Conditions of Participation for Hospice Care. The hospice provider, through its interdisciplinary team, must ensure that all patients are offered the same services, including medically necessary services, regardless of residence (private home versus NF) or payer source (private insurance, Medicare, or Medicaid).

**Rights of IHCP Hospice Members**

The hospice provider must not discontinue or diminish care provided to the IHCP member because of the member’s inability to pay, nor can the hospice provider fail to respect the individual’s rights to an informed consent.
Section 4: Member Eligibility

Overview

This section provides Indiana Health Coverage Programs (IHCP)-enrolled hospice providers with specific information about member eligibility. This section also provides information about the hospice provider's responsibility for hospice authorization and the coordination responsibilities for individuals enrolled in specific programs at the time the IHCP member elects hospice care. For detailed information about hospice authorization, refer to Section 5: Election, Discharge, and Revocation and Section 6: Hospice Authorization in this manual.

The information in this section is not meant to serve as a replacement for compliance with the IHCP Provider Agreement. The hospice provider must review the following information about member eligibility:

- Chapter 2: Member Eligibility and Benefit Coverage in the IHCP Provider Manual located at http://www.indianamedicaid.com/ihcp/Manuals/Provider/chapter02.pdf
- Chapter 3: Electronic Solutions in the IHCP Provider Manual located at http://www.indianamedicaid.com/ihcp/Manuals/Provider/chapter03.pdf
- Any provider bulletins that the IHCP releases about IHCP member eligibility, Automated Voice Response (AVR), the Omni device, and Web interChange


Target Group

Hospice members can be IHCP-only eligible or Medicare and IHCP dually eligible [qualified Medicare beneficiary (QMB)-Also category]. However, all members must be certified as terminally ill.

Note: A member is considered terminally ill if, given that the illness runs its normal course, the medical prognosis suggests a life expectancy of six months or less.

Terminally ill individuals who would like to receive hospice services normally reside in their own homes, private homes, or inpatient facilities.

For purposes of reimbursement, a distinction is made between a home in a nursing facility (NF) and a home in any other type of setting. However, each of these locations is treated as the home of a hospice member because it is their normal place of residence.

Eligibility by Population Category

Although terminally ill individuals eligible for IHCP benefits are also eligible for IHCP hospice care, different population categories have different relationships to the hospice benefit.
Hospice providers are reminded that some IHCP and Hoosier Healthwise members have limitations or restrictions on coverage as described in the Member Eligibility section of the IHCP Provider Manual. The following limitations and restrictions are possible:

- Qualified Medicare beneficiaries (QMB-Only) – Benefits are limited to payment of the Medicare deductible and coinsurance.
- Individuals eligible for emergency services (formerly referred to as aliens) – Benefits are limited to emergency services.
- Limited benefits to pregnant women – Benefits are limited to prenatal care, delivery, post-partum care, and conditions that could complicate the pregnancy.
- Right Choices Program (RCP) (lock-in) – Restricts a member to one physician, one hospital, and one pharmacy.
- Spend-down – Members enrolled with a spend-down are not eligible for claims payment until spend-down has been met for the month.

Hospice providers are reminded that the IHCP Provider Agreement specifies that it is the IHCP-enrolled hospice provider's responsibility to verify IHCP eligibility regularly by using one of the Eligibility Verification System (EVS) options described in the IHCP Provider Manual. The IHCP Provider Agreement is available on the IHCP Web site at [http://www.indianamedicaid.com/ihcp/ProviderServices/enrollment_provider.asp](http://www.indianamedicaid.com/ihcp/ProviderServices/enrollment_provider.asp)

**Temporary Aid to Needy Families Members**

Temporary Aid to Needy Families (TANF) members who receive medical services under Care Select or the risk-based managed care (RBMC) delivery system are eligible to enroll in the IHCP hospice benefit.

**Note:** If members elect this benefit, they are required to disenroll from the RBMC or Care Select managed care programs and be under the direct care of the hospice provider.

**IHCP Disabled Member**

Members who are determined to be eligible for the IHCP due to a disability are also eligible for the IHCP hospice benefit.

**Dually Eligible Medicare/IHCP Population**

Individuals eligible for Medicare Part A and the IHCP receive hospice services through the Medicare system. The IHCP does reimburse for certain services not covered under the Medicare hospice benefit, such as copays for respite care and deductibles for drugs. Accordingly, the IHCP requires the following:

- Dually eligible Medicare and IHCP members residing in nursing facilities elect, revoke, change hospice providers, and change addresses under both the IHCP and Medicare programs at the same time.
  - The IHCP does not require dually eligible Medicare and IHCP hospice members, residing in their private homes, to enroll in the IHCP hospice benefit because Medicare is paying for the hospice services. This same standard applies to dually eligible Medicare/Medicaid members residing in intermediate care facilities for the mentally retarded (ICFs/MR), licensed
residential care facilities enrolled as Medicaid assisted living providers, and Medicaid adult foster care providers.

- In states that offer the Medicaid hospice benefit, State Operations Manual, Section 2082 and federal regulations under OBRA ’89 state that the hospice provider is required to submit the necessary certification paperwork to the State Medicaid agency. Because the dually eligible Medicare and IHCP member elects, revokes, and changes a provider under the Medicare and the IHCP programs, it is the hospice provider’s responsibility to notify Medicare and the IHCP about any change in the hospice member’s hospice care status.

- Failure to submit the necessary certification forms constitutes noncompliance with state and federal statute. In addition to this section, see Section 6: Hospice Authorization Process in this manual for more information about the required certification forms and the different situations in which a dually eligible member is enrolled in both programs.

- The hospice provider and the nursing facility must follow certain procedures to ensure compliance with 405 IAC 1-16-4, Compliance with the Additional Reimbursement for Nursing Facility Room and Board Services. Failure to follow these procedures results in recoupment by the IHCP. See Section 7: Reimbursement in this manual for more information about the procedures that the nursing facility and the hospice provider must follow.

**Home and Community-Based Services Options**

Home and Community-Based Services (HCBS) include services delivered via the Medicaid waiver program, Bureau of Disability and Developmental Services (BDDS) State Line Services or the Community and Home Option to Institutional Care for the Elderly and Disabled (CHOICE) program. HCBS services are always funding of last resorts.

This section clarifies when home health, hospice, and HCBS, delivered via the Medicaid Waiver program, BDDS State Line Services, or the CHOICE program, can be utilized in the delivery of services to our mutual clients.

Additionally, effective September 1, 2009, individuals who have elected the hospice benefit can also apply for and possibly receive HCBS. Therefore, a client electing the hospice benefits can request HCBS, which may supplement the hospice services without duplication.

**Reminder:** Home and community-based services are the funding of last resort.

The terms client, participant, individual, and consumer are used interchangeably within the OMPP and the divisions. Each term refers to the person actually receiving hospice, Medicaid State Plan, CHOICE, state funded, and/or waiver services.

The following examples identify what is allowed through each funding source.

1. **Clients currently receiving HCBS may also elect hospice services.**

Example #1

A client receiving home and community-based services may elect the Medicare or Medicaid hospice benefit as deemed eligible. The HCBS case manager may request additional home and community-based services as long as those home and community-based services are not duplicative of hospice services. Within the Division of Disability and Rehabilitative Services, additional home and community-based services may only be requested when reflected within the client’s/participant’s
Section 4: Member Eligibility

individualized support plan and at the agreement of the participant’s support team. The hospice provider must provide all required services to meet the needs of the client in relation to the terminal diagnosis.

2. A client receiving hospice may supplement services by adding HCBS, effective September 1, 2009.

Example #2

A client who is currently receiving the Medicare or Medicaid hospice benefit may supplement services by applying for HCBS through the appropriate division as long as those HCBS are not duplicative of hospice services and are available through the applicable source. Although no waiting list exists for the Aged and Disabled Medicaid waiver within the Division of Aging, within the Division of Disability and Rehabilitative Services, the otherwise eligible client/applicant may be placed on a waiting list for Indiana Medicaid HCBS waiver services unless specific priority criteria is met, enabling the participant to enter into waiver services at the time of application. The hospice provider must provide all required services to meet the needs of the client in relation to the terminal diagnosis.

3. A client who is eligible to receive Medicaid state plan services may elect hospice benefits.

Example #3

A client who is currently receiving Medicaid state plan services may elect Medicare or Medicaid hospice benefits for his or her terminal illness. The client may receive unduplicated services through both programs.

4. A client who is currently receiving hospice benefits may elect to discontinue those hospice benefits and seek alternate means of meeting his/her health care needs.

Example #4

A client who is currently receiving Medicare or Medicaid hospice benefits may withdraw from the hospice program at any time. The client may choose to seek alternate means of meeting his or her healthcare needs at any time.

It is very important that each client’s medical condition is thoroughly reviewed and all viable options are discussed with the client so that an informed choice can be made. It is our hope that the above information is helpful as you discuss options with your clients.

Please feel free to contact the Division of Aging with any question or concerns:

- Jade Luchauer at (317) 234-1913 – CHOICE program
- Michelle Stein-Ordonez at (317) 233-1956 – home health and hospice
- Susan Waschevski at (317) 232-7148 – nursing facility level of care waivers

Please feel free to contact the Division of Disability and Rehabilitative Services with any questions or concerns:

- Juman Bruce at (317) 232-7820 – BDSS State Line Services
- Lynn Jump at (317) 234-2764 – MR/DD level of care waivers
Right Choices (Lock-In) Members

These IHCP members are restricted to a specific IHCP provider due to abuse of the IHCP. Right Choices Program (RCP) members are allowed to elect the IHCP hospice benefit. Upon receipt of hospice election paperwork, ADVANTAGE Health Solutions-FFS disenrolls the member from the RCP.

Programs and Aid Categories Ineligible for the IHCP Hospice Benefit

The following programs and aid categories are not eligible for the IHCP hospice benefit:

- 590 Program members
- Children’s special health care services (CSHCS)
- Assistance to residents of county homes (ARCH)
- Qualified Medicare beneficiaries (QMB-Only)
- Specified low income Medicare beneficiaries (SLMB)
- Limited benefits to pregnant women under Package B
- Individuals eligible for emergency services under Package E, formerly referred to as alien

For more information about the above-mentioned member eligibility categories, hospice providers should refer to Chapter 2: Member Eligibility and Benefit Coverage of the IHCP Provider Manual.

Note: Hospice providers must verify IHCP eligibility before rendering hospice services to an IHCP member. IHCP eligibility status can change for numerous reasons. It is recommended that the hospice provider verify IHCP eligibility of the IHCP hospice member on a regular basis by using one of the IHCP EVS. Providers can reach the AVR system by calling (317) 692-0819, in the Indianapolis local area, or 1-800-738-6770. Detailed instructions about how to use AVR and other EVS methods are provided in the IHCP Provider Manual.

Children’s Health Insurance Program

Hospice care is a covered service under Package A and Package C if the Children’s Health Insurance Program (CHIP) member requires hospice care. Hospice care under CHIP also requires a prognosis of six months for the CHIP member to live if the illness were to run its natural course. Hospice care under CHIP has a first hospice benefit period of 90 days, a second hospice benefit period of 90 days, and an indefinite number of 60-day periods. For more information about the program, hospice providers can contact the Hoosier Healthwise Helpline at 1-800-889-9949.

Spend-down

For complete information about automated spend-down, refer to the IHCP provider bulletin BT200527. Spend-down is also covered in Chapter 2, Section 4 of the IHCP Provider Manual. See Appendix B for a complete list of referenced IHCP banner pages, bulletins, and newsletters.
Sliding Scale Fees and Spend-down

Some providers have a sliding scale fee policy that incorporates full and discounted fees based on the patient’s ability to pay.

Providers often question whether members who have not met their spend-down obligation for the months should be issued a receipt for the full fee normally charged for the service if billed directly, or the actual amount the patient was charged for the service if billed directly, or for the actual amount the patient was charged based on the discounted or sliding fee scale.

The following procedure is the correct way to handle this situation: When a spend-down member receives services before spend-down is met, the provider submits the claim to HP. The member is charged the amount credited to spend-down on the claim as indicated by the Remittance Advice. Providers should refer to bulletin BT200527 under the heading, Billing A Member on Spend-down for additional information.

Qualified Medicare Beneficiaries

Federal law requires that State Medicaid programs pay Medicare premiums, coinsurance, and deductibles for certain elderly and disabled persons. These persons are designated as qualified Medicare beneficiaries (QMBs).

The IHCP pays Medicare deductibles, coinsurance, and the Part B premium for QMBs. Therefore, only services covered by Medicare are reimbursable by Medicaid. Claims received for Medicare noncovered services, when rendered to a QMB-Only member, will deny. The member is responsible for paying medical supplies, equipment, and services not covered by Medicare, such as routine physicals, dental care, hearing aids, eyeglasses, and room and board services under the IHCP hospice benefit. QMBs are referred to as QMB-Only on the IHCP EVS. When a member is a QMB or a QMB-Only for specified dates of service, that individual is not eligible for the IHCP hospice benefit.

Providers serving QMBs must be Medicare-participating. If a provider is rendering a service to a QMB-Only member, and the service is not a covered service under the Medicare program, the service is not reimbursable under the IHCP.

A QMB member can also be enrolled in the IHCP as a spend-down member. In these situations, it is important to remember that until spend-down is met for the month, the member is still eligible for coverage as a QMB-Only. For example, John Doe is a QMB who met his spend-down on March 5, 2000, and he is receiving hospice services in an NF the entire month of March 2000. Prior to March 5, 2000, John Doe is a QMB-Only member and is not eligible for the Medicaid hospice benefit. Effective March 5, 2000, spend-down date, John Doe’s eligibility status changes to a QMB-Also member and he becomes eligible for IHCP-covered services.

QMB-Only eligibility means that the IHCP only reimburses services covered by Medicare (for example, Medicaid pays Medicare deductibles and coinsurance). IHCP-covered services outside the scope of Medicare coverage, such as transportation, optometry services, room and board services under the IHCP hospice benefit, are not covered by the IHCP until the member's spend-down is met for the month. At that point, the individual’s eligibility becomes QMB-Also.

For a thorough overview of spend-down and QMB scenarios, refer to the Chapter 2: Member Eligibility of the IHCP Provider Manual.
IHCP-Pending Individuals

The IHCP program cannot provide prior authorization (PA) for services for an individual who is not IHCP-eligible. An individual who is not IHCP-eligible when initiating hospice care is considered private pay. This means that the hospice provider must bill the patient or the patient’s private insurance until IHCP eligibility is established.

If hospice providers choose to provide hospice care for an IHCP-pending individual, then those providers do so at their own financial risk. The IHCP cannot guarantee that the individual meets all criteria to be either IHCP-eligible or Medicare-eligible as of the date hospice care was initiated.

The Division of Family Resources (DFR) is the agency within the Indiana Family Social Services Agency (IFSSA) that has the authority to determine an individual’s IHCP eligibility status. The hospice patient or his or her representative must apply for IHCP at the local DFR in the county where the applicant resides. The DFR state eligibility consultant assigned to review the hospice patient’s Medicaid eligibility then notifies the applicant or the applicant’s representative in writing of the eligibility decision.

If appropriate, the local DFR state eligibility consultant can establish the individual’s IHCP eligibility 90 days prior to the date of the individual’s IHCP application. If the DFR state eligibility consultant determines that the hospice patient is IHCP-eligible, then the hospice patient receives written notification from the DFR state eligibility consultant that specifies the start date of the hospice patient’s IHCP coverage.

The DFR state eligibility consultant can establish eligibility even if an applicant has died during the application process.

The hospice analyst cannot review and approve the certification forms for an IHCP-pending individual. The hospice provider must hold all paperwork until the IHCP-pending individual is notified of IHCP eligibility. It is recommended that the hospice provider complete the IHCP hospice forms at the same time the agency completes its own hospice agency forms so that the forms are ready to submit to the ADVANTAGE Health Solutions-FFS when IHCP eligibility is established. A hospice provider can determine the date of IHCP eligibility for an IHCP-pending individual by checking AVR on a regular basis using the patient’s Medicare policy number or Social Security number. The hospice provider can then submit the certification forms to the ADVANTAGE Health Solutions-FFS.

Note: Hospice providers must verify IHCP eligibility before rendering hospice services to an IHCP member. IHCP eligibility status can change for numerous reasons. It is recommended that the hospice provider verify IHCP eligibility of the IHCP hospice member on a regular basis by using one of the IHCP EVS. Providers can reach AVR by calling (317) 692-0819 in the Indianapolis local area or 1-800-738-6770. Detailed instructions about how to use AVR and other EVS methods are provided in the IHCP Provider Manual.

IHCP Members without IHCP Nursing Facility Level of Care

For the IHCP to pay for nursing facility care, including nursing facility room and board services for a hospice member, the nursing facility must complete the Indiana Pre-Admission Screening (IPAS) or Pre-Admission Screening and Resident Review (PASRR) process for that hospice member. Upon completion of this process, IndianaAIM is updated with the NF level of care (LOC). Until there is NF LOC in IndianaAIM, the ADVANTAGE Health Solutions-FFS hospice analyst cannot process the hospice authorization for an NF resident who has elected hospice. If the hospice provider submits the
request for hospice, the request will be placed in a pending status until IndianaAIM reflects the nursing facility level of care. The hospice provider may also choose to hold all paperwork until the NF advises the hospice that the NF has the Nursing Facility Level of Service Authorization and Data Entry State Form 49120 (11-98)/OMPP 450B SA/DE or Physician Certification for Long Term Care Services State Form 38143 (R5/6-93) Form 450B/PASRR2A with an IHCP effective reimbursement date. See the IHCP provider bulletin BT200011 for more information about this topic. See Appendix B for a complete list of referenced IHCP banner pages, bulletins, and newsletters.

NF providers are not required to initiate a new Nursing Facility Level of Service Authorization and Data Entry State Form 49120 (11-98)/OMPP 450B SA/DE or Physician Certification for Long Term Care Services State Form 38143 (R5/6-93) Form 450B/PASRR2A when an NF resident elects, revokes, or is discharged from hospice care if the NF has a current Nursing Facility Level of Service Authorization and Data Entry State Form 49120 (11-98)/OMPP 450B SA/DE or current NF LOC in IndianaAIM. The election, revocation, or discharge of an NF resident from the Medicare or IHCP hospice benefit does not constitute a change in NF LOC. IHCP provider bulletin E98-40 describes the situations when an NF must initiate a new 450B. See Appendix B for a complete list of referenced IHCP banner pages, bulletins, and newsletters.

The Division of Aging recommends the following procedures to determine if the hospice member has nursing facility LOC in IndianaAIM:

- Develop coordination and notification procedures between the appropriate nursing facility staff and hospice staff about the approval of the Nursing Facility Level of Service Authorization and Data Entry State Form 49120 (11-98)/OMPP 450B SA/DE for hospice members
- Address the coordination and notification responsibilities between nursing facility and hospice staff in the hospice contracts with nursing facilities
- Check AVR, Omni, or Web interChange to determine when there is nursing facility LOC for the private home hospice member recently admitted to the nursing facility
- If the NF advises the hospice that there is an approved Nursing Facility Level of Service Authorization and Data Entry State Form 49120 (11-98)/OMPP 450B SA/DE, but the hospice provider still receives error code 2026 – Recipient not eligible for this level of care for the dates of service and revenue codes billed, proceed as follows:
  - Questions about hospice claims payment should be directed to HP Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.
- Contact HP Customer Assistance at (317) 655-3240 in the Indianapolis local area, or 1-800-577-1278, for hospice claims questions when the Remittance Advice (RA) reflects Error Code 2026 – Recipient not eligible for this level of care for the dates of service and revenue codes billed. The following information must be verified:
  - Verify this hospice member with the member identification (RID) number provided has NF LOC for the dates of service
  - Determine when the NF LOC was entered into IndianaAIM. If the hospice claim was processed January 10, 2002, but the NF LOC was not in IndianaAIM until January 11, 2002, the claim denied appropriately.

Hospice claims for room and board services pay only if IndianaAIM reflects hospice LOC and NF LOC for the dates of service the hospice provider is billing the IHCP when the claim is submitted and processed by the IHCP. If the hospice provider encounters lack of problem resolution on hospice or nursing facility level-of-care issues for a hospice member, the provider may contact the Family and Social Services Administration Division of Aging (DA) program director to discuss problem resolution. The Family and Social Services Administration DA program director may be reached at (317) 233-1956 or 1-888-673-0002.
Obtaining IHCP Nursing Facility Level of Care for Individuals Who Die Shortly After Admission to the Nursing Facility

When an individual dies shortly after the NF placement, the IPAS agency issues a PAS 4B stating, “The IPAS/PASRR assessment was not completed due to death on __________.” When the assessment is not completed, there is no authorization on the Nursing Facility Level of Service State Authorization and Data Entry State Form 49120 (11-98)/OMPP 450B SA/DE by the IPAS agency. It is the responsibility of the NF to submit the PAS 4B form with an attached Nursing Facility Level of Service State Authorization and Data Entry State Form 49120 (11-98)/OMPP 450B SA/DE directly to the Division of Aging Nursing Facility LOC/Waiver Operations Unit for review and approval. When the NF obtains approval from the Division of Aging’s Nursing Facility Level of Care, the NF must advise the hospice provider so the hospice provider can bill the IHCP for hospice room and board services.

The NF must complete the above process so the hospice provider can bill the IHCP for room and board services under hospice revenue codes 653, 654 – 659, 183, 185, and 180.

If the above process is not completed, there is no mechanism for the IHCP to reimburse for room and board services billed under hospice revenue code 659. Because hospice revenue code 659 pays only room and board, the hospice provider’s reimbursement is not affected because Medicare pays for the hospice services. Hospice revenue codes 653 and 654 include reimbursement for the hospice per diem plus the room and board add-on for IHCP-only members residing in nursing facility. When the NF does not complete the above process, the hospice provider is precluded from billing the IHCP for the hospice per diem under hospice revenue codes 653 and 654. Therefore, the IHCP has developed the following process to ensure payment of the hospice per diem through a non-claim-specific check:

- The hospice should send a letter to the Hospice Program director within the Division of Aging explaining that the contracted nursing facility does not intend to complete the 450B process. The cover letter should include the name of the nursing facility, nursing facility provider number, and name and telephone number of a contact person at the hospice agency. The Hospice Program director’s complete address is as follows:
  
  Hospice Program Director  
  MS21  
  Family and Social Services Administration  
  Division of Aging  
  402 W. Washington St., Room W454  
  Indianapolis, Indiana 46204  
  1-888-673-0002

- The hospice provider should attach to the letter a properly completed hospice claim reflecting the dates of service that the hospice requires reimbursement for the hospice per diem.

Note: The one-year claims filing limit does apply to this scenario so it is imperative that the hospice biller check eligibility on a regular basis and communicate with the nursing home regularly about the 450B approval process for each hospice member.

Managed Care Member

There are very case-specific eligibility verification and disenrollment procedures that the hospice must follow. Refer to Section 6: Hospice Authorization Process, IHCP Managed Care Member in this manual.
Care Select Member

A Care Select member who elects the IHCP hospice benefit must be disenrolled from Care Select before hospice services can be authorized. There are very case-specific eligibility verification and disenrollment procedures that the hospice must follow. Refer to Section 6: Hospice Authorization Process: Care Select Member in this manual. As Care Select members are fee-for-service, hospice claims for these members will not require special batch payment.

Healthy Indiana Plan Member

The Healthy Indiana Plan (HIP) is a program sponsored by the state of Indiana that provides more affordable healthcare choices to thousands of otherwise uninsured individuals throughout Indiana. HIP provides health insurance for uninsured adult Hoosiers between the ages of 19 and 64 whose income is up to 200 percent of the federal poverty level (FPL) and who are not otherwise eligible for Medicaid. Unlike many other government-sponsored programs, parents and childless adults can participate. Eligible participants must be uninsured for at least six months and cannot have access to employer-sponsored health insurance. Participants will be required to make minimal contributions toward coverage.

Hospice providers must understand that they have certain responsibilities when a HIP member presents for hospice care. Responsibilities include checking eligibility on a regular basis and taking specified steps if the member is in the HIP program. As HIP is a distinct program with three insurance plans, the hospice provider must identify HIP member’s HIP plan. Prior authorization and claims payment must be directed to the HIP member’s specific plan. At this time, HIP members are enrolled in Anthem, MDwise, or the Enhanced Services Plan. A hospice must ensure that they are a HIP enrolled provider in the HIP member’s plan. Specific information about HIP and the distinct plans that administer HIP can be found at the Indiana Medicaid Web site at www.indianamedicaid.com. It is a good practice to immediately begin the process to move the HIP member to another state assistance program because of the limits of hospice care coverage and annual and/or life time maximum benefit for HIP members.

Hospice providers must not submit the request to ADVANTAGE Health Solutions, Inc. for hospice authorization as HIP members are not fee-for-service members under the traditional Medicaid program; and as such, are not eligible for the Medicaid hospice benefit. ADVANTAGE will appropriately return the request to the provider with a Prior Authorization Notice that specifies:

This member is enrolled in the Healthy Indiana Plan. Limited Hospice is covered under this program. This request must be submitted to the correct insurer: Anthem, MDwise, or Enhanced Services Plan. Check patient's membership card for proper carrier and billing information.

Individuals in the Residential Care Assistance Program

The Family and Social Services Administration DA administers the Residential Care Assistance Program (RCAP). An individual who does not meet IHCP NF LOC may be eligible for the RCAP. The RCAP rate pays for room, board, laundry, and minimal administrative direction. The RCAP rate does not include a skilled nurse component. County homes and residential care facilities that agree to participate in the RCAP are provided with an RCAP rate. For more information about the RCAP or a current listing of facilities participating in RCAP, contact the Division of Aging at (317) 234-2944.

IHCP-eligible individuals participating in the RCAP, who reside in residential care facilities licensed by Indiana State Department of Health (ISDH), can elect the IHCP hospice benefit. However, the IHCP does not pay additional room and board for these individuals. Individuals enrolled in RCAP who reside in county homes are not eligible for the IHCP hospice benefit as their eligibility category is ARCH. ARCH individuals are not eligible for the hospice program as noted in this chapter.
Local Area Agencies on Aging and Aging and Disability Resource Centers

The local Area Agencies on Aging (AAAs) and Aging and Disability Resource Centers (ADRCs) serve as the single point of entry for IPAS, the nursing facility Medicaid waivers, CHOICE, and other non-Medicaid funded services. The AAAs also employ specialists who can address questions about IHCP waiver services, CHOICE program, and programs funded under Title III. Hospice providers can contact the local AAA or ADRC in their area toll-free at 1-800-986-3505 or view the Web site at www.iaaaa.org.

Procedures to Request IHCP Hospice Forms

IHCP hospice forms can be downloaded from the Forms page of the Family and Social Service Administration Web site located at http://www.in.gov/icpr/webfile/formsdiv/2908.htm. This page can also be accessed from the Hospice Forms page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Hospice/content/forms.asp.

Appendix A contains a complete list of the IHCP hospice forms referenced in this manual including, Web addresses, and links.

All IHCP hospice forms on the Web site can be downloaded, printed, and completed on paper. The forms are available in Adobe® Acrobat® Portable Document Format (PDF). Some are available in Microsoft® Word format.
Section 5: Election, Discharge, and Revocation

Overview

The purpose of this section is to describe the Indiana Health Coverage Programs (IHCP) hospice benefit program requirements for hospice election, hospice revocation, and hospice discharge. The following is addressed:

• The IHCP forms that the hospice provider must complete and the procedures that hospice providers must follow to submit these forms to the ADVANTAGE Health Solutions-FFS
• The effect that proper paperwork completion by the hospice provider has on reimbursement to hospice providers and nonhospice providers
• The coordination responsibilities that the hospice provider has for providing copies of these forms to the nursing facility (NF) so that the NF staff can include copies of these forms in the IHCP hospice member’s NF medical chart

Federal Mandate under Omnibus Budget Reconciliation Act 89

In states that have a Medicaid hospice benefit, the Omnibus Budget Reconciliation Act (OBRA)-89 requires the State Medicaid agency to pay for room and board under the Medicaid hospice program for dually eligible Medicare and Medicaid hospice members residing in NFs. Medicare pays for the hospice services and Medicaid pays for the member’s room and board as a pass-through payment to the hospice provider. The hospice provider then pays the NF according to their contract. This means that the dually eligible Medicare and Medicaid hospice members must elect, revoke, be discharged, and change hospice providers using the required forms of each program. Hospice providers are reminded to pay close attention to this process, because the IHCP has noted that hospice providers do not consistently have dually eligible hospice members residing in NFs completing the Medicaid hospice forms when a member elects, revokes, is discharged, or changes hospice providers under each program.

Election by Member

Concurrent with the certification process, a member must elect hospice services by completing a Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005 indicating a particular hospice provider. An example of the Medicaid Hospice Election State Form can be found in Appendix A or downloaded from Forms link on the Indiana Medicaid Web site.

According to 42 USC 13959(d)(d), election to the hospice benefit requires the member to waive the following:

• Other forms of healthcare for treatment of the terminal illness for which hospice care was elected or for treatment of a condition related to the terminal illness
• Services provided by another provider equivalent to the care provided by the elected hospice provider
• Hospice services other than those provided by the elected hospice provider or its contractors
The member or member’s representative can designate an effective date for the election that begins with the first day of hospice care or any other subsequent day of hospice care. The individual cannot designate an effective date that is earlier than the date of election.

For those members residing in the NF, the IHCP encourages hospice providers to provide a copy of the Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005 to the NF to be included in the hospice member’s NF clinical record. This ensures that the NF staff knows that the member has the IHCP hospice benefit whether the member is an IHCP-only member or a dually eligible Medicare and IHCP member. To ensure better communication about reimbursement issues between the hospice and NF, the hospice must develop coordination procedures with the appropriate staff in the NF billing department so that the nursing facility biller is aware when the member elects, revokes, or is discharged from hospice care.

The Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005, must be completed in its entirety for the IHCP-only hospice member. If the member is a dually eligible Medicare and IHCP member, then the hospice provider must complete the one-page notification sheet and attach a copy of the hospice agency election form reflecting the member’s hospice election and the member’s or the member’s representative’s signature. The dually eligible member is required to sign the Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005 as well, to ensure compliance with OBRA-89.

Admissions Procedures

It is the hospice provider’s responsibility to provide the member with specific information about Medicare and IHCP hospice benefits and upon admission, to educate the member about what behavior constitutes compliance with the hospice program. The following information should be provided in writing and verbally when admitting a patient to a hospice program:

- Explanation of the benefits that a member waives under the hospice benefit as noted in the above Election by Member section
- Explanation of what procedures constitute palliative versus aggressive treatments under the hospice program; for example, chemotherapy or radiation if the treatment is palliative rather than curative and how the interdisciplinary team makes this decision
- Patient’s responsibility for seeking pre-approval for all treatments not in the hospice plan of care
- Patient’s responsibility for bills incurred for treatments and services with a physician or facility not contracted with the hospice

The hospice provider should inform the patient of all the services that are or are not covered under the hospice benefit.

Revocation by Member

State Operations Manual, Section 2082.D specifies that a dually eligible Medicare and IHCP member residing in an NF must revoke hospice care under the Medicare and Medicaid programs in states that have a Medicaid hospice benefit. Hospice providers should review 42 CFR Section 418.18 to understand federal regulations about hospice revocation. The IHCP hospice benefit mirrors federal Medicare regulations and policy for hospice revocation. Hospice revocation is a patient-initiated process.
In the event that a member, or representative of a member, is not satisfied with hospice care and wishes to revoke hospice services, the following procedures apply:

- The individual must file a Medicaid Hospice Revocation State Form 48735 (4/98)/OMPP 0007. This form includes a signed statement that the individual revokes the election of IHCP hospice services for the remaining days in the election period.

- A member can elect to receive hospice care intermittently, rather than consecutively, over the three benefit periods. The member can therefore elect and revoke hospice coverage an unlimited number of times.

- If a member revokes hospice services at any point in the three benefit periods, time remaining in that benefit period is forfeited.

- If a member re-elects the IHCP hospice benefit, the member returns as a re-enrollment to the next eligible hospice benefit period. The hospice provider is required to submit the following forms to ADVANTAGE Health Solutions-FFS: the Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005 the Medicaid Hospice Physician Certification State Form 48736 (R/12-02)/OMPP 0006, and an updated plan of care so that the ADVANTAGE Health Solutions-FFS hospice analyst can re-enroll the member into the next hospice benefit period. For example, if the individual revokes hospice care in the first hospice benefit period and then re-elects, ADVANTAGE Health Solutions-FFS starts the individual in the second hospice benefit period as of the date the individual signed the election form.

- The member or the member’s representative must revoke hospice care in writing for the hospice revocation to be valid. Neither the Medicare nor the IHCP hospice benefit recognizes revocation by action when a hospice patient is noncompliant with the hospice care philosophy.

- The member or the member’s representative must specify the date that hospice revocation is to be effective. It is the hospice provider’s responsibility to ensure that the member or member’s representative understands that an individual or individual’s representative cannot designate an effective date earlier than the date that the revocation is made according to federal regulation 42 CFR Section 418.28(b)(2).

- The hospice provider can fax the Medicaid Hospice Revocation State Form 48735 (4/98)/OMPP 0007 to the ADVANTAGE Health Solutions-FFS at 1-800-689-2759 if all hospice benefit period(s) preceding the date of the hospice revocation have been previously authorized. Until the hospice revocation is reflected in IndianaAIM, no other IHCP provider can bill the IHCP for services included in the IHCP hospice per diem. These nonhospice providers include, but are not limited to, the nursing facility where a member may be residing.

- For those hospice members residing in an NF, hospice providers must provide a copy of the Medicaid Hospice Revocation State Form 48735 (4/98)/OMPP 0007 to the appropriate staff in the NF to ensure that the form is included in the hospice member’s NF clinical record. This ensures that the nursing facility has this legal document reflecting that the member revoked the Medicaid hospice program. These coordination procedures ensure that the NF staff is aware of the exact date that the hospice member revoked hospice care. To ensure better communication about reimbursement issues between the hospice and NF, the hospice must also develop coordination procedures with the appropriate staff in the NF billing department so that the NF biller is aware when the member revoked hospice care. This permits the NF biller to submit claims for nursing facility care for the service date following the hospice revocation.

- The hospice provider must bill the IHCP for payment of the hospice per diem and for payment of the NF room and board for the date of the hospice revocation. The reason for this reimbursement guideline is that the individual is still under hospice care on that day. The NF can resume billing the IHCP directly for NF care for the date of service after the hospice revocation, once the hospice provider has provided them with a copy of the hospice revocation that has been processed by the ADVANTAGE Health Solutions-FFS Prior Authorization Department.
Discharge by Hospice Provider

While the hospice member initiates hospice revocation, hospice discharge is a process initiated by the hospice provider. Effective January 23, 2006, the Medicare hospice rules reflect a section regarding hospice discharge with specific requirements for discharge with cause. The following are the new documentation requirements for discharge with cause.

Discharge from Hospice Care per 42 CFR Section 418.26

(a) Reasons for discharge. A hospice may discharge a patient if--

(1) The patient moves out of the hospice’s service area or transfers to another hospice;

(2) The hospice determines that the patient is no longer terminally ill; or

(3) The hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause that meets the requirements of paragraphs (a)(3)(i) through (a)(3)(iv) of this section, that the patient’s (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. The hospice must do the following before it seeks to discharge a patient for cause:

(i) Advise the patient that a discharge for cause is being considered;

(ii) Make a serious effort to resolve the problem(s) presented by the patient’s behavior or situation;

(iii) Ascertain that the patient’s proposed discharge is not due to the patient’s use of necessary hospice services; and

(iv) Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.

(b) Discharge order. Prior to discharging a patient for any reason listed in paragraph (a) of this section, the hospice must obtain a written physician’s discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.

(c) Effect of discharge. An individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice--

(1) Is no longer covered under Medicare for hospice care;

(2) Resumes Medicare coverage of the benefits waived under Sec. 418.24(d); and

(3) May at any time elect to receive hospice care if he or she is again eligible to receive the benefit.

(d) Discharge planning.

(1) The hospice must have in place a discharge planning process that takes into account the prospect that a patient’s condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.

(2) The discharge planning process must include planning for any necessary family counseling,
patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

The IHCP has the same documentation requirements for discharge with cause as noted in 42 CFR 418.26. Before the State Medicaid agency discharges an individual under this section, the hospice needs to complete the Medicaid Hospice Discharge State Form 48734 (R/12-02)/OMPP 0008, check the box “other” under reason, specify the discharge for cause in the comment section of the Medicaid Hospice Discharge State Form 48734 (R/12-02)/OMPP 0008, and attach the medical documentation that supports the discharge for cause requested by the hospice medical director. If a patient has an attending physician involved in his or her care, the physician should be consulted before discharge and his or her review and decision included in the discharge note. If the member does not have an attending physician, this must be reflected in the medical documentation supporting discharge with cause. In those cases, the hospice medical director serves as the patient’s attending physician. Hospice providers are reminded that only the hospice medical director or the patient care coordinator are the only hospice disciplines that may sign the Medicaid Hospice Discharge State Form 48734 (R/12-02)/OMPP 0008.

This new procedure applies for Medicaid-only members residing at home, Medicaid-only members residing in nursing facilities, and dually eligible Medicare/Medicaid hospice members residing in nursing facilities. Hospice providers are reminded that federal regulations require dually eligible Medicare/Medicaid hospice members residing in nursing facilities to elect, revoke, change hospice providers and be discharged from hospice care simultaneously under the Medicare and Medicaid hospice programs since State Medicaid Agencies pay for these nursing facility resident’s room and board as required by OBRA-89 and state regulations at 405 IAC 1-16-4. Hospice providers are required to submit the appropriate paperwork under each program. Dually eligible Medicare/Medicaid hospice members residing at home are not required to elect, revoke, change hospice providers or be discharged from hospice care under both programs because Medicare pays for the hospice services and Medicaid has no room and board payment responsibilities.

Patients Admitted to a Noncontracted Nursing Facility: Hospice providers are reminded that if a member is admitted to a noncontracted nursing facility that the hospice must discharge the member as they do not have a contract required under 42 CFR 418.56.

Patients Admitted to Noncontracted Hospital: Clarifications from Palmetto Government Benefits Administrators (GBA) specify that the best reference for this issue is Pub. 100-4; Chapter 11; Section 30.1, which talks about the hospice being reimbursed at the daily rate for every day that the beneficiary is in hospice. This includes a noncontracted facility for related care as well as nonrelated care. The important thing that the hospice must remember is that wherever the beneficiary is, they must maintain professional management of that patient.

A hospice provider cannot continue to follow a patient and maintain professional management when the patient is admitted to a hospital that hospice does not have a contract with and the patient was admitted with diagnosis unrelated to primary hospice diagnosis. The hospice is required to have a contract with the hospital as required under 42 CFR 418.56 (e). The hospice should try to work with the noncontracted hospital to enter into a contract if the patient is admitted for care related to the terminal illness so that professional management can continue. All efforts should be documented in the patient record of the attempts made and the appropriate personnel contacted at the hospital to pursue a contract. If a contract cannot be obtained, then discharge is appropriate. Providers must follow the requirements outlined in discharge with cause to be followed and submitted to the Prior Authorization (PA) Unit.

While the IHCP has provided specific documentation requirements for discharge with cause, the hospice may still have to coordinate with the Indiana State Department of Health (ISDH) Acute Care Unit for situations where a Medicare beneficiary’s safety is compromised. Hospices should contact the ISDH Acute Care Unit at 317-233-7474 under those circumstances as ISDH is the Center for Medicare and Medicaid Services (CMS) contracted agent for these case-specific coordination concerns. The
following is a reprint from the September 2005 Provider Monthly Newsletter (NL200509) regarding coordination recommendations:

20.2.1-Hospice Discharge
(Rev.1, 10-01-03)

HOSP 210, and comments by CMS representative of the policy area of the CMS Central Office.

“There may be extraordinary circumstances in which a hospice would be unable to continue to provide hospice care to a patient. These situations would include issues where patient safety is compromised. The hospice must make every effort to resolve these problems satisfactorily before it considers discharge an option. All efforts by the hospice to resolve the problem(s) must be documented in detail in the patient’s clinical record and the hospice must notify the Part A MAC and State Survey Agency of the circumstances surrounding the impending discharge. The hospice may also need to make referral to other relevant state/community agencies (i.e., Adult Protective Services) as appropriate.”

After speaking to representatives from CMS Region V and ISDH, the IHCP recommends the following steps be taken when an IHCP-only hospice member is compromised or noncompliant with the hospice care philosophy:

During those situations where a hospice provider feels that a member has reflected significant noncompliance with the hospice plan of care, the documentation standard outlined below in the last paragraph of IOM 102-9-20-2.1 must be followed. It is very important that a hospice have written clear admissions policies, inform the member of his responsibilities under the hospice benefit, and document thoroughly the issues of noncompliance before taking the concern to the Part A MAC or Medicaid Prior Authorization Contractor.

Hospice providers are further reminded of the following program guidelines about the Medicaid Hospice Discharge State Form 48734 (R/12-02)/OMPP 0008:

- The hospice provider can fax this form to the ADVANTAGE Health Solutions-FFS at 1-800-689-2759 if all hospice benefit period(s) preceding the date of the hospice revocation have been previously authorized.

- According to the IHCP Provider Bulletin BT200011, the patient care coordinator (PCC) can sign in lieu of the hospice medical director. See Appendix B for a complete list of referenced IHCP banner pages, bulletins, and newsletters.

- For hospice members residing in an NF, hospice providers are encouraged to provide a copy of the Medicaid Hospice Discharge State Form 48734 (R/12-02)/OMPP 0008 to the appropriate staff in the NF to ensure that the form is included in the hospice member's NF clinical record. These coordination procedures ensure that the NF staff is aware of the exact date that the hospice provider discharged the member from hospice care. To ensure better communication about reimbursement issues between the hospice and NF, the hospice must develop coordination procedures with appropriate staff in the NF billing department so that the NF biller is aware that the member was discharged from hospice care and can resume billing the IHCP directly for NF care the date after the hospice discharge.

- The hospice provider must bill the IHCP for the hospice per diem and for NF room and board for the date of the hospice discharge. The reason for this reimbursement guideline is that the individual is still under hospice care on that day. The NF can resume billing the IHCP directly for NF care for the date of service after the hospice discharge once the hospice provider has provided them with a copy of the Medicaid Hospice Discharge State Form 48734 (R/12-02)/OMPP 0008 that was processed by the ADVANTAGE Health Solutions-FFS.
Hospice providers must not bill the IHCP for room and board for the date of death of an NF resident. Current IHCP regulations for NF reimbursement state that the IHCP does not pay the NF for the date that an NF resident is physically discharged from the NF. For reimbursement purposes, an NF resident’s date of death is equivalent to nonpayment for the date of the NF resident’s physical discharge from the NF. The election of hospice care by an NF resident does not rescind the current NF reimbursement regulations for NF room and board services.

A hospice provider that wishes to discharge a member is required to file a Medicaid Hospice Discharge State Form 48734 (R/12-02)/OMPP 0008. A copy of the Medicaid Hospice Discharge State Form 48734 (R/12-02)/OMPP 0008 must also be sent to the member. In circumstances where safety is an issue, the Office of Medicaid Policy and Planning (OMPP) requires notification of the circumstances surrounding the impending discharge. The hospice provider can fax this form to the ADVANTAGE Health Solutions-FFS Prior Authorization Unit at 1-800-689-2759.

Hospice providers are reminded that it is a violation of medical records standard to predate the hospice discharge. Hospice discharge mirrors hospice revocation in that the date the discharge is to be effective cannot be earlier than the date the hospice discharge occurred.

**Change in Hospice Provider**

Federal regulations 42 CFR Section 418.30(a) specify that an individual or individual’s representative can change, once in each election period, the designation of the particular hospice where hospice care is received. Federal regulations 42 CFR Section 418.30(b) further specify that this change of the designated hospice does not constitute a revocation of the election for the period when it is made. The OMPP was legislatively mandated to model the IHCP hospice benefit after the Medicare hospice benefit. As such, state regulations 405 IAC 5-34-6(f) mirror the federal regulations cited in this paragraph.

A member, or representative of the member, who is not satisfied with a hospice provider can change hospice providers during any benefit period. This change does not constitute a revocation of services. To change a designated hospice provider, the member, or the member’s representative, must file a Hospice Provider Change Request Between Indiana Hospice Providers State Form 48733 (R/12-02) OMPP 0009. The hospice provider can fax this form to the ADVANTAGE Health Solutions-FFS Prior Authorization Department at 1-800-689-2759 as long as all hospice benefit period(s) preceding the date of the hospice revocation were previously authorized.

If the ADVANTAGE Health Solutions-FFS hospice analyst discovers that there is a hospice authorization for the same dates of service in IndianaAIM that have been authorized for another hospice provider, the ADVANTAGE Health Solutions-FFS hospice analyst cannot process the hospice authorization submitted by the new hospice provider until this discrepancy is resolved. The ADVANTAGE Health Solutions-FFS hospice analyst resolves this issue as follows:

- For purposes of this explanation, **original** hospice provider refers to the provider that first provided hospice services to the IHCP hospice member under the IHCP hospice benefit but who never formally notified ADVANTAGE Health Solutions-FFS of any discharge or transfer to another provider. **New** hospice provider refers to the provider that recently assumed the management of the IHCP member’s hospice care.

- The new hospice provider that submits the hospice authorization must coordinate with the original hospice provider that maintains the hospice authorization for dates of service that duplicates the new hospice provider’s dates of service.

- When the new hospice provider obtains the Hospice Provider Change Request Between Indiana Hospice Providers State Form 48733 (R/12-02) OMPP 0009, the new hospice provider must resubmit the Hospice Provider Change Request Between Indiana Hospice Providers State Form...
The ADVANTAGE Health Solutions-FFS hospice analyst enters the day of the change in provider as the first day of that hospice benefit period.

- The original hospice provider and the new hospice provider must coordinate and agree upon the discharge and admission date in advance. Coverage cannot overlap and coverage must be continuous.

- For hospice members residing in an NF, hospice providers are encouraged to provide a copy of the Hospice Provider Change Request Between Indiana Hospice Providers State Form 48733 (R/12-02) OMPP 0009 to the appropriate staff in the NF to ensure that the form is included in the hospice member’s NF clinical record. This ensures that all NF staff is aware of the change of hospice provider. To ensure better communication about reimbursement issues between the hospice and the NF, the hospice must develop coordination procedures with appropriate staff in the NF’s billing department so that the NF’s billing department is aware of the change in hospice provider.

**Short Absences for Hospice Patients**

The CMS has changed its policy regarding short absences when a hospice patient moves out of the hospice’s service area for short periods of time (such as a few days or a couple of weeks) when the patient wants to visit family members in other cities or states. The CMS allows hospices to contract with another hospice in these instances whether the subcontracted hospice is located in Indiana or another state in the United States. The subcontracted hospice is required to implement the hospice plan of care developed by the contracting hospice and the contracting hospice retains the professional management of the patient’s care. The contract must follow the minimum criteria outlined in 42 CFR 418.56.

Family and Social Services Administration (FSSA) and ISDH staff attorneys have reviewed CMS’ policy on short absences and reviewed their respective state statutes on hospice. It has been determined that there are no restrictions for an in-state hospice contracting with a hospice in another state for the short absences noted in CMS’ policy.

The in-state hospice provider has two options in handling short absences and the paperwork requirements will be listed under each option.

**Option 1**

The hospice provider (Hospice A) can discharge the hospice patient from the hospice program and make arrangements in advance for the admitting date of the second hospice (Hospice B). If both providers are in Indiana, this step would not require a contract between two hospices, because this would be treated as a discharge/transfer:

- Hospice A must complete the [Medicaid Hospice Discharge Form](#) and note the member is moving out of the service area and specify which hospice is assuming the care during the short absence.

- Hospice A must also complete the [Hospice Provider Change Request Between Indiana Hospice Providers Form](#) and have the patient specify they are changing providers.

- Hospice B must also submit paperwork to ensure authorization of hospice care under their provider number.

- Hospice B should submit the [Medicaid Hospice Election Form](#), the [Medicaid Hospice Physician Certification Form](#), and a [Medicaid Hospice Plan of Care Form](#). It would be helpful if Hospice B would submit a copy of the [Hospice Provider Change Request Between Indiana Hospice Providers Form](#).
It is important to note that the IHCP does not authorize or reimburse out-of-state hospice providers for hospice care so a hospice agency should not use option 1 when setting up a short absence as this would put the patient in a situation where he would not have coverage under the IHCP Hospice Program. Option 2 noted below should be used in these circumstances.

**Option 2**

This option allows hospice providers to contract with other Indiana hospice providers or out-of-state hospice providers when the hospice patient moves out of the hospice’s service area. In these situations, the hospice authorization continues under the hospice provider who submitted the original request for authorization to the Medicaid prior authorization contractor. These steps should be followed:

- The hospice needs to ensure that they submit a [*Change in Status of Medicaid Hospice Patient Form*](#) to the Medicaid prior authorization contractor. The hospice should state on the [*Indiana Medicaid Prior Authorization Request Form*](#) that the hospice is contracting with another hospice to provide care during this short absence. This permits the Medicaid prior authorization contractor to note this in the IndianaAIM claims processing system.
- Hospice A (contracting hospice) is responsible for ensuring that Hospice A continues to submit required paperwork each benefit period so that there is no break in hospice coverage.
- When the person returns from the short absence, Hospice A should submit another [*Change in Status of Medicaid Hospice Patient Form*](#) notifying the Medicaid prior authorization contractor of the patient’s return.
- The contracting hospice does incur a liability while transporting the patient to the subcontracted hospice so it is important that all liabilities be addressed by an attorney.

**Medical Records Standards**

The OMPP reminds hospice providers that the hospice agency’s forms and the IHCP hospice forms are considered medical documentation and must adhere to medical records standards and are subject to the requirements under 42 CFR 418.104 Conditions of Participation: Medical Records. Failure to comply with proper medical records standards may affect a hospice provider’s licensure and accreditation status during a State hospice licensure survey.

The [*National Hospice Organization’s Hospice Operation Manual*](#) (Kilburn, Linda H., 1997), on page 155, has clear medical record guidelines for all hospice providers as follows:

> The hospice medical record is a legal document. As such, it must be organized, written legibly in pen or in type (no pencil) and without obliterations or embellishments. It should be completed in a timely fashion so that at any point during the time the patient or family is in the care of the hospice, the documentation accurately reflects current care plan, service being provided and the status of the patient or family unit. The hospice should develop policies governing the format, content, access, review procedures (including quality assurance and utilization review activities), and a determination of the length of time that a medical record must be retained.

The OMPP has noted the following noncompliance with medical records standards on IHCP hospice forms as well as the hospice agency forms submitted for dually eligible Medicare and IHCP members:

- The use of correction fluid rather than the staff person appropriately correcting an error by crossing out the error and then noting the staff person’s initials by the cross-out
- Failure of the hospice personnel to sign or date the forms, including the hospice agency’s physician certification or hospice plans of care that are submitted for dually eligible Medicare and IHCP members
Submission of a packet of paperwork that reflects hospice discharge on a particular date due to the hospice member’s date of death, yet the hospice physician still signed the hospice certification form the date after this individual died recertifying the individual for another hospice benefit period (reflects lack of review of the hospice medical chart by internal quality assurance reviewer)
Section 6: Hospice Authorization Process

Overview

Within the specific context of the hospice benefit, the hospice authorization process consists of the following two parts:

- Election, plan of care, and benefit period process
- Prior authorization (PA) for services not covered by the Indiana Health Coverage Programs (IHCP) hospice per diem as described in 405 IAC 5-34-8.

ADVANTAGE Health Solutions’ Preferred Method for Processing Prior Authorizations

ADVANTAGE Health Solutions’ preferred method for providers to submit prior authorization requests is by fax at 1-800-689-2759. The fax is the most efficient manner for providers and the contractor to process hospice authorizations.

Hospice providers must submit the hospice election form to ADVANTAGE so that ADVANTAGE staff can coordinate with the managed care enrollment broker contractor to disenroll the member from managed care. The hospice dedicated fax number for managed care disenrollment is (317) 810-4488. Hospice authorization will start the date after the member is disenrolled from managed care. Because ADVANTAGE receives fax prior authorization requests from all provider types, it is recommended that hospice providers follow up the fax with a telephone call to ADVANTAGE notifying ADVANTAGE staff that a fax has been sent for disenrollment of a hospice member from managed care.

Benefit Periods

Hospice eligibility is available to qualifying IHCP-eligible members in three consecutive benefit periods. Table 6.1 lists the benefit periods.

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<tr>
<th>Benefit Period</th>
<th>Eligibility</th>
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<tr>
<td>Period I</td>
<td>90 days</td>
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<tr>
<td>Period II</td>
<td>90 days (expected maximum length of illness to run its course)</td>
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<tr>
<td>Period III</td>
<td>Unlimited 60-day period</td>
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</tbody>
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The IHCP Hospice Program mirrors the Medicare Hospice Program eligibility. For dually eligible Medicare and Medicaid hospice members residing in nursing facilities (NFs), hospice providers should refer to eligibility requirements at Subpart B, 42 CFR 418.20, “In order to be eligible to elect hospice care under Medicare, an individual must be: (a) Entitled to Part A of Medicare; and (b) Certified as being terminally ill in accordance with 418.22, which is the Certification of terminal illness regulations.”
Medicaid-only hospice members must be eligible for the Medicaid program and also be certified as being terminally ill in accordance with 42 CFR 418.22. Furthermore, the medical documentation contained in the Medicaid Hospice Physician Certification State Form 48736 (R/12-02)/OMPP 0006 and the Medicaid Hospice Plan of Care State Form 48731 (R2/11-04)/OMPP 0011 must support a terminal diagnosis versus a chronic condition.

**Election, Plan of Care, and Benefit Period Process**

When an eligible member elects to receive services from a certified hospice provider, a plan of care must be developed. This plan must be submitted to the ADVANTAGE Health Solutions-FFS Prior Authorization Department with the Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005 and the Medicaid Hospice Physician Certification State Form 48736 (R/12-02)/OMPP 0006. Refer to Section 5: Election, Discharge, and Revocation in this manual for more information about the Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005.

In developing the plan of care, the Medicaid Hospice Plan of Care State Form 48731 (R2/11-04)/OMPP 0011 must be completed. The following requirements apply to development of the plan:

- The interdisciplinary team member who drafts the plan must confer with at least one other member of the interdisciplinary team.
- One of the conferees must be a licensed physician or nurse, and all team members must review the plan of care.
- All the services stipulated within the plan of care must be reasonable and necessary for palliation or management of the terminal illness and related conditions.
- The plan of care must be signed by the hospice medical director and include two signatures from any of the other disciplines listed on the Medicaid Hospice Plan of Care State Form 48731 (R2/11-04)/OMPP 0011. Failure to include the three required signatures results in return of the hospice authorization forms by ADVANTAGE Health Solutions-FFS so that the hospice provider can make the required corrections.

In addition, the hospice provider must comply with Section 1902(a)(57) of the Social Security Act, whereby the hospice:

- Provides written information to patients about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives
- Provides written information to individuals about the institution’s or program’s written policies about the implementation of the right to formulate an advance directive
- Documents on the patient’s medical record whether an advance directive has been executed
- Complies with all advance directive requirements of State law
- Provides individual or group advance directive education for staff and the community
- Prevents placement of conditions for the provision of care or discrimination against an individual who has executed an advance directive

The Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005, the Medicaid Hospice Physician Certification State Form 48736 (R/12-02)/OMPP 0006, and the Medicaid Hospice Plan of Care State Form 48731 (R2/11-04)/OMPP 0011 together constitute the basis for determination of the hospice authorization for the first benefit period. Assuming information is sufficient and accurate, an initial benefit period of 90 days is approved.
If benefit periods beyond the first 90 days are necessary, for example Periods II or III, then recertification on the Medicaid Hospice Physician Certification State Form 48736 (R/12-02)/OMPP 0006 and an updated Medicaid Hospice Plan of Care State Form 48731 (R2/11-04)/OMPP 0011 is required for hospice authorization of the next benefit period requested. The Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005 does not need to be completed again unless the patient revoked hospice care or the hospice provider discharged the patient from hospice care and chose to resume hospice care at a later date. This is represented in Table 6.2.

Refer to Section 5: Election, Discharge, and Revocation and this section in this manual for more detailed information about how to complete hospice authorization paperwork for dually eligible Medicare and IHCP hospice members residing in an NF and for IHCP-only members in each of the three hospice benefit periods.

Criteria for Adequate Medical Documentation

Since the implementation of the IHCP Hospice Benefit, each Prior Authorization contractor has notified the State of concerns with hospice providers’ medical documentation concerns. ADVANTAGE Health Solutions-FFS has assumed that responsibility since November 1, 2007. During this time period, the Office of Medicaid Policy and Planning (OMPP) was advised by all IHCP PA contractors that as a group, hospice providers were submitting medical documentation for IHCP hospice authorization that was either incomplete in the required forms or was insufficient for the hospice analyst to confirm the ongoing terminal condition of the patient. Because all hospice providers are required to be Medicare-certified before the IHCP can enroll the hospice agency as an IHCP hospice provider, each hospice agency must ensure that the medical documentation submitted to ADVANTAGE Health Solutions-FFS hospice authorization meets Medicare conditions of participation.

All Medicare-certified hospices have a designated Part A Medicare Administrative Contractor (MAC). In Indiana, the Part A MAC for most Indiana hospice providers is Palmetto Government Benefits Administrators (GBA), LLC. Palmetto has established Medicare Local Medical Review Policies as a matter of protocol for medical criteria. The Palmetto Medicare Local Medical Review Policies were established with the collaboration of the National Hospice and Palliative Care Organization (NHPCO), Inc. The NHPCO also has established medical criteria for the noncancer diagnoses.

When entering the third hospice benefit period of 60 continuous days, hospice providers must be as specific as possible about the medical documentation that supports the appropriateness of the individual’s hospice care. If the ADVANTAGE Health Solutions-FFS determines that the information is insufficient to process the request, the ADVANTAGE Health Solutions-FFS hospice analyst must return it for the required documentation. Medicare and the IHCP can request additional information when the documentation submitted by a provider is insufficient. Guidelines for hospice providers include the following:

• The individual must have a terminal prognosis as well as the physician certification that meets the Medicare guidelines of participation (providers can refer to the IHCP Provider Manual Chapter 6, Section 4 for a description of the certification requirements).

• The clinical evidence must support the terminal diagnosis at the time of the initial certification and at the time of each subsequent certification and must describe the patient’s condition.

• Documentation must illustrate why the patient is considered to be terminal and not chronic. History is helpful when it provides clarification as to why the current documentation only reflects a chronic condition.

• Each patient’s documentation must be specific to that individual and include any additional documentation that distinguishes this patient from other patients with the same disease who may be chronic but who are not terminal.
• For each hospice benefit period, the interdisciplinary team must assess the patient’s condition and hospice appropriateness and the documentation must distinguish between exacerbation and stabilization as well as exacerbation and deterioration.
• The documentation must include the most specific and most terminal ICD-9 code appropriate to the patient.
• The documentation must specify why any medication, treatments, or services that could be considered aggressive are considered necessary for the patient’s palliative treatment.
• The patient’s decline must be documented in detail.
• Providers must show how the systems of the body are in a terminal condition.

The Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) have expressed ongoing concerns that inadequate review of a hospice patient’s status during the interdisciplinary team meetings during the third hospice benefit periods of 60 days has resulted in the hospices receiving improper reimbursement for services provided to a patient who fails to continue to be eligible for the Medicare hospice benefit. Failure to document hospice care appropriateness to justify reimbursement for Medicare and Medicaid can result in recoupment of the appropriate hospice per diem by Medicare auditors for the dually eligible Medicare and IHCP hospice members and recoupment from the IHCP for payment of the IHCP per diem for the IHCP-only hospice members.

When approval for a benefit period is granted, a hospice provider can manage a patient’s care at the four levels of care according to the medical needs determined by the interdisciplinary team and the requirements of the patient, the patient’s family, or primary care provider.

Note: Changes in levels of care do not require hospice authorization as long as these levels are rendered within a hospice benefit period that the ADVANTAGE Health Solutions-FFS has previously authorized.

<table>
<thead>
<tr>
<th>Table 6.2 – Hospice Authorization Process for IHCP-Only Members</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time Period</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>First 90 Days</strong></td>
</tr>
<tr>
<td><strong>Second 90 Days</strong></td>
</tr>
</tbody>
</table>
Dually Eligible Medicare and IHCP Members in Nursing Facilities

Dually eligible Medicare and IHCP members residing in nursing facilities must elect, revoke, or change providers under both the Medicare and the IHCP programs at the same time. The hospice provider is required to notify both programs of any changes in the dually eligible Medicare and IHCP member’s hospice care status. The IHCP requires that the hospice provider submit all the required certification forms as described in Section 4: Member Eligibility in this manual.

The following paragraphs address different scenarios whereby a dually eligible Medicare and IHCP member residing in an NF must be enrolled in both programs:

- An IHCP-eligible member already enrolled in the IHCP hospice benefit becomes eligible for Medicare benefits midway through IHCP hospice care. The hospice member must be enrolled in the Medicare hospice benefit at the same time of Medicare eligibility. In this situation, a Change in Status of Medicaid Hospice Patient State Form 48732 (4/98)/OMPP 0010 must be completed and sent to the IHCP Hospice Authorization Unit. This form indicates that the IHCP member is now eligible for Medicare. For such individuals, hospice providers must, prior to the initiation of hospice care, make adequate preparation in the event that the IHCP hospice member becomes Medicare-eligible.

- If a dually eligible Medicare and IHCP member who turns down Medicare hospice services to choose Medicare skilled nursing facility (SNF) care instead, and then exhausts the 100 days of Medicare NF care, then the dually eligible Medicare and IHCP hospice member elects the Medicare hospice benefit. In that situation, dually eligible Medicare and IHCP members who live in an NF must complete the required certification forms as described in this section, if Medicare benefits for NF care have been exhausted. The hospice provider must bill Medicare for the hospice services and then bill IHCP for 95 percent of the nursing facility case mix rate for the NF room and board services.

- If a dually eligible Medicare/IHCP member residing in an NF has elected the Medicare hospice benefit and then becomes eligible for the IHCP, the dually eligible Medicare and IHCP member must also be enrolled in the IHCP hospice benefit by completing the required certification forms as described in this section. The hospice provider must bill Medicare for the hospice services and then bill the IHCP for 95 percent of the NF case mix rate.

- The IHCP, like the Medicare Hospice Program, requires that hospice providers coordinate on a regular basis with the NF provider. Despite the release of several IHCP provider bulletins to hospice and NF providers, there is still confusion about IHCP program guidelines for the dually eligible Medicare/IHCP hospice member and reimbursement. To ensure that the IHCP member’s enrollment in the IHCP hospice benefit is clear to both hospice and NF staff and is also compliant with medical records standards, the hospice provider must furnish the NF staff with the following Medicaid hospice forms to include in the member’s chart:
  - Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005 with the ADVANTAGE Health Solutions-FFS hospice authorization stamp
  - Medicaid Hospice Revocation State Form 48735 (4/98)/OMPP 0007
  - Medicaid Hospice Discharge State Form 48734 (R/12-02)/OMPP 0008
  - Hospice Provider Change Request Between Indiana Hospice Providers State Form 48733 (R/12-02) OMPP 0009

The staff at the NF billing department must also be informed by the hospice provider of the dates of hospice election, revocation, discharge, and change in hospice providers for billing purposes. It is the responsibility of the hospice to develop the coordination procedures.
The following forms must be placed in the IHCP member’s NF clinical record to clarify patient care and reimbursement issues:

- For the IHCP-only hospice member, the Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005, the Medicaid Hospice Physician Certification State Form 48736 (R/12-02)/OMPP 0006, and the Medicaid Hospice Plan of Care State Form 48731 (R2/11-04)/OMPP 0011

- For the dually eligible Medicare and IHCP hospice member, the Hospice Authorization Notice for Dually Eligible Medicare/Medicaid Nursing Facility Residents State Form 51098 (3-03)/OMPP 0014, the hospice agency election form, and the coordinated plan of care prepared by the NF and the hospice providers

- Medicaid Hospice Revocation State Form 48735 (4/98)/OMPP 0007
- Medicaid Hospice Discharge State Form 48734 (R/12-02)/OMPP 0008

For more information about hospice care in NFs, refer to IHCP provider bulletin E98-30. See Appendix B for a complete list of referenced IHCP banner pages, bulletins, and newsletters.

For more information about the OMPP quarterly recoupment process based on IHCP overpayments to NFs, refer to the IHCP provider bulletins E98-37 and BT199919. See Appendix B for a complete list of referenced IHCP banner pages, bulletins and newsletters.

Hospice Authorization Process

Hospice providers are required to use hospice revenue code 651 on the Indiana Prior Review and Authorization Request Form. The Indiana Prior Review and Authorization Request Form serves as a cover sheet for all hospice authorization requests. This form can be found on the Forms page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/forms.asp in the Prior Authorization section.

Hospice Authorization Request for dually eligible Medicare and IHCP hospice member residing in a nursing facility

The following steps for the hospice authorization of a dually eligible Medicare and IHCP hospice member residing in an NF should be completed by hospice providers.

Indiana Prior Review and Authorization Request Form

Obtain a copy of the Indiana Prior Review and Authorization Request Form and complete the following fields as listed in Table 6.3
Table 6.3 – Indiana Prior Review and Authorization Request Form Fields

<table>
<thead>
<tr>
<th>Form Field</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requesting Provider Number</td>
<td>On the top left side of the form, type the IHCP hospice provider number, hospice agency name, complete address, and telephone number.</td>
</tr>
<tr>
<td>Member Information</td>
<td>On the top right side of the form, type the IHCP member identification number (RID), date of birth, name, and complete address.</td>
</tr>
<tr>
<td>Dates of Service and Service Code</td>
<td>Complete the following fields on the authorization request form.</td>
</tr>
<tr>
<td>Dates of Service</td>
<td>Type the start date and the end date of the hospice benefit period.</td>
</tr>
<tr>
<td>Service Code</td>
<td>Type hospice revenue code 651 only (required). If any other revenue code is used, the ADVANTAGE Health Solutions-FFS hospice analyst will return the request to the provider for correction.</td>
</tr>
<tr>
<td>Modifier</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Requested Service</td>
<td>Type hospice.</td>
</tr>
<tr>
<td>Taxonomy</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>POS</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Units</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Dollars</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Clinical Summary</td>
<td>Leave this section blank, because the ADVANTAGE Health Solutions-FFS hospice analyst must refer to the attached Hospice Authorization Notice for Dually Eligible Medicare/Medicaid Nursing Facility Residents State Form 51098 (3/03)/OMPP 0014 (HF-1) for required hospice authorization information.</td>
</tr>
<tr>
<td>Signature of Requesting Provider</td>
<td>The individual hospice member completing this sheet should sign for the agency.</td>
</tr>
<tr>
<td>Date</td>
<td>Type the date signed.</td>
</tr>
</tbody>
</table>

**State Form 51098 (3-03)-Hospice Authorization Notice for Dually Eligible Medicare and Medicaid Nursing Facility Residents**

Complete this form in its entirety. Blank boxes are not permissible. If a particular box does not apply, simply type “not applicable” or NA. and attach it to the Indiana Prior Review and Authorization Request form. The Indiana Prior Review and Authorization Request form should serve as a cover sheet to the Hospice Authorization Notice for Dually Eligible Medicare/Medicaid Nursing Facility Residents State Form 51098 (3/03)/OMPP 0014 (HF-1), and a copy of the hospice agency form showing the Medicare hospice election date should be placed behind the State Form 51098. See Appendix B for a complete list of referenced IHCP banner pages, bulletins, and newsletters.
Completion of the Hospice Authorization Request for IHCP-only Members Residing at Home

Hospice providers should take the following steps to complete the hospice authorization for an IHCP-only member.

Indiana Prior Review and Authorization Request Form

Obtain a copy of the Indiana Prior Review and Authorization Request form and complete the following fields:

Table 6.4 – Indiana Prior Review and Authorization Request Form Fields

<table>
<thead>
<tr>
<th>Form Field</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requesting Provider Number</td>
<td>On the top left side of the form, type the IHCP hospice provider number, hospice agency name, complete address, and telephone number.</td>
</tr>
<tr>
<td>Member Information</td>
<td>On the top right side of the form, type the IHCP member identification number (RID), date of birth, name, and complete address.</td>
</tr>
<tr>
<td>Dates of Service and Service Code</td>
<td>Complete the following fields on the authorization request form.</td>
</tr>
<tr>
<td>Dates of Service</td>
<td>Type the start date and the end date of the hospice benefit period.</td>
</tr>
<tr>
<td>Service Code</td>
<td>Type hospice revenue code 651 only (required). If any other revenue code is used, the ADVANTAGE Health Solutions-FFS hospice analyst will return the request to the provider for correction.</td>
</tr>
<tr>
<td>Modifier</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Requested Service</td>
<td>Type hospice.</td>
</tr>
<tr>
<td>Taxonomy</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>POS</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Units</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Dollars</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Clinical Summary</td>
<td>Leave this section blank, because the ADVANTAGE Health Solutions-FFS hospice analyst must refer to the attached Medicaid Hospice Election (SF 48737/OMPP 0005), Medicaid Hospice Physician Certification (SF 48736/OMPP 0006), and Medicaid Hospice Plan of Care (SF 48731/OMPP 0011) for required hospice authorization information.</td>
</tr>
<tr>
<td>Signature of Requesting Provider</td>
<td>The individual hospice member completing this sheet should sign for the agency.</td>
</tr>
<tr>
<td>Date</td>
<td>Type the date signed.</td>
</tr>
</tbody>
</table>
Completion of Other Hospice Authorization Forms

Providers must also complete a Prior Authorization System Update Request Form and attach it to the front of the following four forms:

- Hospice Provider Change Request Between Indiana Hospice Providers State Form 48733 (R/12-02)/OMPP 0009
- Change in Status of Medicaid Hospice Patient State Form 48732 (4/98)/OMPP 0010
- Medicaid Hospice Revocation State Form 48735 (4/98)/OMPP 0007
- Medicaid Hospice Discharge State Form 48734 (R/12-02)/OMPP 0008


When an original request is suspended for additional information or due to pending Medicaid nursing facility level of care, the hospice provider must resubmit an update form and note the prior authorization number assigned to the original suspended request. This will ensure that the subsequent request is not denied as a duplicate of the original request.

Certification for Dually Eligible Medicare and Medicaid Hospice Members Residing in Nursing Homes

Changes to the documentation requirements are for IHCP hospice authorization of dually eligible Medicare and IHCP hospice members residing in NFs for whom the IHCP pays for room and board services as specified in 405 IAC 1-16-4 and for whom Medicare pays for the hospice services. Because the Part A MAC determines medical necessity for hospice care, the IHCP has opted to change the documentation requirements to a one-page notification sheet that permits the ADVANTAGE Health Solutions-FFS to enter the hospice authorization without evaluating medical necessity. The provider must provide the information in each box and ensure that the form is signed by the patient care coordinator to ensure hospice authorization. Failure to properly complete the form results in ADVANTAGE Health Solutions-FFS returning the paperwork to the hospice provider for correction.

Certification for IHCP-Only Hospice Members

Certification that a member is terminally ill with a prognosis of six months or less is indicated on the Medicaid Hospice Physician Certification State Form 48736 (R/12-02)/OMPP 0006. The following medical personnel must complete this form:

- According to 42 CFR Section 418.22, the medical director or the physician member of the hospice interdisciplinary team and the attending physician must both sign the Medicaid Hospice Physician Certification State Form 48736 (R/12-02)/OMPP 0006 if the individual has an attending physician for the first hospice benefit period of 90 days.
- For subsequent benefit periods, either the hospice medical director or the physician member of the hospice interdisciplinary team must sign the physician certification.
- For cases when the member has no attending physician, the hospice provider must specify this in the box where the attending physician’s signature is required.
- To expedite physician certification form processing, the IHCP accepts a physician certification form that reflects a faxed signature of the member’s attending physician.
The following certification rules apply to the benefit periods:

- The signed and dated Medicaid Hospice Physician Certification State Form 48736 (R/12-02)/OMPP 0006 must identify the diagnosis that prompted the client to elect hospice and must include a statement that the prognosis is six months of life or less. The physician signature alone is not sufficient to constitute a valid physician certification and results in the return of the hospice authorization forms by the ADVANTAGE Health Solutions-FFS hospice analyst for correction by the hospice provider.

- For Period I, the hospice provider must forward to the IHCP Prior Authorization Department, within 10 business days from the member’s election effective date, written certification statements and a plan of care signed by the appropriate medical personnel. Hospice providers are reminded that the IHCP program guidelines require the signature of the hospice medical director and any of the two other disciplines listed in the Medicaid Hospice Plan of Care State Form 48731 (R2/11-04)/OMPP 0011. If the required signatures are not on the IHCP forms, the ADVANTAGE Health Solutions-FFS hospice analyst suspends the hospice authorization paperwork for correction by the hospice provider. The subsection titled Hospice Plan of Care Documentation Requirements in this section provides more information about the content in the plan of care.

- For Periods II and III the hospice provider must forward to the IHCP Prior Authorization Department, within 10 business days, a written recertification on the physician certification form and an updated plan of care prepared and signed by the appropriate medical personnel. Hospice providers are reminded that the IHCP program guidelines require the signature of the hospice medical director and any of the two other disciplines listed in the Medicaid Hospice Plan of Care State Form 48731 (R2/11-04)/OMPP 0011. If the required signatures are not on the IHCP forms, the ADVANTAGE Health Solutions-FFS hospice analyst suspends the hospice authorization paperwork for correction by the hospice provider.

- Hospice providers are also reminded that exceptions to the 10 business day time frame for hospice authorization paperwork required for each of the hospice benefit periods include IHCP-pending individuals or IHCP hospice members residing in an NF for whom IndianaAIM does not reflect NF level of care (LOC).

If the following requirements are not met, payment cannot be made for services rendered for that benefit period because the hospice authorization process cannot be completed and no level of approval has been provided.

- The certification forms can be mailed to the ADVANTAGE Health Solutions-FSS at the following address:

  ADVANTAGE Health Solutions-FSS  
P.O. Box 40789  
Indianapolis, IN 46240

Or the certification forms can be faxed to 1-800-689-2759.

- If the certification forms are complete and correct, the hospice analyst authorizes the hospice services for the requested benefit period. The hospice provider receives a prior authorization notice with a hospice effective date and the hospice analyst’s name. The prior authorization notice is the hospice provider’s notification that claims can be submitted for that benefit period.

- If the forms are incomplete, the hospice analyst suspends the request and sends a letter asking the hospice to resubmit a copy of that form with the corrected information. ADVANTAGE Health Solutions-FSS does not return the entire packet.

- The hospice must submit one physician certification form with both signatures to the Medicaid PA contractor as this is proper medical documentation.

- Hospice providers can also contact the ADVANTAGE Health Solutions-FSS at 1-800-269-5720 to speak to a hospice reviewer if they have any questions about form completion.
Indiana Health Coverage Programs  
Hospice Provider Manual  

Section 6: Hospice Authorization Process  

Hospice Plan of Care Documentation Requirements

Providers should refer to 42 CFR Section 418.58, Condition of Participation Plan of Care for the pertinent regulations for the hospice plan of care.

The following information is taken from Section 4: Coverage Issues of the Medicare Part A Hospice Training Manual (October 2006) published by Palmetto GBA and available as an Acrobat file at http://www.palmettogba.com/. This information is to remind providers of Medicare’s requirements for the development of the plan of care. The following information also includes clarification from the Indiana State Department of Health on questions about standing orders in nursing homes and how to document services that are provided when necessary (PRN).

- The plan of care must be established before services are provided. The plan of care must be dated on the day it is first established.
  - The member of the basic interdisciplinary team who first assesses the patient’s needs must meet or call at least one other group member (nurse, physician, medical social worker, or counselor) before writing the initial plan of care. At least one of the persons involved in developing the plan of care must be a nurse or physician.
  - The other two members of the basic interdisciplinary team (attending physician and medical director) must review the initial plan of care and provide their input within two days of assessment. This input may be provided by telephone.
  - The plan of care must include an assessment of the individual’s needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient’s and family’s needs.

  Note: Hospice providers are reminded that the Indiana State Department of Health stated that during an interdisciplinary group (IDG) meeting, the hospice should note PRN times how many visits. Frequency must be provided using the formula “range plus PRN.” Zero is not acceptable to use when establishing a range.

- The plan of care should only include services that are reasonable and necessary for the palliation and management of the terminal illness and related conditions:
  - The hospice interdisciplinary team (including consultation with attending physician and/or medical director) should decide which services are related or not related to the individual patient’s terminal condition.
  - The hospice interdisciplinary team decides what services are necessary for palliation and what services would be considered curative, and therefore, noncovered. Chemotherapy, radiation therapy, and other modalities may be used for palliative purposes if the hospice determines that these services are needed for palliation. This determination is based on the patient’s condition and the hospice’s caregiving philosophy. There will be no additional Medicare (or Medicaid) reimbursement for these services.
  - The plan of care must be reviewed and updated at intervals specified in the plan of care. It should be continually assessed to ensure the care the patient receives meets his or her needs and to verify that the patient continues to be appropriate for Hospice Medicare Benefit. The plan of care should be updated if the patient’s condition improves or deteriorates and if the level of care changes.
  - The plan of care sent to the Medicaid PA contractor must reflect all three signatures of the interdisciplinary team members on the same plan of care.
Penalty for Untimely Submission of Hospice Authorization Paperwork

The following information was published in the IHCP provider bulletin BT200331. See Appendix B for a complete list of referenced IHCP banner pages, bulletins, and newsletters.

Hospice providers are required to submit IHCP hospice authorization paperwork to the ADVANTAGE Health Solutions-FFS within 10 business days of the effective date of the member’s election of hospice services or within 10 business days of the beginning of the second and subsequent benefit periods. The signatures by the attending physician, the hospice medical director, and hospice interdisciplinary team members must be completed within the 10 business days for the hospice authorization request to be considered timely. The hospice authorization start date will be modified consistent with the late signature dates. This practice has been in effect since the hospice rule changes that became effective August 2003. Suspending a request for an additional 30 days does not mean that the hospice provider has an additional 30 days to obtain required signatures and still be considered timely with regard to completion of the physician certification form and the hospice plan of care.

When there is insufficient information submitted to render a hospice authorization decision, or the documentation contains errors, a hospice authorization request will be suspended for 30 days and the IHCP or its contractors will request additional information from the provider. The provider must make the corrections and resubmit the proper documentation within 30 calendar days after the additional information or correction is requested. If the provider fails to resubmit the documentation with the appropriate corrections within the 30-day time period, the request for hospice authorization will be denied. The IHCP contractor must receive the request in the office within the 30th day for the request to be considered timely. The start date for hospice will be modified for untimeliness for hospice authorization requests for IHCP-only and dually eligible Medicare/IHCP hospice members residing in nursing facilities.

If the provider submits additional documentation, within the 30-day time period, but the documentation submitted does not provide sufficient information to render a decision, the IHCP or its contractors, can request additional information. The provider must submit the additional information within the additional 30 days. If the provider fails to submit the requested information within the additional 30 days, or if the additional documentation does not provide sufficient information to render a decision, the request for hospice authorization will be denied.

The hospice provider can appeal the denied hospice authorization. The following explanation provides information about the administrative reconsideration and the appeals process.

Exceptions to the Penalty for Untimely Submissions: If a request for hospice authorization or supporting documentation is received after the time limits in this section, authorization can be granted only for services provided on or after the date that the request is received.

The following circumstances list when authorization can be granted for services furnished prior to the date of a request that does not comply with the time limits in this section:

- **Pending or Retroactive Member Eligibility:** The hospice authorization must be submitted within 12 months of the date of the issuance of the member’s Hoosier Healthwise card.

- **Provider Unaware the Individual was Medicaid-eligible:** If the provider was unaware that the member was eligible for services at the time services were rendered, hospice authorization will be granted only under the following circumstances:
  - The provider’s records document that the member refused, or was physically unable to provide the member identification number (RID or Medicaid) or the IHCP number.
The provider can substantiate that the provider continually pursued reimbursement from the patient until IHCP eligibility was discovered.

- The provider submitted the request for prior authorization within 60 days of the date IHCP eligibility was discovered.

**Pending or Retroactive Approval of Nursing Facility Level of Care:** The hospice authorization must be submitted within 12 months of the date nursing facility level of care was approved by the IHCP.

**Review of Medical Necessity:** The IHCP relies on current professional guidelines, including the Medicare Local Coverage Determination (LCD) for hospice services.

As noted above there are four case-specific reasons that an individual may be retroactively enrolled in the IHCP Hospice Program. Retroactive consideration is given to benefit periods in which IndianaAIM does not reflect a current nursing facility level of care or member eligibility. Providers must check eligibility on a regular basis and must check this each hospice benefit period. Subsequent benefit periods are not affected by eligibility or level-of-care status of previous benefit periods. For example, there was no nursing facility level of care for the first two hospice benefit periods for hospice patient. Patient elected January 2007. Nursing facility level of care was entered onto IndianaAIM May 1, 2007. While the first two benefit periods would not have been processed due to lack of nursing facility level of care, the third hospice benefit period starting in June 2007 should have had a timely submission.

According to Palmetto GBA, the Part A MAC for Indiana, Medicare coverage for hospice care depends upon a physician’s certification of an individual’s prognosis of a life expectancy of six months or less. Recognizing that determination of life expectancy during the course of a terminal illness is difficult, the Part A MAC has established medical criteria for determining prognosis for noncancer diagnoses. These criteria form a reasonable approach to the determination of life expectancy based on research, and can be revised as more research is available, particularly because remedial care is a new and changing field. The Medicare program indicates that coverage of hospice care for patients not meeting the criteria under a specific LCD could be denied. However, some patients may not meet the criteria, yet still be appropriate for hospice care because of other disease or rapid decline. **Coverage for these patients may be approved individually.**

The IHCP recognizes that the LCD is only a guide to assist in determining if a patient is appropriate for hospice care and is not meant to replace overall clinical evaluation either by the hospice provider or by the IHCP and its contractor in evaluating the unique clinical condition of each hospice member. Each hospice authorization is reviewed as a stand-alone request taking into consideration the hospice member’s unique clinical history.

Hospice providers must adhere to the LCD published by the Part A MAC for the state of Indiana when evaluating an IHCP-only hospice member for hospice care appropriateness.

**Administration Reconsideration and Appeals Process**

The following appeals procedures are noted in this section:

- IHCP members can appeal the denial or modification of hospice authorization under 405 IAC 1.1.

- Any provider submitting a request for hospice authorization that was denied, under this rule, can appeal the decision under 405 IAC 5-7-2 and 405 IAC 5-7-3 for administrative consideration of prior authorization decisions.

- When insufficient information is submitted to render a decision, or the documentation contains errors, a hospice authorization is suspended pursuant to 405 IAC 5-34-4 and the IHCP or its
contractor requests additional information from the provider. **Suspension is not a final decision on the merits of the request and cannot be appealed.** If the provider does not submit sufficient information within the time frames set out in 405 IAC 5-34-4(h), the request shall be denied. **Denial is a final decision and may be appealed pursuant to subsections (a) and (b).**

- The Administrative Review Process: Pursuant to 405 IAC 5-7-2, an IHCP-enrolled provider entitled to submit PA requests wishing a review of denial or modification of a PA decision, must request an administrative review before filing an appeal under 405 IAC 1.1.
  - An administrative review request by the provider who submitted the PA request must be initiated within seven working days of the receipt of modification or denial. The request must be forwarded in writing to the IHCP PA contractor. Telephone requests are not accepted.
  - Pursuant to 405 IAC 5-7-3, the IHCP PA contractor performs the review. The review assesses medical information pertinent to the case in question. The review decision of the IHCP contractor is rendered within seven working days of the request. **The time limit issuance of a decision does not commence until the provider submits a complete request including all necessary documentation required by the contractor to render the decision.** The requesting provider and member receive written notification of the decision containing the following:
    - The determination reached by the IHCP contractor and the rationale for the decision.
    - The provider’s and member’s appeal rights through the OMPP

- Administrative Law Judge (ALJ) Hearings and Appeal: Pursuant to 405 IAC 1.1-1-3, any party complaining of any OMPP or county Division of Family Resources (DFR) action can file a request for an administrative hearing as provided in this section.

Unless otherwise provided by statute, regulation, or rule, appeal requests by members or applicants must be filed in writing with the local county DFR or the Family Social Services Agency (FSSA) Hearings and Appeals Section, no later than 30 days following the effective date of the action being appealed. Applicant and member appeal hearings are conducted at a reasonable time, place, and date.

A continuance of a hearing may be granted only for good cause. An objection to a request for a continuance must be considered before a continuance is granted or denied. Requests for a continuance must be in writing and accompanied by adequate documentation of the reasons for the request. Good cause includes the same factors as cause for a continuance in the *Supplemental Security Income program* (20 CFR 416.1436):

- Inability to attend the hearing because of a serious physical or mental condition
- Incapacitating injury
- Death in the family
- Severe weather conditions making it impossible to travel to hearing
- Unavailability of a witness and the evidence cannot be obtained otherwise
- Other reasons similar to those listed in this section

The request for continuance must also include alternative dates for the scheduling of a new hearing when the appellant is represented by counsel. However, the Family and Social Services Administration Hearings and Appeals Section may schedule a new hearing without respect to the requested date, if such date cannot be accommodated or confirmed with the requesting attorney within a reasonable time of the request.

The Family and Social Services Administration Hearings and Appeals Section, upon application of any party, or in its own discretion, could consolidate appeals to promote administrative efficiency. Family and Social Services Administration Hearings and Appeals Section could consolidate hearings only in cases in which the sole issue involved is one of federal or state law or policy.
Any party filing the appeal under this article is not excused from exhausting all interim procedures that could be required by statute or rule for administrative review prior to the filing of an appeal. Any issues not presented in a timely manner within the interim review process are waived and not an issue during the evidentiary hearing. The Family and Social Services Administration Hearings and Appeals Section schedules evidentiary hearings and issues notices to the parties about the date, time, and location of the hearing.

- **Conduct of Agency Review:** Any party not satisfied with the decision of the administrative law judge can request agency review of the decision within 10 days of receipt of the decision in accordance with instructions issued with the decision.

After receiving a request for an agency review of a hearing decision, the Family and Social Services Administration Hearings and Appeals Section notifies all parties when the decision is to be reviewed. The agency review is completed by the secretary or the Family and Social Services Administration secretary’s designee. All such reviews are conducted upon the record as defined in IC 4-21.5-3-33, except that a transcript of the oral testimony is not necessary for review unless a party requests a transcript at its expense.

No new evidence is considered during the agency review; however, any party wishing to submit a memorandum of law, citing evidence in the record, may do so pursuant to instructions issued by the Family and Social Services Administration Hearings and Appeals Section of the FSSA.

**Certification Forms for IHCP-Only Hospice Members**

The IHCP requires hospice providers to use the IHCP hospice forms to enroll the IHCP-only member in the IHCP hospice benefit. No other forms are accepted in lieu of the IHCP hospice forms for IHCP-only hospice members.

This policy also applies to an IHCP-only member who has private insurance (that may or may not cover hospice care), but who is not enrolled in the Medicare hospice benefit. Enrollment in the IHCP hospice benefit ensures that the IHCP covers, as the payer of last resort, any hospice services not covered by an IHCP-only member’s private insurance.

**Expediting Attending Physician Signature**

Because the implementation of the IHCP hospice benefit, the IHCP has indicated that it is permissible for hospice providers to fax the Medicaid Hospice Physician Certification State Form 48736 (R/12-02)/OMPP 0006 to the member’s attending physician (AP) to obtain the AP’s signature. The AP’s office may then return the faxed form to the hospice with the AP’s signature and then the hospice provider can submit the completed form to ADVANTAGE Health Solutions-FFS with all required documentation.

**Clarification Regarding Original Copies of Hospice Medical Documentation**

The IHCP recommends that hospice providers keep all IHCP hospice forms that reflect the original signature of the required parties and submit copies of these forms to ADVANTAGE Health Solutions-FFS.

IHCP forms with original signatures are legal documents that reflect the member’s enrollment in the IHCP hospice benefit and must be kept in the hospice member’s clinical chart.
Clarification Regarding when the IHCP Can Mirror a Hospice Agency’s Benefit Periods

The IHCP has been asked two questions about when the IHCP will mirror a hospice agency’s benefit periods. To provide written clarification, this section provides a formal response to two case-specific scenarios.

Example 1: Medicare Beneficiary Residing at Home Who Is Admitted To the Nursing Facility

Scenario

A patient is a Medicare beneficiary who resides at home. The patient elects the Medicare hospice benefit on February 10, 2007. The patient is admitted to an NF February 28, 2007. When IHCP eligibility is established and the Indiana Pre-Admission Screening (IPAS) is completed, the hospice member is deemed eligible for the IHCP and has an approved OMPP as of February 28, 2007. This is also the date of admission to the NF.

Question

Can ADVANTAGE Health Solutions-FFS process the hospice authorization so that the IHCP hospice benefit mirrors the Medicare hospice benefit periods by an agency?

OMPP Response

Yes. The ADVANTAGE Health Solutions-FFS has the IHCP hospice benefit periods mirror the Medicare hospice benefit periods.

- The IHCP processes all hospice authorization requests using the Julian calendar. Hospice care dates cannot overlap from one hospice benefit period to the next hospice benefit period in IndianaAIM.
- To facilitate the process for the ADVANTAGE Health Solutions-FFS hospice analyst, the hospice provider must include a cover letter for ADVANTAGE Health Solutions-FFS with a request that the hospice analyst have the IHCP hospice benefit periods mirror the Medicare hospice benefit periods. The hospice agency must include the following information in the cover letter:
  - The election or re-election date of the Medicare hospice benefit
  - A copy of the Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005 to validate the date the individual elected hospice
  - The IHCP hospice form with Sections A and B completed to reflect IHCP-required information
  - The Change in Status of Medicaid Hospice Patient State Form 48732 (4/98)/OMPP 0010 that explains date the individual left home and was admitted to the nursing facility
  - The date the individual became IHCP-eligible
  - IHCP hospice benefit periods cannot be authorized prior to the date of IHCP eligibility. Therefore, in this example, the ADVANTAGE Health Solutions-FFS hospice analyst must enter February 28, 2007, as the start date of the IHCP hospice benefit.
- To have the hospice authorization end at the same time as the Medicare hospice benefit period, the ADVANTAGE Health Solutions-FFS hospice analyst must perform the following review using the Julian calendar method:
  - Use the Medicare election date of February 10, 2007, to determine the end date of the Medicare hospice benefit period.
The initial Medicare election date of February 10, 2007, is Julian day 41.

Julian day 41 (February 10, 2007, or hospice election date) plus 90 days in first hospice benefit period equals Julian day 131 or May 11, 2007, which is the end date of first Medicare hospice benefit period.

IHCP hospice authorization is then granted from February 28, 2007, the start date of IHCP eligibility, through May 11, 2007, the end date of the first Medicare hospice benefit period.

**Example 2: Hospice Patient with Private Insurance (such as Blue Cross and Blue Shield) Becomes IHCP-Eligible During a Hospice Benefit Period**

**Scenario**

A hospice patient residing at home elects hospice January 31, 2010. The patient has private insurance and is **not a Medicare beneficiary**. The patient becomes IHCP-eligible February 10, 2010, and elects the IHCP hospice benefit on the same date by signing the *Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005*.

**Question**

Can ADVANTAGE Health Solutions-FFS process the hospice authorization so that the IHCP hospice benefit period mirrors the start date of private insurance so that the hospice agency does not have to track two sets of hospice benefit periods?

**OMPP Response**

No. The IHCP works with the hospice agency to authorize IHCP hospice benefit periods that mirror the Medicare hospice benefit periods so that the hospice agency does not have to track two sets of hospice benefit periods. However, an IHCP-only hospice member cannot be tracked in the same manner because the member’s enrollment date in the IHCP hospice benefit is not the same date as enrollment in the hospice agency’s hospice program. In this example, the first IHCP hospice benefit period is authorized from February 10, 2010, the date of IHCP hospice election, through May 11, 2010.

**IHCP Managed Care Members Electing the IHCP Hospice Benefit**

The information in this section outlines policy previously stated in the IHCP provider bulletin *BT199905* and subsequent banner pages. See *Appendix B* for a complete list of referenced IHCP banner pages, bulletins, and newsletters.

As previously mentioned in this section, members enrolled in one of the three managed care delivery systems must disenroll from managed care before hospice authorization can be completed. Managed care members who elect to enroll in the IHCP hospice benefit become eligible for hospice care the day following disenrollment from the IHCP managed care program. The OMPP’s managed care program for the aged, blind, and disabled; and *Care Select*, excludes hospice members. *Care Select* was implemented in phases, beginning November 1, 2007; see *BT200723* for details about the program and the implementation phases.

The hospice provider can determine if the IHCP member is in one of the three managed care programs by using one of the IHCP eligibility verification systems as outlined in the *IHCP Provider Manual*. 
Hospice providers can fax member enrollment information for IHCP managed care members to the IHCP PA contractor. Upon receipt of the enrollment information, the hospice analyst contacts the appropriate person at MAXIMUS, IHCP’s managed care program enrollment broker, on the same day. The hospice provider may start billing the IHCP the day after the individual is disenrolled from managed care.

As the fax is ADVANTAGE Health Solutions’ preferred method of receiving prior authorization requests from all providers, it is imperative that hospice providers note in the subject line of the fax "Hospice Member Disenrollment from Managed Care." Hospice providers should also follow up the fax with a telephone call to ADVANTAGE to ensure the hospice analyst has received the fax. This will ensure that the disenrollment of the hospice member is completed in a timely manner and prioritized within the overall workflow.

The ADVANTAGE Health Solutions-FVS fax number is (317) 810-4488. To facilitate the hospice authorization process, the hospice provider may fax the Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005 to ADVANTAGE Health Solutions-FVS to initiate the disenrollment of the member from managed care. The corresponding Medicaid Hospice Physician Certification State Form 48736 (R/12-02)/OMPP 0006 and Medicaid Hospice Plan of Care State Form 48731 (R2/11-04)/OMPP 0011 must be sent to the ADVANTAGE Health Solutions-FVS within 10 business days as outlined in 405 IAC 5-34-4 to ensure the request is timely.

If the hospice fails to check IHCP eligibility to determine whether a member is enrolled in managed care and fails to immediately fax the Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005 to ADVANTAGE Health Solutions-FVS, the hospice provider does not receive payment for the dates of service that the IHCP member was still enrolled in managed care.

Hospice providers are encouraged to ensure that ADVANTAGE can coordinate with MAXIMUS to disenroll a member from managed care on the same date that ADVANTAGE Health Solutions-FVS receives the fax by 4 p.m., Indianapolis time. This ensures that there is ample time for MAXIMUS to process the disenrollment on that day along with its overall workflow.

Effective March 1, 2004, the IHCP issued special batch claims for the following scenarios in which a hospice provider admits a member enrolled in managed care to their hospice program:

- Weekend admissions where the member dies during the weekend and the hospice could not fax the Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005 to ADVANTAGE Health Solutions-FVS Prior Authorization Unit, because ADVANTAGE Health Solutions-FVS is closed until Monday morning or in the case of holidays the following business day. The hospice must still meet the timeliness requirement of faxing the Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005 on the first possible business day by the 4 p.m. deadline outlined in IHCP banner page BR200329. For instance, if the patient was admitted on Friday at 8 p.m., the Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005 must be faxed to ADVANTAGE Health Solutions-FVS on the following Monday prior to the 4 p.m. deadline.

- Admissions to the hospice program where the member dies on the day of admission and ADVANTAGE Health Solutions-FVS could not have disenrolled the member even if the hospice faxed the form to ADVANTAGE Health Solutions-FVS the day of admission.

- One-day admissions in which the hospice member revokes or is discharged from hospice care is to be considered for a special batch payment, as the one-day admission in which a member dies on the day of admission is equivalent to a physical hospice discharge. Hospice providers are reminded that the IHCP does not pay for room and board under the IHCP hospice benefit if the hospice member dies or is physically discharged from the nursing facility on the day he or she elected hospice. In those circumstances where special batch payment would be warranted, the IHCP reimburses the hospice only for the hospice per diem.
To meet the parameters for the special batch payment for the scenarios outlined above, the hospice must be able to produce a copy of the Medicaid eligibility verification strip that demonstrates that the hospice checked eligibility upon admission per the IHCP provider agreement, the Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005 and other paperwork must be faxed to ADVANTAGE Health Solutions-FFS on the first available business day so that ADVANTAGE Health Solutions-FFS can still perform a review for medical necessity, and the hospice must complete the UB-04 claim form so that the OMPP may request that HP process the claim by special batch.

To facilitate paperwork for hospice providers and to minimize the possibility of auto-enrollment of hospice members between hospice benefit periods, the following policy changes are in effect:

- The hospice provider may complete and fax to the ADVANTAGE the Medicaid Hospice Physician Certification State Form 48736 (R/12-02)/OMPP 0006 and the Medicaid Hospice Plan of Care State Form 48731 (R2/11-04)/OMPP 0011 two weeks prior to the start date of the recertification period.
- The hospice provider must assume responsibility for contacting the ADVANTAGE hospice analyst prior to faxing the paperwork so that the ADVANTAGE Health Solutions-FFS hospice analyst can be prepared for its impending arrival.
- Paperwork is returned if not properly completed; the provider should ensure its own quality assurance (QA) review to maximize this opportunity.

Effective October 1, 2007, the Medicaid prior authorization contractor will be noting on the prior authorization notice the service dates for which the hospice must fax a claim to the Hospice Program director within Family and Social Services Administration Division of Aging to fax (317) 233-2182. The Hospice Program director will then forward the claim to HP for special batch processing. Providers may refer to BR200739, which provides more detailed information. It is the responsibility of the hospice to develop internal procedures to ensure that the individual who receives the PA notice coordinates with the hospice biller on these payment issues. The hospice provider has one year from the date of the written request to submit the documentation and hospice claim to the OMPP for special batch payment. If the provider does not submit the required documentation and hospice claim by the one-year deadline, then no expenditure payout is issued.

The IHCP may special batch hospice claims. When a claim is special batched, it appears on the hospice provider’s Remittance Advice (RA) with an internal control number (ICN) that begins with 90. Some hospice claims with service dates that had been paid by special batch have been denied payment when they were adjusted during the hospice retro-rate adjustments. However, Indiana AIM was updated July 14, 2005, and the mass claims adjustment process no longer provides a mechanism for an adjusted claim to suspend for edit 2024. Currently, an HP claims clerk can view a paid claim to determine if it was previously forced. If a claim was not forced, the clerk forces the claim to ensure payment during a hospice claims retro rate adjustment. Service dates paid through the special batch process prior to July 14, 2005, which have denied during retro rate adjustments, must be corrected. To meet the criteria, the claim must have been a hospice claim with an ICN starting with 90, and a hospice retro rate adjustment must have resulted in a denial of service dates that were previously on the original claim through the special batch process on their RA. Providers may contact Hospice Program director, at (317) 233-1956 for case-specific questions or concerns. To correct a claim for a retro rate adjustment, the hospice provider must fax a corrected and complete hospice claim for denied service dates to the Hospice Program director at (317)233-2182. The Hospice Program director sends the claim to HP with a special batch request to reprocess the original claim and the adjustment. Hospice providers should not have denied claims for service dates paid through the special batch claims process after July 14, 2005. This information was published in BR200547.
Care Select Members Electing the IHCP Hospice Benefit

Care Select members who elect the IHCP hospice benefit must be disenrolled from the assigned Care Select plan.

Hospice providers must check eligibility on a regular basis, especially upon referral and admission. If the member is assigned to a Care Select plan, the hospice must follow the same disenrollment procedures as noted for IHCP members.

The ADVANTAGE Health Solutions-FFS fax number is (317) 810-4488. To facilitate the hospice authorization process, the hospice provider may fax the Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005 to ADVANTAGE Health Solutions-FFS to initiate the disenrollment of the member from Care Select. The corresponding Medicaid Hospice Physician Certification State Form 48736 (R/12-02)/OMPP 0006 and Medicaid Hospice Plan of Care State Form 48731 (R2/11-04)/OMPP 0011 must be sent to the ADVANTAGE Health Solutions-FFS within 10 business days as outlined in 405 IAC 5-34-4 to ensure the request is timely. The forms are located on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Hospice/content/forms.asp.

As Care Select members are also fee-for-service, there is no need to special batch hospice claims.

Prior Authorization for Treatment of the Nonterminal Condition

Except as described in the following paragraph, PA is required for any IHCP-covered service not related to the hospice member’s terminal condition, if PA is not required under this section. A written PA request for treatment of the nonterminal condition must fulfill all the requirements specified in 405 IAC 5-3-5. For more information about IHCP PA, refer to Chapter 6: Prior Authorization of the IHCP Provider Manual.

Notwithstanding any other provision under this section, PA is not required for the following services when provided to hospice patients:

- Pharmacy services, for conditions not related to the patient’s terminal condition, except as described in the IHCP provider bulletin BT200132. Pharmacy services related to the patient’s terminal condition are included in the hospice per diem.

  Note: Effective September 4, 2001, a prescriber’s indication of brand medically necessary for a prescribed drug requires PA. This means if a prescriber chooses to specify brand medically necessary for a drug, PA must be obtained for the brand name drug before the pharmacist can be paid for the brand name drug. This action implements rule 405 IAC 5-24-8, PA; brand name drugs. Refer to the IHCP provider bulletin BT200132 for more information. BT200132 was released to all IHCP physicians, podiatrists, dentists, hospitals, clinics, mental health providers, and pharmacies August 10, 2001.

- Dental services
- Vision care services

Note: The ADVANTAGE Health Solutions-FFS Prior Authorization Department must review requests for payment of services that are outside the per diem rates established within the context of the plan of care on a case-by-case basis.
Request for Home Health Services in Addition to Hospice Per Diem

The IHCP has directed that a hospice member cannot be enrolled concurrently in the IHCP hospice benefit and the IHCP home health program for treatment of the terminal diagnosis and related conditions. This IHCP policy is consistent with Medicare program guidelines. The IHCP member must determine which program’s overall service better meets the member’s needs for the terminal illness.

The ADVANTAGE Health Solutions-FFS denies PA requests for home health hours for treatment of an IHCP hospice member’s terminal illness that is duplicative of hospice care.

If the ADVANTAGE Health Solutions-FFS receives a request for additional home health hours for treatment of the nonterminal condition, the request must fulfill all of the requirements in 405 IAC 5-3-5. The following criteria must clearly appear on the written PA request to ensure that the request is not suspended for additional information:

• Diagnosis and ICD-9 code for the terminal and the nonterminal illness are required
• Thorough explanation of the medical necessity that clearly documents that there is no relationship between the terminal illness and the required or requested treatments outlined in the PA request

The IHCP has the same standards as the Medicare Hospice Program in that each provider must thoroughly document that there is no relationship between the terminal illness and the required treatments. If the IHCP determines during a hospice agency review that the services are related, the hospice provider is liable for all services rendered.

It is important to note that the hospice provider must submit the hospice plan of care and the home health plan of care to the Medicaid PA contractor to ensure a comprehensive review.

The Family and Social Services Administration sought clarification from the CMS regarding the current policy. Clarification was received by CMS. Representatives from CMS indicated that the State has no reason to treat pediatric patients any differently with regard to the prohibition on receiving hospice and home health for treatment of the terminal illness. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate specific to children only requires the provision of any medically necessary 1905(a) service – receiving hospice care for the terminal illness and related conditions, and home health for unrelated conditions would seem to satisfy that mandate.

Clarification to Hospice Agencies about Hospice Authorization and Hospice Billing for a Hospice Member Discharged from the Hospital

This section provides policy clarification for those hospice agencies whose corporation also has a distinct home health agency.

When an IHCP home health member is discharged from the hospital to return to a private home, the IHCP provides the home health agency with a 30-day grace period from the date of the hospital discharge to submit a request for IHCP PA to ADVANTAGE Health Solutions-FFS. This same policy does not apply to the IHCP hospice member. The hospice provider is required to submit the IHCP hospice authorization request within 10 days of the date of hospice election or the start date of a hospice benefit period regardless of whether the member elects hospice in the hospital or was admitted to the hospital during a hospice benefit period.

It is important that the hospice provider ensure that the provision of hospice services is consistent with all Medicare conditions of participation. This includes the requirement that the hospice has a contract with the hospital that stipulates that the hospice is the manager of that individual’s hospice care as described in 42 CFR Section 418.56. For more information about this subject, refer to the policy
directive found in the *Hospice Provider’s Contractual Responsibilities as the Professional Manager of the Member’s Hospice Care* section.

**Treatment for the IHCP-Only Hospice Member’s Nonterminal Condition**

When the IHCP member elects the IHCP hospice benefit, care for the terminal condition comes under the supervision of the IHCP hospice provider. The IHCP covers the IHCP hospice member’s medical care for conditions not related to the terminal illness. The IHCP expects the hospice provider to actively interact and coordinate services with other IHCP providers providing nonhospice services. The IHCP hospice member’s medical care for the nonterminal conditions can be met by one of the following methods:

- Outpatient physician services
- Inpatient and outpatient hospital admissions
- Emergency admission to an NF from a private home

The hospice provider’s coordination and billing responsibilities for each treatment option are described in the following paragraphs. The provider billing for the treatment of the nonterminal illness must obtain PA for the nonhospice services.

**Outpatient Physician Services for Nonterminal Condition**

If the IHCP hospice member requires outpatient physician services for conditions unrelated to the terminal condition, the member can obtain services from the physician and the physician must bill the IHCP directly for those services.

A hospice provider’s coordination responsibilities for treatment of the nonterminal condition are case-specific. The following guidelines provide clarification for hospice providers. If the hospice patient has no physician to treat the nonterminal condition, then the hospice provider must find a physician to treat the nonterminal condition. To ensure that the hospice member is not billed for those services, the hospice provider must ensure that the physician is enrolled as an IHCP provider. The hospice provider’s coordination responsibilities also include advising the physician that the individual is an IHCP hospice member to ensure that any treatment for the nonterminal condition does not compromise the patient’s hospice care.

**Inpatient or Outpatient Hospital Admissions for Nonterminal Conditions**

If the IHCP hospice member requires inpatient or outpatient admission to a hospital for conditions unrelated to the terminal illness, the hospital must bill the IHCP directly for those services. The hospice provider coordinates the inpatient or outpatient hospital services.

A hospice provider’s coordination responsibilities for treatment of the nonterminal condition are case-specific. The following guidelines provide clarification for hospice providers. If the hospice patient currently does not receive treatment for the nonterminal condition, then the hospice provider must make arrangements to find a hospital where the hospice patient can receive treatment for the nonterminal condition. To ensure that the hospice member is not billed for those services, the hospice provider must ensure that the hospital physician, the hospital’s other medical service group, and the hospital are enrolled as IHCP hospice providers. The hospice provider’s coordination responsibilities also include advising the hospital’s medical personnel providing treatment for the nonterminal condition that the individual is an IHCP hospice member to ensure that any treatment for the nonterminal condition does not compromise the patient’s hospice care.
If the IHCP hospice member is admitted to the hospital from a private home, the hospice provider must submit to the ADVANTAGE Health Solutions-FFS a Change in Status of Medicaid Hospice Patient State Form 48732 (4/98)/OMPP 0010. This form reflects the hospice member’s change in normal residence from a private home to the hospital. The same form must be completed once the hospice member is discharged from the hospital to either another institutional care setting or to a private home.

Refer to the following provider bulletins for more information about treatment and reimbursement of the nonterminal conditions for hospice members:

• The IHCP provider bulletin BT199924, Treatment for Non-Terminal Conditions for Hospice Recipients Admitted to a Nursing Facility After a Hospital Stay
• The IHCP provider bulletin BT199925, Policies and Procedures on Medicaid Prior Authorization and Reimbursement for the Treatment of the Medicaid Hospice Recipient’s Non-Terminal Conditions

See Appendix B for a complete list of referenced IHCP banner pages, bulletins, and newsletters.

**Submission of the Medicaid Hospice Discharge State Form 48734 (R/12-02)/OMPP 0008 and ADVANTAGE Health Solutions-FFS Authorization Procedures**

All IHCP-enrolled hospice providers are required to notify the IHCP of a member’s date of death. To facilitate paperwork for IHCP-enrolled hospice providers and to ensure that ADVANTAGE Health Solutions-FFS staff time is maximized when processing hospice paperwork for new hospice members and recertifications, the OMPP has provided a directive to ADVANTAGE Health Solutions-FFS:

• The ADVANTAGE Health Solutions-FFS hospice analyst processes the hospice certification paperwork. If IndianaAIM has a date of death on the member eligibility screen, the ADVANTAGE Health Solutions-FFS hospice analyst enters the date of death at the time of the initial hospice certification or the processing of hospice recertifications if the forms have been properly completed to meet IHCP program guidelines. The date of death in IndianaAIM is provided by the local DFR state eligibility consultant.

• The ADVANTAGE Health Solutions-FFS hospice analyst suspends the paperwork with a prior authorization notice requesting the hospice provider submit the Medicaid Hospice Discharge State Form 48734 (R/12-02)/OMPP 0008 retroactively to ADVANTAGE Health Solutions-FFS by mail or by fax.

• If the date of death entered by the ADVANTAGE Health Solutions-FFS hospice analyst does not match the date of death recorded by the hospice provider, it is the responsibility of the hospice provider to coordinate with the local DFR office to correct this discrepancy. The local DFR office has procedures in place to contact the Indiana Client Eligibility System (ICES) help desk if the problem cannot be corrected at the local DFR office. When the discrepancy is corrected, the hospice provider can request a correction of the hospice LOC from ADVANTAGE Health Solutions-FFS. The local DFR office requires the death certificate to correct this matter.

• If the hospice provider encounters an impasse with DFR in the correction of the date of death discrepancy, the provider may contact the FSSA Hospice Program director at (317) 0233-1956.

IHCP-enrolled hospice providers are encouraged to review current procedures to ensure that hospice staff does not incorrectly submit Medicaid Hospice Discharge State Form 48734 (R/12-02)/OMPP 0008 for members not enrolled in the IHCP hospice benefit.
Noncancerous Hospice

Hospice services refer to a healthcare provider that owns or operates a hospice program and/or facility, which uses an interdisciplinary team directed by a licensed physician. These programs provide planned and continuous care for hospice program patients and their families. Hospice programs are designed to alleviate the physical, emotional, social, and spiritual needs of an individual who is experiencing the last phase of a terminal illness or disease. The diagnostic information in this section was researched from the following organizations: American Academy of Neurology, American College of Cardiology, American Heart Association, American Lung Association, American Psychiatric Association, National Institute of Neurological Disorders and Stroke, Renal Physicians Association and American Society of Nephrology, and the U.S. National Library of Medicine and National Institutes of Health.

Coverage Criteria

Hospice care is dependent upon a physician certification stating a member's prognosis of life expectancy is six months or less, if the terminal illness runs its normal course. In addition, the services provided in hospice care must be reasonable and meet medical necessity for the palliation or management of the terminal illness. Coverage for hospice care is strongly dependent on documentation of the member's condition as recorded in the provider’s records. Documentation is used in the prior authorization and review process to determine the presence of medical necessity. Each case will be evaluated on its own merit. The existence of documented comorbidities, as well as the documentation of decline in the member's health status, will be used in the evaluation. Existence of a patient advance directive should also be taken into consideration.

The IHCP will use existing medical documentation submitted by the hospice provider to determine medical necessity for hospice. Existing labs and other forms of medical tests may be helpful to determine appropriateness for hospice care and may be requested of the provider if such documentation exists; however, the IHCP would not expect the patient to undergo invasive tests at the end of life unless absolutely necessary to validate a prognosis. The IHCP and its contractors are not prevented from requesting medical documentation about any hospice member at any point during that member’s enrollment in the IHCP. This practice is consistent with the IHCP Provider Agreement.

Amyotrophic Lateral Sclerosis (ALS)

The following information is for general diagnosis and consideration of medical necessity for ALS:

1. ALS tends to progress in a linear fashion over time; therefore, the overall rate of decline in each patient is fairly constant and predictable, unlike many other noncancerous diseases.

2. No single variable deteriorates at a uniform rate in all patients; therefore, multiple clinical parameters are required to judge the progression of ALS.

3. Although ALS usually presents in a localized anatomical area, the location of initial presentation does not correlate with survival time. By the time patients become end-stage, muscle denervation has become widespread, affecting all areas of the body, and initial predominance patterns do not persist.

4. Progression of disease differs markedly from patient to patient. Some patients decline rapidly and die quickly; others progress more slowly. For this reason, the history of the rate of progression in individual patients is important to predict prognosis.

5. In end-stage ALS, two factors are critical in determining prognosis. These factors are the ability to breathe and the ability to swallow. The former can be managed by artificial ventilation, and the latter by gastrostomy or other artificial feeding, unless the patient has recurrent aspiration pneumonia.
While not necessarily a contraindication to hospice care, the decision to institute either artificial ventilation or artificial feeding will significantly alter a six-month prognosis.

6. Examination by a neurologist within three months of assessment for hospice is advised, both to confirm the diagnosis and to assist with prognosis.

All members must demonstrate a rapid progression of ALS within the 12 months preceding initial hospice certification. All of the following clinical findings document this progression:

1. Progression from independent ambulation to wheelchair, or to bed-bound status
2. Progression from normal to barely intelligible or unintelligible speech
3. Progression from normal to pureed diet
4. Progression from independence in most or all activities of daily living (ADLs) to needing maximum assistance by caretaker in all ADLs

All members must demonstrate critically impaired breathing capacity by the following characteristics occurring within 12 months preceding initial hospice certification. Presence of any of the following will support a terminal illness status:

1. Vital capacity is less than 30 percent of normal
2. Significant dyspnea at rest
3. Requiring supplemental oxygen at rest
4. Patient declines artificial ventilation

All members must demonstrate critical nutritional impairment by all the following characteristics occurring within 12 months preceding initial hospice certification:

1. Oral intake of nutrients and fluids insufficient to sustain life
2. Continuing weight loss
3. Dehydration or hypovolemia
4. Absence of artificial feeding methods

All members must demonstrate life-threatening complications by one of the following characteristics occurring within 12 months preceding initial hospice certification.

1. Recurrent aspiration pneumonia (with or without tube feedings)
2. Upper urinary tract infection, such as pyelonephritis
3. Sepsis
4. Fever recurrent after antibiotic therapy

Table 6.5 includes the only ICD-9-CM code for ALS. This is the only code appropriate for ALS hospice services.

Table 6.5 – ALS Diagnosis

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>335.20</td>
<td>Amyotrophic lateral sclerosis</td>
</tr>
</tbody>
</table>
**Alzheimer’s Disease and Related Disorders**

Alzheimer’s disease and related disorders must support a prognosis of six months or less to be considered to meet medical necessity for hospice services. The identification of specific structural impairments, functional impairments, and relevant activity limitations serve as the basis for palliative interventions and care planning. The structural and functional impairments associated with a primary diagnosis of Alzheimer’s disease may be complicated by comorbid and/or secondary conditions. Documentation of structural impairments, functional impairments, and activity limitations facilitates the selection of intervention strategies and provides objective criteria for determining the effects of such interventions.

**Comorbid Conditions**

The significance of a given comorbid condition is defined by the structural and functional impairments together with any limitation in activity related to the comorbid condition. Ultimately, the combined effect of the Alzheimer’s disease (stage 7) and any comorbid condition should be such that most members with Alzheimer’s disease and similar impairments would have a prognosis of six months or less.

**Secondary Conditions**

Secondary conditions, such as delirium and pressure ulcers, are directly related to a primary condition. Secondary conditions may be described by defining the structural and/or functional impairments together with any limitation in activity, or related to the secondary condition. The occurrence of secondary conditions in members with Alzheimer’s disease may be facilitated by the presence of impairments in body functions such as mental functioning and movement functions. Such functional impairments may contribute to the increased incidence of secondary conditions such as delirium and pressure ulcers. Secondary conditions themselves may be associated with a new set of structural and/or functional impairments that may respond to treatment. The combined effects of the Alzheimer’s disease and any secondary condition may indicate a prognosis of six months or less.

**FAST Scale**

The Reisberg Functional Assessment Staging (FAST) Scale may be used to assess the functional level of members with Alzheimer’s Disease and establish a prognosis of six months or less. Members who have a FAST score of 7 and specific comorbid or secondary conditions, may meet medical necessity.

Table 6.6 includes appropriate ICD-9-CM codes for Alzheimer’s disease and related diagnoses that may meet medical necessity for noncancerous hospice services.

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>291.2</td>
<td>Alcohol induced persisting dementia</td>
</tr>
<tr>
<td>331.0</td>
<td>Alzheimer's disease</td>
</tr>
<tr>
<td>331.11</td>
<td>Pick's disease</td>
</tr>
<tr>
<td>331.2</td>
<td>Senile degeneration of brain</td>
</tr>
</tbody>
</table>

**Cardiopulmonary Disease**

Cardiopulmonary conditions are associated with impairments, activity limitations, and disability. Their impact on any given individual depends on the individual’s overall health status. Health status...
mediates the much studied relationship between ICD-9-CM diagnosis and care outcomes. Health status includes environmental factors, such as the availability of palliative care services. The objective of this policy is to present a framework for identifying, documenting, and communicating the unique health care needs of individuals with cardiopulmonary conditions and thus promote the overall goal of the right care for every person, every time.

Cardiopulmonary conditions may support a prognosis of six months or less under many clinical scenarios. Indiana Health Coverage Programs (IHCP) rules and regulations addressing hospice services require the documentation of sufficient “clinical information and other documentation” to support the certification of individuals as having a terminal illness with a life expectancy of six or fewer months, if the illness runs its normal course. The identification of specific structural/functional impairments, together with any relevant activity limitations, should serve as the basis for palliative interventions and care-planning. Use of the International Classification of Functioning, Disability, and Health (ICF) to help identify and document the unique service needs of individuals with cardiopulmonary conditions is suggested, but not required.

The health status changes associated with cardiopulmonary conditions can be characterized using categories contained in the ICF. The ICF contains domains (for example, structures of cardiovascular and respiratory systems, functions of the cardiovascular and respiratory system, communication, mobility, and self-care) that allow for a comprehensive description of an individual’s health status and service needs. Information addressing relevant ICF categories, defined within each of these domains, should form the core of the clinical record and be incorporated into the care plan, as appropriate.

Additionally, the care plan may be impacted by relevant secondary and/or comorbid conditions. Secondary conditions are directly related to a primary condition. In the case of cardiopulmonary conditions, examples of secondary conditions could include delirium, pneumonia, stasis ulcers, and pressure ulcers. Comorbid conditions affecting beneficiaries with cardiopulmonary conditions are, by definition, distinct from the primary condition itself. An example of a comorbid condition would be end-stage renal disease (ESRD).

The important roles of secondary and comorbid conditions are described below to facilitate their recognition and assist providers in documenting their impact. The identification and documentation of relevant secondary and comorbid conditions, together with the identification and description of associated structural/functional impairments, activity limitations, and environmental factors would help establish hospice eligibility and maintain a beneficiary-centered plan of care.

**Secondary Conditions**

Cardiopulmonary conditions may be complicated by secondary conditions. The significance of a given secondary condition is best described by defining the structural/functional impairments – together with any limitation in activity and restriction in participation – related to the secondary condition. The occurrence of secondary conditions in beneficiaries with cardiopulmonary conditions results from the presence of impairments in such body functions as heart/respiratory rate and rhythm, contraction force of ventricular muscles, blood supply to the heart, sleep functions, and depth of respiration. These impairments contribute to the increased incidence of secondary conditions such as delirium, pneumonia, stasis ulcers, and pressure ulcers observed in Medicaid beneficiaries with cardiopulmonary conditions. Secondary conditions themselves may be associated with a new set of structural/functional impairments that may or may not respond/be amenable to treatment.

Ultimately, to support a hospice plan of care, the combined effects of the primary cardiopulmonary condition and any identified secondary condition(s) should be such that most beneficiaries with the identified impairments would have a prognosis of six months or less.
Comorbid Conditions

The significance of a given comorbid condition is best described by defining the structural/functional impairments – together with any limitation in activity and restriction in participation – related to the comorbid condition. For example, a beneficiary with a primary cardiopulmonary condition and ESRD could have specific ESRD-related impairments of water, mineral and electrolyte balance functions coexisting with the cardiopulmonary impairments associated with the primary cardiopulmonary condition, such as aortic stenosis, chronic obstructive pulmonary disease, or heart failure.

Ultimately, to support a hospice plan of care, the combined effects of the primary cardiopulmonary condition and any identified comorbid condition(s) should be such that most beneficiaries with the identified impairments would have a prognosis of six months or less.

The documentation of structural/functional impairments and activity limitations facilitate the selection of the most appropriate intervention strategies (palliative/hospice vs. long-term disease management) and provide objective criteria for determining the effects of such interventions. The documentation of these variables is thus essential in the determination of reasonable and necessary IHCP Hospice Services.

Heart Disease

The intent of the criteria provided in this section is to serve as a guideline that will assist in the determination of medical necessity of hospice services for persons with heart disease.

Member may have current findings from 1 and 2 listed below. Findings from 3 are primarily supportive documentation for medical necessity.

1. Member has been treated with diuretics and vasodilators, which may include angiotensin-converting enzymes (ACE) inhibitors or the combination of hydralazine and nitrates. If side effects, such as hypotension or hyerkalemia, prohibit the use of ACE inhibitors or the combination of hydralazine and nitrates, the documentation submitted must reflect this reasoning. If a member has angina pectoris, at rest, resistant to standard nitrate therapy and is not a candidate for or declines invasive procedures, these factors must be documented in the medical records. Member has significant findings of recurrent congestive heart failure at rest and is classified as New York Heart Association Class III or IV. Class III or IV patients with heart disease have an inability to carry on any physical activity without discomfort. Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased. Class III heart failure (moderate) is defined as the marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnea. Class IV heart failure (severe) is defined as the inability to carry out any physical activity without discomfort along with symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased.

2. Congestive heart failure may be documented by an ejection fraction of <40 percent. Documentation of an ejection fraction is not required if not already available.

3. Documentation of the following findings will support eligibility for hospice care:
   a. Treatment of resistant symptomatic supraventricular or ventricular arrhythmias
   b. History of cardiac arrest or resuscitation
   c. History of unexplained syncope
   d. Brain embolism of cardiac origin
   e. Concomitant HIV disease
   f. Documentation of ejection fraction 40 percent or less

Table 6.7 includes appropriate ICD-9-CM codes for heart disease diagnoses that may meet medical necessity for noncancerous heart disease hospice services.
Table 6.7 – Heart Disease Diagnoses

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>411.1</td>
<td>Intermediate coronary syndrome</td>
</tr>
<tr>
<td>412</td>
<td>Old myocardial infarction</td>
</tr>
<tr>
<td>428.0</td>
<td>Congestive heart failure, unspecified</td>
</tr>
<tr>
<td>428.1</td>
<td>Left heart failure</td>
</tr>
<tr>
<td>428.30</td>
<td>Diastolic heart failure, unspecified</td>
</tr>
<tr>
<td>428.9</td>
<td>Heart failure, unspecified</td>
</tr>
</tbody>
</table>

Pulmonary Disease

The intent of the criteria provided in this section is to serve as a guideline that will assist in the determination of medical necessity of hospice services for persons with pulmonary disease.

Member may have current findings from 1-5 listed below. Findings from 6-9 primarily support documentation for medical necessity.

1. Severe chronic lung disease as documented by both a and b:
   a. Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, which results in decreased functional capacity, such as bed-to-chair existence, fatigue, and cough
   b. Prior visits to the emergency department or hospitalizations, which have increased over time, for pulmonary infections and/or respiratory failure indicating end-stage pulmonary disease

2. Progression of end-stage pulmonary disease as evidenced by the following:
   a. Prior increasing visits to the emergency department
   b. Prior hospitalizations for pulmonary infections
   c. Respiratory failure (documentation of FEV1 (forced expiratory volume after 1 second) < 30 percent is objective evidence for disease progression that may not be necessary to obtain)

3. Swelling to the lower extremities, which may be indicative of cor pulmonale or right-sided heart failure secondary to pulmonary disease; for example, not secondary to left heart disease or valvulopathy

4. Hypoxemia

5. Long-term oxygen therapy

6. Unintentional progressive weight loss of greater than 10 percent of body weight over the preceding six months

7. Resting tachycardia >100/min.

8. Previous use of ventilator during hospital admissions

9. Pulmonary hypertension

There is no ICD-9-CM diagnosis code for end-stage pulmonary disease. Diagnoses for pulmonary disease, which lead to end-stage pulmonary disease, will be covered with appropriate documentation that supports medical necessity.

Table 6.8 includes appropriate ICD-9-CM codes for pulmonary disease diagnoses that may meet medical necessity for noncancerous pulmonary disease hospice services.
Table 6.8 – Cardiopulmonary Disease Diagnoses

<table>
<thead>
<tr>
<th>ICD-9 CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>416.0</td>
<td>Primary Pulmonary Hypertension</td>
</tr>
<tr>
<td>416.9</td>
<td>Cor Pulmonale, unspecified</td>
</tr>
<tr>
<td>496</td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
</tr>
<tr>
<td>799.02</td>
<td>Hypoxemia</td>
</tr>
<tr>
<td>799.1</td>
<td>Respiratory Arrest</td>
</tr>
</tbody>
</table>

**Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS)**

Member must have current findings from 1 and 2 listed below. Findings from 3 primarily support documentation for medical necessity.

1. CD4+ Count less than or equal to 200 cells/mm³ or persistent viral load >100,000 copies/ml, plus one of the following findings:
   a. CNS lymphoma
   b. Wasting (loss of 33 percent lean body mass), untreated, or not responsive to treatment
   c. Mycobacterium avium complex bacteremia, untreated, unresponsive to treatment, or treatment refused
   d. Progressive multifocal leukoencephalopathy
   e. Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy
   f. Visceral Kaposi's sarcoma unresponsive to therapy
   g. Renal failure in the absence of dialysis
   h. Cryptosporidium infection
   i. Toxoplasmosis, unresponsive to therapy

2. Decreased performance status, as measured by the Karnofsky Performance Status Scale, of < 50 percent

3. Documentation of the following findings will support eligibility for hospice care:
   a. Chronic persistent diarrhea for one year
   b. Persistent serum albumin <2.5 gm/dl
   c. Age > 50 years old
   d. Absence of antiretroviral, chemotherapeutic, and prophylactic drug therapy related specifically to HIV disease
   e. Toxoplasmosis
   f. Congestive heart failure, symptomatic at rest
   g. Advanced AIDS dementia complex
   h. Concomitant, active substance abuse

Table 6.9 includes the appropriate ICD-9-CM code for HIV diagnosis that meets medical necessity for noncancerous HIV hospice services. No other HIV-related diagnosis will be covered. Table 6.10 illustrates examples of ICD-9-CM codes that are noncovered.

Table 6.9 – HIV Diagnosis

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>042</td>
<td>Human immunodeficiency virus (HIV) disease</td>
</tr>
</tbody>
</table>
Table 6.10 – Examples of Noncovered HIV ICD-9-CM Codes

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>795.71</td>
<td>Nonspecific serologic evidence of human immunodeficiency virus (HIV)</td>
</tr>
<tr>
<td>V08</td>
<td>Asymptomatic human immunodeficiency virus (HIV) infection status</td>
</tr>
</tbody>
</table>

**Liver Disease**

Members must have current findings from 1 and 2 listed below. Findings from 3 primarily support documentation for medical necessity.

1. The member must present with findings from a and b:
   a. Prothrombin time prolonged more than five seconds over control, or International Normalized Ratio (INR) >1.5
   b. Serum albumin <2.5 gm/dl

2. End-stage liver disease is present and the patient shows at least one of the following:
   a. Ascites, refractory to treatment or patient noncompliant
   b. Spontaneous bacterial peritonitis
   c. Hepatorenal syndrome (elevated creatinine and BUN with oliguria (<400 ml/day) and urine sodium concentration <10 meq/l)
   d. Hepatic encephalopathy, refractory to treatment, or patient noncompliant
   e. Recurrent variceal bleeding, despite intensive therapy

3. Documentation of the following findings will support eligibility for hospice care:
   a. Progressive malnutrition
   b. Muscle wasting with reduced strength and endurance
   c. Continued active alcoholism (>80 gm ethanol/day)
   d. Hepatocellular carcinoma
   e. HBsAg (Hepatitis B) positive
   f. Hepatitis C refractory to interferon treatment

Members awaiting a liver transplant who otherwise fit the noncancerous hospice criteria may receive hospice benefits. However, if a donor organ is procured, the member must be discharged from hospice services.

Table 6.11 includes appropriate ICD-9-CM liver disease diagnoses that meet medical necessity for noncancerous liver disease hospice services.

Table 6.11 – Liver Disease Diagnoses

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>155.0</td>
<td>Malignant neoplasm of liver, primary</td>
</tr>
<tr>
<td>571.2</td>
<td>Alcoholic cirrhosis of liver</td>
</tr>
<tr>
<td>571.40</td>
<td>Chronic hepatitis, unspecified</td>
</tr>
<tr>
<td>571.41</td>
<td>Chronic persistent hepatitis</td>
</tr>
<tr>
<td>571.49</td>
<td>Chronic hepatitis, other</td>
</tr>
<tr>
<td>571.5</td>
<td>Cirrhosis of liver without mention of alcohol</td>
</tr>
<tr>
<td>571.6</td>
<td>Biliary cirrhosis</td>
</tr>
<tr>
<td>572.2</td>
<td>Hepatic coma</td>
</tr>
<tr>
<td>572.4</td>
<td>Hepatorenal syndrome</td>
</tr>
<tr>
<td>573.3</td>
<td>Hepatitis, unspecified</td>
</tr>
</tbody>
</table>
Renal Disease

Members with acute renal failure must have current findings from 1 and 2 listed below. Findings from 3 primarily support documentation for medical necessity.

1. Creatinine clearance <10 cc/min (<15 cc/min for diabetics)
2. Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics)

3. Comorbid conditions
   a. Mechanical ventilation
   b. Malignancy (other organ system)
   c. Intractable hyperkalemia (>7.0) not responsive to treatment
   d. Uremic pericarditis
   e. Hepatorenal syndrome
   f. Intractable fluid overload, not responsive to treatment
   g. Immunosuppression/acquired immunodeficiency syndrome (AIDS)
   h. Albumin <3.5 gm/dl
   i. Cachexia
   j. Platelet count <25,000
   k. Disseminated intravascular coagulation
   l. Gastrointestinal bleeding
   m. Chronic lung disease
   n. Advanced cardiac disease
   o. Advanced liver disease
   p. Sepsis

Member with chronic renal failure must have current findings from 1 and 2 listed below. Findings from 3 primarily support documentation for medical necessity.

1. Creatinine clearance <10cc/min (<15 cc/min for diabetics)
2. Serum creatinine > 8.0 mg/dl (>6.0 mg/dl for diabetics)

3. Signs and symptoms or renal failure
   a. Uremia
   b. Oliguria (<400 cc/day)
   c. Intractable hyperkalemia (>7.0) not responsive to treatment
   d. Uremic pericarditis
   e. Hepatorenal syndrome
   f. Intractable fluid overload, not responsive to treatment

Table 6.12 includes appropriate ICD-9-CM codes for kidney disease diagnoses that meet medical necessity for noncancerous liver disease hospice services.

Table 6.12 – Renal Diagnoses

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>403.11</td>
<td>Hypertensive chronic kidney disease, benign, with chronic kidney disease Stage V or end-stage renal disease</td>
</tr>
<tr>
<td>584.5</td>
<td>Acute renal failure with lesion of tubular necrosis</td>
</tr>
<tr>
<td>584.6</td>
<td>Acute renal failure with lesion of renal cortical necrosis</td>
</tr>
<tr>
<td>584.7</td>
<td>Acute renal failure with lesion of renal medullary [papillary] necrosis</td>
</tr>
<tr>
<td>584.8</td>
<td>Acute renal failure with other specified pathological lesion in kidney</td>
</tr>
<tr>
<td>584.9</td>
<td>Acute renal failure, unspecified</td>
</tr>
</tbody>
</table>
### Stroke and Coma

#### Stroke

The medical criteria listed below would support a terminal prognosis for members with a diagnosis of stroke. Medical criteria are indicators of functional and nutritional status that support medical necessity for hospice services.

1. Palliative Performance Scale (PPS) of 40
   a. Degree of ambulation (for example, bedridden)
   b. Activity and extent of disease (for example, unable to work and extensive disease)
   c. Inability to do self-care (for example, assistance needed) or the incapability of regaining the ability to do self-care
   d. Food and fluid intake (for example, greatly reduced or reduced to the point of inability to maintain homeostasis)
   e. State of consciousness (for example, fully conscious, drowsy, or confused)

2. Inability to maintain hydration and caloric intake with one of the following.
   a. Weight loss > 10 percent during previous six months
   b. Weight loss > 7.5 percent in previous three months
   c. Serum albumin > 2.5 gm/dl
   d. Current history of pulmonary aspiration without effective response to intervention by a speech/language therapist
   e. Calorie counts documenting inadequate caloric and fluid intake

3. Determination of the inability to improve by a neurologist, neurosurgeon, internal medicine specialist, or family practitioner, along with a review by a physical or occupational therapist

If a member does not meet the medical criteria, documentation must describe a relevant comorbidity and rapid decline of functional abilities. For example, a stroke patient with a comorbidity, such as Alzheimer’s, Parkinson’s disease, adult failure to thrive syndrome, or ALS, may not be able to regain functionality.

#### Coma

Medical criteria listed below may support a terminal prognosis for members with a diagnosis of coma when any three of the following conditions are met on day three of a coma:

1. Abnormal brain stem response
2. Absent verbal response
3. Absent withdrawal response to pain
4. Serum creatinine > 1.5 mg/dl

Medical criteria would be based on a neurological evaluation, which may include electroencephalography (EEG), magnetic resonance imaging (MRI), or computed axial tomography (CT scan).

Table 6.13 includes appropriate ICD-9-CM codes for stroke and coma diagnoses that meet medical necessity for noncancerous stroke or coma hospice services.
<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>430</td>
<td>Subarachnoid hemorrhage</td>
</tr>
<tr>
<td>431</td>
<td>Intracerebral hemorrhage</td>
</tr>
<tr>
<td>432</td>
<td>Other and unspecified intracranial hemorrhage</td>
</tr>
<tr>
<td>432.0</td>
<td>Nontraumatic extradural hemorrhage</td>
</tr>
<tr>
<td>432.1</td>
<td>Subdural hemorrhage</td>
</tr>
<tr>
<td>432.9</td>
<td>Unspecified intracranial hemorrhage</td>
</tr>
<tr>
<td>433.01</td>
<td>Occlusion and stenosis of basilar artery, with cerebral infarction</td>
</tr>
<tr>
<td>433.11</td>
<td>Occlusion and stenosis of carotid artery, with cerebral infarction</td>
</tr>
<tr>
<td>433.21</td>
<td>Occlusion and stenosis of vertebral artery, with cerebral infarction</td>
</tr>
<tr>
<td>433.31</td>
<td>Occlusion and stenosis of arteries multiple and bilateral, with cerebral infarction</td>
</tr>
<tr>
<td>433.81</td>
<td>Occlusion and stenosis of other specified precerebral artery, with cerebral infarction</td>
</tr>
<tr>
<td>433.91</td>
<td>Occlusion and stenosis of unspecified precerebral artery, with cerebral infarction</td>
</tr>
<tr>
<td>434.01</td>
<td>Cerebral thrombosis, with cerebral infarction</td>
</tr>
<tr>
<td>434.11</td>
<td>Cerebral embolism, with cerebral infarction</td>
</tr>
<tr>
<td>434.91</td>
<td>Cerebral artery occlusion, unspecified, with cerebral infarction</td>
</tr>
<tr>
<td>436</td>
<td>Acute, but ill-defined, cerebrovascular disease</td>
</tr>
<tr>
<td>780.01</td>
<td>Coma</td>
</tr>
<tr>
<td>850.4</td>
<td>Concussion with prolonged loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.05</td>
<td>Cerebral laceration and contusion; cortex (cerebral) contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.15</td>
<td>Cerebral laceration and contusion; cortex (cerebral) contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.25</td>
<td>Cerebral laceration and contusion; cortex (cerebral) laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.35</td>
<td>Cerebral laceration and contusion; cortex (cerebral) laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.45</td>
<td>Cerebral laceration and contusion; cerebellar or brain stem contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.55</td>
<td>Cerebral laceration and contusion; cerebellar or brain stem contusion with open intracranial wound with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>ICD-9-CM Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>851.65</td>
<td>Cerebral laceration and contusion; cerebellar or brain stem laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.75</td>
<td>Cerebral laceration and contusion; cerebellar or brain stem laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.85</td>
<td>Cerebral laceration and contusion; other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>851.95</td>
<td>Cerebral laceration and contusion; other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>852.05</td>
<td>Subarachnoid hemorrhage following injury without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>852.15</td>
<td>Subarachnoid hemorrhage following injury with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness without return to pre-existing conscious level</td>
</tr>
<tr>
<td>852.25</td>
<td>Subdural hemorrhage following injury without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>852.35</td>
<td>Subdural hemorrhage following injury with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>852.45</td>
<td>Extradural hemorrhage following injury without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>852.55</td>
<td>Extradural hemorrhage following injury with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>853.05</td>
<td>Other and unspecified intracranial hemorrhage following injury without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>853.15</td>
<td>Other and unspecified intracranial hemorrhage following injury with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>854.05</td>
<td>Intracranial injury of other and unspecified nature without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>854.15</td>
<td>Intracranial injury of other and unspecified nature with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>997.02</td>
<td>Nervous system complications; iatrogenic cerebrovascular infarction or hemorrhage</td>
</tr>
</tbody>
</table>
Adult Failure to Thrive Syndrome

The following information is for general diagnosis and consideration of medical necessity for adult failure to thrive syndrome:

1. The adult failure to thrive syndrome is characterized by unexplained weight loss, malnutrition, and disability.

2. This syndrome has been associated with multiple primary conditions (for example, infections and malignancies) but always includes two defining conditions, those being malnutrition and disability.

3. The syndrome may be an irreversible progression in the member’s malnutrition or worsening of disability despite therapy (for example, failure of treatment intended to affect the primary condition responsible for the patient’s clinical presentation).

4. Comorbid conditions may increase the progression of this syndrome and thus should be identified and addressed.

The following medical criteria would support a terminal prognosis of adult failure to thrive syndrome:

1. Nutritional impairment should be significant enough to have an impact on the member’s weight.
   a. Member’s Body Mass Index (BMI) is below 22kg/m².
   b. Member is either refusing enteral/parenteral nutritional support or has not responded to such nutritional support, despite an adequate caloric intake.

2. Disability associated with adult failure to thrive should be such that the member is significantly disabled, which would be demonstrated by a Karnofsky or Palliative Performance scale value less than or equal to 40 percent.

BMI and the level of disability of the member should be determined using measurements and observations made within six months (180 days) of the most recent certification/recertification date. If enteral nutritional support has been instituted prior to consideration for hospice and will be continued, the BMI and levels of disability should be determined using measurements and observations at the time of the initial certification and at each subsequent recertification for hospice. At the time of recertification, recumbent measurements such as mid-arm muscle area in cm² may be used instead of BMI measurement, so long as there is documentation proving the necessity of such replacement in the member’s file. Also, in the event a member with nutritional impairment does not meet the criteria in section B, but is still considered eligible for noncancerous hospice care, may have an alternative diagnosis that adequately describes the clinical circumstances of the member (for example, 783.2 “abnormal loss of weight” and 799.4 “Cachexia”).

Following are the documentation requirements needed for noncancerous hospice admission of members with adult failure to thrive syndrome.

1. Documentation supporting the medical necessity should be legible, maintained in the member’s medical records, and be available for review upon request.

2. Documentation certifying terminal status must contain sufficient information to confirm that the status is based on the criteria of medical necessity.

3. Measurement of BMI and functional status of the member using the Karnofsky scale must be documented every 180 days for recertification of hospice benefits.

Table 6.14 includes appropriate ICD-9-CM code for diagnoses that meet medical necessity for noncancerous adult failure to thrive syndrome.
Table 6.14 – Adult Failure to Thrive Syndrome

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>783.41</td>
<td>Failure to thrive</td>
</tr>
<tr>
<td>783.7</td>
<td>Adult failure to thrive</td>
</tr>
<tr>
<td>799.3</td>
<td>Disability unspecified</td>
</tr>
<tr>
<td>799.89</td>
<td>Other ill-defined conditions</td>
</tr>
<tr>
<td>799.9</td>
<td>Other unknown and unspecified cause of morbidity or mortality</td>
</tr>
</tbody>
</table>

**Prior Authorization**

The IHCP consults hospice criteria published by the fiscal intermediary for Indiana Medicare hospice providers, Palmetto Government Benefits Administrators, LLC. Palmetto has established these guidelines as a matter of protocol for medical criteria. Providers are to use current professional guidelines, including the Local Coverage Determination (LCD), to determine when hospice services meet medical necessity. Hospice providers are reminded that the IHCP recognizes that the LCD is only a guideline to determine when members may be appropriate for hospice or palliative services. The LCD is not meant to replace the overall clinical evaluation by the hospice provider, IHCP, or its contractor, when evaluating the unique clinical condition of each hospice member.

While the IHCP requires hospice providers to request prior authorization (PA) for members at the beginning of each hospice benefit period, the IHCP and its contractors are not prevented from requesting medical documentation about any hospice member at any point during that member’s enrollment in the IHCP. This practice is consistent with the IHCP provider agreement.

Any Medicaid member who is terminally ill and meets medical necessity criteria may receive services from an IHCP hospice provider. Hospice providers are required to comply with federal hospice regulations at 42 CFR Part 418 and the Balanced Budget Act of 1997, which requires hospice providers to list all hospice covered services in frequency and scope on the hospice plan of care necessary to treat the terminal illness and related conditions. Furthermore, hospice providers must provide care based on the medical acuity of the member at one of four distinct hospice levels of care:

- Routine home care
- Continuous home care
- General inpatient hospice care
- Inpatient hospice respite care

Hospice inpatient care must be provided in an inpatient unit or contracted inpatient facility that meets the parameters at 42 CFR Part 418.100 et al. Table 6.15 reflects Medicare LCD hospice guidelines and IHCP services.
### Table 6.15 – MRP Hospice Guidelines and IHCP Services

<table>
<thead>
<tr>
<th>Admission Criteria</th>
<th>Continued Services</th>
<th>Discharge Criteria</th>
<th>Covered IHCP Services</th>
<th>Noncovered IHCP Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prior authorization required</td>
<td>• IHCP physician certification</td>
<td>• Member dies</td>
<td>• All services stipulated within the plan of care must be reasonable and meet medical necessity for the palliation or management of the terminal illness and related conditions.</td>
<td></td>
</tr>
<tr>
<td>• Terminally ill with a life-expectancy of six months or less</td>
<td>• Clinical documentation supporting the member’s terminal condition for the first benefit period and indicating a decline since the last request period</td>
<td>• Member is determined to have a prognosis greater than six months</td>
<td>- Interdisciplinary team approach</td>
<td></td>
</tr>
<tr>
<td>• Recipient election statement</td>
<td>• If a decline has not occurred, the physician certification must provide information that distinguishes the member from other patients with the same disease who may be chronic but who are not terminal</td>
<td>• Member moves out of the service area</td>
<td>- Physician and nursing services</td>
<td></td>
</tr>
<tr>
<td>• IHCP physician certification</td>
<td>• Hospice plan of care must include services that are reasonable and meet medical necessity</td>
<td>• Safety of the member, other patients, or hospice staff is compromised</td>
<td>- Medical equipment and supplies</td>
<td></td>
</tr>
<tr>
<td>• Hospice plan of care must be signed by the medical director and two of the other disciplines listed</td>
<td>• If a decline has not occurred, the physician certification must provide information that distinguishes the member from other patients with the same disease who may be chronic but who are not terminal</td>
<td>• Member is admitted to a noncontracted nursing facility or noncontracted hospital where hospice cannot retain professional management</td>
<td>- Medicine for symptom control and pain relief</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Member moves out of the service area</td>
<td>- Short-term inpatient hospice care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Safety of the member, other patients, or hospice staff is compromised</td>
<td>- Home health aide and homemaker services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Member is determined to have a prognosis greater than six months</td>
<td>- Physical, occupational, and speech therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Member moves out of the service area</td>
<td>- Medical Social services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Safety of the member, other patients, or hospice staff is compromised</td>
<td>- Dietary counseling</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Member is determined to have a prognosis greater than six months</td>
<td>- Room and board under 405 IAC 1-16-4</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Member moves out of the service area</td>
<td>- Any service or supply specified in the member’s hospice plan of care if is a Medicare covered service</td>
<td></td>
</tr>
</tbody>
</table>

- Treatment to cure terminal illnesses
- Treatment from another hospice that was not arranged by the elected hospice
- Treatment from a non-elected hospice provider
- Duplicated services
Billing Requirements

Hospice providers are required to use hospice revenue code 651 when prior authorizing for these services. Providers are also required to use the Indiana Prior Review and Authorization Request Form. If any other revenue code is used, the ADVANTAGE hospice prior authorization reviewer will suspend the request pending correction by the provider. For billing purposes, providers are to use the most appropriate revenue code.

The total per diem amounts reimbursed to an IHCP-enrolled hospice provider are calculated according to the IHCP hospice member’s LOC. A member’s hospice LOC is covered in one of the following situations:

- Routine home hospice LOC in the private home
- Routine home hospice LOC in the nursing home
- Continuous home hospice LOC
- Continuous home hospice LOC in the nursing home
- Inpatient respite care for the private home members or nursing facility members
- General inpatient care for the private home members or nursing facility members

Indiana Health Coverage Programs

For members enrolled in the Hoosier Healthwise risk-based managed care (RBMC) program, the Healthy Indiana Plan (HIP), HIP-ESP Plan, or any other plan, providers must contact the member’s managed care organization (MCO) or plan administrator for more specific guidelines regarding their policies and prior authorization procedures. IHCP members enrolled in Care Select receive the same benefit coverage and are subject to the same limitations as members enrolled in traditional Medicaid fee-for-services (FFS).

Please refer to IHCP Provider Manual Chapter 1 for detailed information about the FFS, Care Select, and RBMC delivery systems.
Section 7: Reimbursement

Overview

Reimbursement for the Indiana Health Coverage Programs (IHCP) hospice benefit follows the methodology and levels established by the Centers for Medicare & Medicaid Services (CMS) for administration of the federal Medicare Hospice Program. IHCP hospice reimbursement rates are therefore based on Medicare reimbursement rates and methodologies, adjusted to disregard offsets attributed to Medicare premium amounts. The rates are adjusted for regional differences in wages using indices published by the CMS.

Method of Calculation

The total hospice per diem amounts reimbursed to a hospice provider are calculated according to the member’s level of care (LOC) and the member’s location of care as listed below:

- Routine home hospice care delivered in a private home, hospice per diem only
- Routine home hospice care delivered in a nursing facility (NF), hospice per diem plus room and board per diem
- Continuous home hospice care delivered in a private home, hospice per diem only
- Continuous home hospice care delivered in an NF, hospice per diem plus room and board per diem
- Respite care for private home members, hospice per diem only
- Inpatient hospice care for private home members or NF members who elect hospice care. The IHCP reimburses the hospice provider for the hospice per diem. There is no additional room and board per diem for this service.

These reimbursement rules are listed in Tables 7.1 and 7.2.

<table>
<thead>
<tr>
<th>Location of Service</th>
<th>Private Home</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospice Per Diem</td>
</tr>
<tr>
<td>Routine home</td>
<td>Yes</td>
</tr>
<tr>
<td>Continuous home</td>
<td>Yes</td>
</tr>
<tr>
<td>Respite</td>
<td>Yes</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location of Service</th>
<th>Nursing Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospice Per Diem</td>
</tr>
<tr>
<td>Routine home</td>
<td>Yes</td>
</tr>
<tr>
<td>Continuous home</td>
<td>Yes</td>
</tr>
<tr>
<td>Respite</td>
<td>No</td>
</tr>
<tr>
<td>Inpatient</td>
<td>No</td>
</tr>
</tbody>
</table>
Payment for Nursing Facility Residents

A distinction is made between private home and nursing facility LOC because hospice residents in an IHCP-certified NF who receive routine or continuous care services require an additional room and board per diem that is paid directly to the hospice provider. The IHCP pays 95 percent of the rate on file at the time the hospice claims is processed. The hospice provider is then responsible for paying the NF according to their contract. The contract must be in compliance with federal and state regulations.

Myers and Stauffer, LC is the long-term care (LTC) rate-setting contractor that sets the IHCP rates for NFs, hospices, home health agencies, and group homes. Hospice providers can obtain current rate information for a particular NF by accessing the Myers and Stauffer’s LTC Web site as follows:

2. Click the Long Term Care button located on the left, to go to the Long Term Care page.
3. Click the Nursing Facility tab.
4. Click the Reports tab to find a report titled Cumulative Rate Listing. Click on Cumulative Rate Listing.
5. Cumulative Rate Listing opens a report listing Medicaid rates for all Medicaid-certified NFs.

Medicaid rates are updated within 24 hours of the finalization.

Room and Board

The room and board rate is 95 percent of the NF case mix rate the IHCP paid to the NF for the dates of service the member was a resident of that facility.

In the context of the hospice benefit only, the term room and board includes personal care services not otherwise provided by the hospice and all assistance in the activities of daily living and socializing activities, administration of medication, maintaining the cleanliness of a resident’s room, and supervision and assistance in the use of durable medical equipment (DME) and prescribed therapies, as stated in 405 IAC 1-16-4.

Once an NF resident elects hospice, whether it is Medicare or IHCP, direct IHCP payment to the NF for the resident must be discontinued because the hospice provider becomes responsible for coordinating all the hospice care. The NF can no longer bill IHCP directly for room and board service once the NF resident elects the Medicare or the IHCP hospice benefit.

The implementation of the IHCP hospice benefit on July 1, 1997, changed the reimbursement for room and board services from 100 percent of the NF IHCP daily rate to 95 percent of the lowest NF per diem rate as described in 405 IAC 1-16-4. To ensure compliance with 405 IAC 1-16-4, IHCP-enrolled hospice providers and IHCP-enrolled NFs must comply with the following guidelines. Failure to comply with these procedures results in recoupment of funds.

• The NF and the hospice provider must first have a written agreement (contract) stating that the hospice provider takes full responsibility for the professional management of the individual’s hospice care. This contract must also specify that the NF agrees to provide room and board services as described in 42 USC 1396d(o)(3). Hospice services cannot be provided until both parties have finalized a contract.

• The NF resident must elect hospice by signing the Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005. The resident can designate an effective date for the election that is later than the date that the election form is signed. The effective date of the election form is the date that hospice services begin and payment by IHCP to the NF must stop.
Hospice providers must properly complete and send the election form, the physician certification form, and the plan of care as required by 405 IAC 5-34-5, 405 IAC 5-34-6, and 405 IAC 5-24-7 for the IHCP-only hospice member. All three forms must be submitted to the Hospice Authorization Unit within 10 days of the effective date of the election.

Hospice providers must properly complete the Hospice Authorization Notice for Dually Eligible Medicare/Medicaid Nursing Facility Residents State Form 51098 (3-03)/OMPP 0014 and attach a copy of the hospice agency’s election form, which reflects the date of hospice election and the signature of the member or the member’s representative. The form and the hospice agency’s election form must be submitted to the Hospice Authorization Unit within 10 days of the effective date of the election.

Failure to comply with these paperwork submission procedures is a violation of State and federal regulations because hospice providers are required to notify state Medicaid agencies when a dually eligible Medicare and IHCP hospice member elects, revokes, or changes hospice providers under both programs. Hospice providers are also reminded that the terms of the IHCP provider agreement that the hospice agency signed include but are not limited to the following:
– To abide by and comply with all federal and State statutes and regulations pertaining to the IHCP because they are amended from time to time
– To abide by the IHCP Provider Manual when amended as well as all provider bulletins and notices. Any amendments to the IHCP Provider Manual and all provider bulletins and notices are communicated to the provider and are binding upon receipt. Amendments, provider bulletins, and notices are posted to the IHCP Web site at www.indianamedicaid.com.

The IHCP reimbursement for NF room and board services to a hospice provider is 95 percent of the lowest nursing facility rate, or 95 percent of the NF case mix rate, effective October 1, 1998. Case mix rates are adjusted four times each calendar year in January, April, July, and October. The Office of Inspector General (OIG) has advised the IHCP that the hospice provider and the NF can negotiate payment of anywhere between 95 to 100 percent of the NF’s IHCP daily rate for room and board services in their contract. This allows the rates to be negotiated without concern about fraud or kickbacks.

Refer to IHCP provider bulletin **E98-30**, for more detailed information about reimbursement and survey issues with the IHCP hospice benefit. This bulletin was released to all IHCP-enrolled hospice providers and all IHCP-enrolled NFs in September 1998 and offers substantial information about additional reimbursement for NF residents who elect hospice. This bulletin provides general guidelines that NFs and hospice providers must follow when negotiating contracts for hospice care in NFs. See **Appendix R** for a complete list of referenced IHCP banner pages, bulletins, and newsletters.

**Decertification of a Nursing Facility and Payment of Room and Board**

When the Indiana State Department of Health (ISDH) decertifies a facility, the notification letter sent to the NF specifies the effective date that the IHCP reimbursement for NF care (including hospice room and board) must cease. IndianaAIM is updated to reflect the stop payment date. IHCP payment for hospice revenue codes 653, 654, and 659 must also cease.

**IHCP payment for any hospice services provided in an NF is subject to the NF being certified by the IHCP.** For example, if an NF is decertified for the entire month of October, the effect on hospice reimbursement is as follows:

- Hospice Revenue Codes 653 and 654 – hospice per diem plus nursing facility room and board for IHCP-only hospice members is not reimbursed for the month of October.
- Hospice Revenue Code 659 – room and board only for dually eligible Medicare/IHCP hospice member is not reimbursed for the month of October.

The NF is sent a notification letter that specifies the effective date that IHCP reimbursement ceases.
Upon completion of the follow-up survey by the ISDH, the NF is sent a notification letter that specifies the findings. If the ISDH has recertified the facility for IHCP reimbursement, the notification letter specifies the start date that IHCP reimbursement can resume.

While the hospice provider is not copied on the ISDH letters, the hospice does have the following mechanisms to ensure notification of an NF decertification:

- The hospice’s contract with the NF can address notification procedures that the nursing facility must follow to inform the hospice about any change in certification that affects IHCP reimbursement and any involvement in the transfer or discharge to the resident to another certified NF.
- The patient is also notified by the local Division of Family Resources (DFR) office about the NF’s decertification.

When an NF is decertified, the local ombudsman is also notified. The local ombudsman is involved in working with the family and the NF for the discharge or transfer of the resident to another facility.

Hospice providers can check the ISDH Web site at http://www.state.in.us/isdh to determine if an NF has been decertified.

**Payment of Room and Board for Date of Discharge**

Hospice and NF providers have asked many questions about whether the Office of Medicaid Policy and Planning (OMPP) pays for the NF room and board per diem for the day of admission to the NF and the day of discharge from the NF for the hospice member. The following paragraphs provide clarification about these reimbursement issues.

The OMPP pays 95 percent of the NF per diem rate for the hospice member’s day of admission to the NF. The OMPP does not pay the NF per diem or NF room and board services for the day a hospice member is discharged from the NF. When a hospice member dies in an NF, the hospice member’s date of death follows the same reimbursement procedures as the date of physical discharge from the NF. If a hospice member is admitted to the NF and dies on the day of admission, the NF is not paid for room and board services for that day. These reimbursement procedures for hospice members residing in nursing facilities are consistent with current IHCP reimbursement for NF covered services.

Hospice providers are reimbursed the hospice per diem according to the hospice member’s level of service on the day of the hospice member’s admission to the NF and the day the hospice member is physically discharged from the NF. The reimbursement procedures for hospice providers are consistent with current Medicare and IHCP guidelines for the Medicare and the IHCP hospice benefit.

The following reimbursement procedures apply to IHCP reimbursement to hospice providers and NF providers when the hospice provider discharges the hospice member from hospice care or the hospice member revokes hospice care, but the IHCP member physically remains in the NF:

- The hospice provider must still bill the IHCP for NF room and board services and the hospice per diem for the date of hospice discharge or the date of hospice revocation because the hospice member is still under hospice care on those dates of service.
- The NF can resume billing the IHCP directly for NF care on the day after hospice discharge or hospice revocation because the IHCP member has resumed NF care on that date.

Refer to the IHCP provider bulletin BT200107, for instructions on how to complete an Indiana Family and Social Services Administration UB-04 and Inpatient/Outpatient Crossover Adjustment Request to refund the IHCP for any overpayments for a hospice member’s date of death. See Appendix B for a complete list of referenced IHCP banner pages, bulletins, and newsletters.
When billing for a date of service that is the same as the date of death, hospice providers must bill occurrence code 51 in Field 32a of the UB-04 claim form, along with the date of death. The IHCP only pays for hospice service for the date of death when billed with occurrence code 51 and revenue code 653 and 654. If providers bill revenue codes 653 and 654 without occurrence code 51, the claim denies. When providers bill revenue code 659, the claim denies even if it is billed with occurrence code 51.

**Patient Liability for a Hospice Member Residing in a Nursing Facility**

An IHCP member (either dually eligible Medicare and IHCP or IHCP-only) residing in an NF is responsible for the member’s portion of the payment before the IHCP pays the remaining balance of NF care (this includes room and board services when the individual elects the Medicare and IHCP hospice benefits). Patient liability includes but is not limited to an individual’s personal savings account, Medicare pension funds, or Social Security checks. A member’s patient liability is deducted starting the first date of service the individual is residing in an NF and is eligible for the IHCP NF LOC.

When a hospice provider submits hospice claims for NF room and board services for a dually eligible Medicare and IHCP or IHCP-only hospice member, IndianaAIM deducts the patient liability portion from the claim and the remaining balance reflects the room and board payment. The total patient liability is not reflected on the Remittance Advice (RA) because the hospice claim is paid as a UB-04 claim with home health edits.

Hospice providers can obtain a member’s patient liability for a particular month by contacting HP Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278, or using one of the eligibility verification systems (EVS).

When a provider obtains the patient liability amount, the RA is used to determine how HP calculates the paid amount. The following formula is used if the RA does not match the rates that the provider originally submitted on the claims:

- Step 1: NF case mix rate on file × 95 percent (.95) = allowed amount on the RA for room and board
- Step 2: (Number of dates of service × allowed amount on RA) - patient liability = room and board amount

**IHCP Reimbursement Policy**

This section clarifies IHCP reimbursement policy and the process for billing Medicaid hospice claims when a member has private insurance, Medicare hospice/Medicaid room and board; and the process for billing Medicaid hospice claims when the member has private insurance and Medicaid.

When a member who receives hospice services and resides in a nursing facility has dual eligibility, the hospice provider must bill claims to the IHCP using revenue code 659 – Hospice services/other/dual eligibility NF recipients only. A member is considered dually eligible if he or she is enrolled in both Medicare and Medicaid. The member may also have other commercial insurance.

When verifying member eligibility, members who are dually eligible will be listed as being a qualified Medicare beneficiary (QMB-Also).

When a member who receives hospice services and resides in a nursing facility is not dually eligible (not a QMB), the hospice provider must bill claims to the IHCP using revenue code 653 – Hospice services/routine home care delivered in a nursing facility or 654 – Hospice services/continuous home care delivered in a nursing facility. The provider must use revenue code 653 or 654 even if the member has other commercial insurance and Medicaid.
If other insurance pays for the hospice care services in full, the hospice provider shall only receive payment from the IHCP for room and board services. If other insurance and the IHCP reimbursed the provider for hospice care services, the provider was overpaid and must refund the overpayment to the IHCP.

To refund the overpayment, the provider must complete a Hospice Accounts Receivable Refund Adjustment form. The form is located on the following page of the IHCP Web site: http://www.indianamedicaid.com/ihcp/Hospice/content/forms.asp. Mail the completed form and a check for the overpayment amount to:

HP Refunds
P.O. Box 2303 Dept. 130
Indianapolis, IN 46206-2303

The following example shows how to calculate the amount of an overpayment for revenue code 653 or 654.

Table 7.3 – Nursing Home Room and Board Calculation

<table>
<thead>
<tr>
<th>Letter Represented</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Nursing Home’s Room and Board Rate</td>
<td>$136.98</td>
</tr>
<tr>
<td>B</td>
<td>Payment Percentage of the Room and Board Rate</td>
<td>95</td>
</tr>
<tr>
<td>C</td>
<td>Medicaid Reimbursement Per Day (A*B=C)</td>
<td>$130.13</td>
</tr>
<tr>
<td>D</td>
<td>Number of Days in the Month</td>
<td>31</td>
</tr>
<tr>
<td>E</td>
<td>Total Reimbursement Amount for the Month (C*D=E)</td>
<td>$4,034.03</td>
</tr>
<tr>
<td>F</td>
<td>Patient Liability for the Month</td>
<td>$1,019.00</td>
</tr>
<tr>
<td>G</td>
<td>Total Medicaid Reimbursement for Room and Board (E-F=G)</td>
<td>$3,015.03</td>
</tr>
</tbody>
</table>

Table 7.4 – Hospice Routine Healthcare Calculation

<table>
<thead>
<tr>
<th>Letter Represented</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Routine Home Care Rate for the County of the Provider</td>
<td>$126.92</td>
</tr>
<tr>
<td>B</td>
<td>Number of Days in the Month</td>
<td>31</td>
</tr>
<tr>
<td>C</td>
<td>Medicaid Hospice Reimbursement for the Month (A*B=C)</td>
<td>$3,934.52</td>
</tr>
<tr>
<td>D</td>
<td>Amount Paid by Third-party Liability</td>
<td>$3,410.00</td>
</tr>
<tr>
<td>E</td>
<td>Total Medicaid Reimbursed for Hospice (C-D=E)</td>
<td>$524.52</td>
</tr>
</tbody>
</table>

In this example, the provider received the full hospice reimbursement (Table 7.3, line C) of $3,934.52. The IHCP should have reimbursed the provider $3,539.55 (Total Medicaid Reimbursement for Room and Board, $3,015.03, plus the Total Medicaid Reimbursement for Hospice, $524.52). The provider was overpaid and must refund the IHCP $394.37 ($3,934.52 minus $3,539.55). This information was published in provider newsletter NL200704.

Note: An individual form must be completed for each claim that is being refunded.
Revenue Codes

As indicated in Tables 7.1 and 7.2, IHCP reimbursement for hospice services is made at one of four all-inclusive per diem rates or levels of service and one of two LOCs for each day that an IHCP member is under the care of the hospice provider.

Hospice providers must bill only one hospice-related revenue code per day. However, revenue codes 657, 183, and 185 can be billed on the same day as other hospice revenue codes. A detailed description of each revenue code is provided later in this section.

Hospice providers complete the UB-04 claim form and identify hospice service delivery according to one of the following revenue codes:

- Revenue Code 651 – Routine home care delivered in a private home
- Revenue Code 652 – Continuous home care delivered in a private home
- Revenue Code 653 – Routine home care delivered in a nursing facility
- Revenue Code 654 – Continuous home care delivered in a nursing facility
- Revenue Code 655 – Inpatient respite care
- Revenue Code 656 – General inpatient hospice care

Note: Inpatient facility is defined as a hospital, long-term care facility, or the facility of a hospice provider that provides care 24 hours a day as outlined in federal regulations 42 CFR Section 418.100.

- Revenue Code 657 – Hospice direct care physician services
- Revenue Code 659 – Medicare/IHCP dually eligible nursing facility members only. Revenue code 659 cannot be billed with the following hospice-related revenue codes designated for IHCP-only hospice members:
  - 651
  - 652
  - 653
  - 654
  - 655
  - 656
- Revenue Code 183 – Nursing facility bed hold for hospice therapeutic leave days
- Revenue Code 185 – Nursing facility bed hold policy for hospitalization for services unrelated to the terminal illness of the hospice member

Changes to Nursing Facility Bed Hold Days

The following information was outlined in the IHCP provider bulletin BT200146. See Appendix B for a complete list of referenced IHCP banner pages, bulletins, and newsletters.

An amendment to 405 IAC 5-34-12(e) states, “In no instance will Medicaid reimburse a nursing facility for reserving nursing facility beds for hospice Medicaid recipients when the nursing facility has an occupancy rate of less than 90 percent. For purposes of this rule, the occupancy rate
shall be determined by dividing the total number of residents in licensed beds, excluding residential beds, in the nursing facility taken from the midnight census of the day that a Medicaid hospice member takes a leave of absence, by the total number of licensed nursing facility beds, excluding residential beds.”

It is the hospice agency’s responsibility to confirm the NF occupancy rate is at 90 percent or greater on the day the leave begins. If the NF occupancy rate falls below 90 percent following the date the leave began, the hospice provider can continue to bill the half rate for the entire hospital or therapeutic leave.

When the NF occupancy is below 90 percent, the hospice agency should use revenue code 180 to bill the IHCP for leave days. Revenue code 180 is a nonpaid revenue code used to generate an IHCP denial, and can be used when charging a resident or legal guardian for nonreimbursed bed hold days.

The explanation of benefits (EOB) detail for revenue code 180 lists the claim as denied, with EOB 4215 – Leave days not a covered service for this bill type—nursing facility occupancy less than 90 percent.

**Limitation of Payments for Inpatient Care**

Reimbursement for inpatient days, general and respite, is subject to an overall annual limitation established by the federal Medicare program as described at 42 CFR 418.30299(f) and State regulations at 405 IAC 1-16-3. Total inpatient days (general inpatient days and inpatient respite care days) for an individual hospice provider, and any contracted agents, may not exceed 20 percent of all days provided to all IHCP hospice members serviced by that specific provider during the 12-month period beginning November 1 of each year, and ending October 31 of the next year.

This payment limitation for inpatient services at the end of the inpatient capitation period, October 31, is determined by the following calculation:

1. The maximum number of allowable inpatient days is calculated by multiplying the total number of a provider’s IHCP hospice days by 20.

2. If the total number of days of inpatient care to IHCP hospice members is less than or equal to the maximum number of inpatient days computed in Step 1 above, then there is no adjustment.

3. If the total number of days of inpatient care to IHCP hospice members is greater than the maximum number of inpatient days computed in Step 1 above, then the payment limitation is determined by the following calculation:
   a. Calculate the ratio of maximum allowable inpatient days to the number of actual days of inpatient care, and multiply this ratio by the total reimbursement for inpatient care
   b. Multiply excess inpatient care days by the routine home care rate
   c. Add together the amounts calculated in 3.a. and 3.b. above
   d. Compare the amount in 3.c. above with total reimbursement to the hospice provider for inpatient care during the cap period. The amount that total reimbursement to the hospice for inpatient care exceeds the amount calculated in 3.c. above is the amount due from the hospice provider.

If it is determined that the inpatient rate should not be paid, any days the hospice receives payment at a routine home care rate are not counted as inpatient days.
Completion of the UB-04 Claim Form

Hospice providers must bill hospice services using the UB-04 claim form. Chapter 8 identifies form indicator numbers on the UB-04 claim form that must be completed so that proper reimbursement can be made to the hospice provider. For a complete overview of the UB-04 claim form, refer to bulletin BT200702.

Unlike the Medicare Hospice Program, IHCP hospice providers must bill only one hospice-related revenue code per day. However, revenue codes 657, 183, and 185 can be billed on the same day as other hospice revenue codes. A detailed description of each revenue code is provided later in this section.

Completion of Continuation Claim Using UB-04 Claim Form

The UB-04 claim form has only 22 lines, so an entire month cannot be billed on one page. However, the hospice provider has the option to prepare a continuation claim. A continuation claim has more than one UB-04 claim form, but must be completed as if it is one claim for payment by IndianaAIM. The hospice provider must complete the continuation claim as follows:

1. Mark the first UB-04 claim form page 1 of 2 on line 23 of the form.
2. Complete the first 22 lines of the UB-04 claim form.
3. Do not subtotal the first page of the claim (only the last page of the continuation claim must be totaled or IndianaAIM reads the claim as two claims rather than one).
4. Mark the second UB-04 claim form page 2 of 2 on line 23.
5. Complete the second UB-04 claim form for remaining dates of service for the month.
6. Provide a grand total for the continuation claim on the second UB-04 claim form.
7. Rotate the second UB-04 claim form (end to end) and place under the first UB-04 claim form. Do not staple or paperclip.

If the hospice provider does not want to complete a continuation claim, the hospice provider has the option to complete two separate UB-04 claim forms. The first claim form has enough space for the hospice provider to bill for the first 22 days of service for the month. The hospice provider totals the daily amounts for a grand total. The hospice provider then completes a second UB-04 claim form for the remaining days of service for the month, and totals the daily amounts for a grand total.

Refer to the IHCP Provider Manual, Chapter 10: Claim Processing Procedures for more information about the IHCP claims process.

Hospice Billing Revenue Codes

Table 7.5 is a list of revenue codes with their descriptions.
<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine home care delivered in a private home</td>
<td>The hospice provider is paid at the routine home care rate for each day the member is at home, under the care of the hospice provider, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services on any given day.</td>
</tr>
<tr>
<td>652</td>
<td>Continuous home care delivered in a private home</td>
<td>Continuous home care is provided only during a period of crisis. A period of crisis occurs when a patient requires continuous care, which is primarily nursing care, to achieve palliation and management of acute medical symptoms. A minimum of eight hours of care must be provided during a 24-hour day that begins and ends at midnight. A registered nurse (RN) or a licensed practical nurse (LPN) must provide care for over half the total period of time. This care need not be continuous and uninterrupted. If less skilled care is needed on a continuous basis to enable the member to remain at home, this is covered as routine home care. The continuous home care <em>per diem</em> rate is divided by 24 hours to calculate an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate is reimbursed to the hospice provider for up to 24 hours a day.</td>
</tr>
<tr>
<td>653</td>
<td>Routine home care delivered in a nursing facility</td>
<td>The hospice provider is paid at the routine home care rate for each day the member is in an NF under the care of the hospice provider, and not receiving continuous home care. The rate is paid without regard to the volume or intensity of routine home care service on any given day. In addition, the hospice provider is paid an additional room and board <em>per diem</em> at 95 percent of the lowest NF rate to cover costs incurred by the contracted NF. Effective October 1, 1998, the additional room and board <em>per diem</em> is 95 percent of the NF case mix rate.</td>
</tr>
<tr>
<td>654</td>
<td>Continuous home care delivered in a nursing facility</td>
<td>As in the private home setting, the continuous home care rate is divided by 24 hours in order to calculate an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate is reimbursed to the hospice provider up to 24 hours a day. All of the limitations listed for the private home setting also apply to the NF setting. In addition, the hospice provider is paid an additional room and board <em>per diem</em> at 95 percent of the lowest NF rate to cover costs incurred by the contracted NF. Effective October 1, 1998, the additional room and board <em>per diem</em> is 95 percent of the NF case mix rate.</td>
</tr>
</tbody>
</table>
### Revenue Code | Description | Explanation
--- | --- | ---
655 | Inpatient respite care | The hospice provider is paid at the inpatient respite care rate for each day that the member is in an approved inpatient facility and receiving respite care. Respite care is short-term inpatient care provided to the member only when necessary to relieve the family members or other persons caring for the member. Respite care can be provided only on an occasional basis. Payment for respite care can be made for a maximum of five consecutive days at a time. Payment for the sixth and any subsequent days is to be made at the routine home care rate. This service applies only to members who reside in their private home. See Table 7.1.

656 | General inpatient hospice care | The hospice provider is paid at the general inpatient hospice rate for each day the member is in an approved inpatient hospice facility, and is receiving general inpatient hospice care for pain control or acute or chronic symptom management that cannot be managed in other settings. See Table 7.1.

657 | Hospice direct care physician services | Physician services provided by a physician who is an employee of the hospice provider or by arrangement of the hospice provider are reimbursed outside the per diem rate, on a fee-for-service basis. These services are billed by the hospice provider, under the hospice provider number. Revenue code 657 can be billed on the same day as other hospice revenue codes.

659 | Medicare/IHCP dually eligible nursing facility members only | For dually eligible Medicare and IHCP hospice members residing in an NF, the hospice provider must bill Medicare for the hospice services and then bill IHCP for the room and board portion of the hospice per diem rate. This revenue code is used for Medicare and IHCP dually eligible members residing in an NF. This code represents the room and board portion of the hospice per diem rate. The hospice provider is paid 95 percent of the lowest NF per diem to cover the room and board cost incurred by the contracted NF. Effective October 1, 1998, the room and board portion of the hospice per diem rate is 95 percent of the single NF case mix rate. Revenue code 659 must not be billed with the hospice related revenue codes 651, 652, 653, 654, 655, and 656 designated for IHCP-only hospice members because this results in the hospice claim denying or suspending appropriately.
### Section 7: Reimbursement

**Indiana Health Coverage Programs**

**Hospice Provider Manual**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>183</td>
<td>Nursing facility bed hold for hospice therapeutic leave days</td>
<td>The hospice provider receives 50 percent of the 95 percent of the NF per diem rate to cover the NF room and board associated with therapeutic leave of absence days. A total of 18 therapeutic leave of absence days are allowed per patient per calendar year. This revenue code may also be used to pay for bed hold days when a member is hospitalized for the terminal illness. Effective October 1, 1998, the room and board portion of the hospice per diem rate is 95 percent of the NF case mix rate. Hospice providers should not bill the IHCP using this revenue code when the NF occupancy rate is below 90 percent pursuant to §405 IAC 5-34-12 (e).</td>
</tr>
<tr>
<td>185</td>
<td>Nursing facility bed hold policy for hospitalization for services unrelated to the terminal illness of the hospice member</td>
<td>The hospice provider receives 50 percent of the 95 percent of the lowest NF per diem rate to cover NF room and board associated with each hospitalization up to 15 days per occurrence. Effective October 1, 1998, the room and board portion of the hospice per diem rate is 95 percent of the NF case mix rate. Hospice providers should not bill the IHCP using this revenue code when the NF occupancy rate is below 90 percent pursuant to §405 IAC 5-34-12 (e).</td>
</tr>
<tr>
<td>180</td>
<td>Nursing Facility Bed Hold Non-Paid Revenue Code</td>
<td>When the NF occupancy is less than 90 percent, the hospice agency should use revenue code 180 to bill the IHCP for leave days. Revenue code 180 is a revenue code used to generate an IHCP denial and can be used to charge a resident or legal guardian for nonreimbursed bed hold days.</td>
</tr>
</tbody>
</table>

### Reimbursement for Physician Services

The following sections describe how to bill for physician services under the IHCP hospice benefit.

**Physician Services Under Revenue Codes 651 through 655**

The basic payment rates for IHCP hospice care represent full reimbursement to the hospice provider for covered services related to the treatment of the patient’s terminal illness, including the administrative and general activities performed by physicians who are employees of, or working under arrangements with the hospice provider. The physician who serves as medical director and the physician member of the hospice interdisciplinary group generally performs these activities. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of the plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for revenue codes 651 or 653, 652 or 654, and 655.
Physician Services Under Revenue Code 657

Reimbursement for a hospice-employed physician’s direct patient services, not rendered by the hospice physician volunteer, is billed as an additional payment by the hospice provider under the hospice provider number. The only physician services billed by a hospice provider are direct patient care services. Laboratory and X-ray services are included in the hospice provider’s daily rates.

Consulting physicians are physicians who see the hospice patient for treatment of the terminal illness and are paid for the services out of the hospice per diem. To bill for consulting physician charges, the hospice must do the following:

- Ensure that hospice providers have a contract with the consulting physician that addresses contracted service, cost for service, rate paid for service, and acknowledgement that the hospice is the professional manager of the patient’s hospice care.
- Bill Medicaid using hospice revenue code 657 and track the claims payment by keeping Medicaid’s Remittance Advice for this charge along with the consulting physician’s bill or invoice for the service rendered.

Hospice providers must meet all standard billing rules and claim filing limits when billing for a consulting physician. If the consulting physician has submitted a bill that is past the one-year filing limit, that claim will deny.

Prior Authorized Physician Services

Reimbursement for an independent physician’s direct patient services not rendered by a hospice volunteer is made as an additional payment in accordance with the usual IHCP reimbursement methodology for physician services. Accordingly, these services are not billed by the hospice provider under the hospice provider number. The only services billed by an attending physician are the physician’s personal professional services. Costs for services such as laboratory or x-rays are not included on the attending physician’s billed charges to the IHCP. These costs are included in the daily hospice provider’s rates and are the responsibility of the hospice provider. These physician services must be billed on the CMS-1500 professional claim form.

Volunteer Physician Services

Volunteer physician services are excluded from IHCP reimbursement. A physician who provides volunteer services to a hospice can be reimbursed for nonvolunteer services provided to hospice patients.

If the volunteer physician is working under a specific arrangement with the hospice to provide nonvolunteer direct patient services, then the hospice can be reimbursed on behalf of a volunteer physician for specific nonvolunteer direct patient care services. The hospice must have a liability to reimburse the physician for the services rendered. The hospice provider must bill under the hospice provider number for an additional amount using revenue code 657. The hospice provider must only bill for the physician’s direct care services. Laboratory and X-ray services are included in the hospice provider’s daily rate.

To determine which services are furnished on a volunteer basis and which are not, a physician must treat IHCP patients on the same basis as other hospice patients. For example, a physician cannot designate all physician services rendered to non-IHCP patients as volunteer and at the same time seek payment for all physician services rendered to IHCP patients.
Emergency Services

If emergency services are related to the terminal illness and the hospice member has not revoked the hospice benefit, the hospice provider is responsible for hospice and transportation charges associated with all emergency services provided.

If the emergency services are unrelated to the terminal illness, the IHCP pays the transportation and hospital claims associated with the emergency services.

IHCP as the Payer of Last Resort

The IHCP is always the payer of last resort. This means that the hospice provider must first bill other payer sources before billing the IHCP. The following scenarios for IHCP-only hospice members and dually eligible Medicare/IHCP hospice members provide guidelines for hospice providers.

IHCP-Only Hospice Member Residing in the Private Home

If the IHCP-only hospice member has private insurance, the hospice provider must first bill the private insurance for hospice services. When the private insurance company denies or partially pays the claim, the hospice provider can then bill the IHCP for the remaining balance for the hospice services.

If the private insurance company has denied payment for hospice services, in whole or in part, the hospice provider must then complete a UB-04 claim form and attach a copy of the notice from the private insurance company that outlines the denial of payment for those dates of service. Upon receipt of the UB-04 claim form, the IHCP processes the claim for payment.

IHCP-Only Hospice Member Residing in a Nursing Facility

If the IHCP-only hospice member has private insurance, the hospice provider must bill the private insurance company first for the hospice services and the room and board services. When the private insurance company denies or partially pays the claim, the hospice provider can then bill the IHCP for the remaining balance for the hospice services and the room and board services.

If the private insurance company has denied payment for hospice services or room and board, in whole or in part, the hospice provider must bill the IHCP for the outstanding balance. The hospice provider must attach to the UB-04 claim form a copy of the notice from the private insurance company that describes denial of payment for those dates of service. Upon receipt of the UB-04 claim form, the IHCP processes the claim for payment.

Hospice providers must refer to IHCP Reimbursement Policy in this section for instructions on how a hospice refunds the IHCP when private insurance and the IHCP have both reimbursed the provider for hospice services.

Dually Eligible Medicare and IHCP Hospice Member Residing in a Private Home

The hospice provider bills Medicare for the hospice services. If the individual has private insurance, the hospice provider must then bill the private insurance company first and bill Medicare as the secondary payer for the outstanding balance according to the guidelines established by the Medicare program.
Dually Eligible Medicare and IHCP Hospice Member Residing in a Nursing Facility

For the dually eligible Medicare and IHCP hospice member, the hospice provider must bill Medicare for the hospice services and IHCP for the nursing facility room and board services.

If the dually eligible Medicare hospice member has private insurance, Medicare and the IHCP require that the hospice provider bill the private insurance company first for the hospice services and the room and board services.

If the private insurance company denies payment, in whole or in part, for the hospice services, the hospice provider must bill Medicare for the outstanding balance according to the billing guidelines established by the Medicare program.

CHOICE and Hospice Members

As previously mentioned in Section 4: Member Eligibility in this manual, the Community and Home Option to Institutional Care for the Elderly and Disabled (CHOICE) Program is a State-funded program administered by the Division of Aging (DA). Because CHOICE is funded 100 percent by the state of Indiana, DA stipulates that CHOICE is the funding of last resort. This means that all other funding sources must be considered prior to the use of CHOICE funding.

Medicare or IHCP Eligibility Changes During the Month

As mentioned previously, an IHCP-only hospice member residing in an NF can become Medicare-eligible during a one-month billing period. Inversely, a dually eligible Medicare and IHCP hospice member residing in an NF can become an IHCP-only hospice member during a one-month billing period. The change in eligibility status changes how the hospice provider completes the UB-04 claim form for those dates of service.

IHCP-Only Hospice Member in a Nursing Facility Who Becomes Medicare-Eligible

The following example provides guidelines for the completion of the UB-04 claim form for this scenario. The hospice provider must complete the necessary paperwork to enroll the IHCP-only hospice member in the Medicare hospice benefit once that individual is Medicare eligible. The hospice provider must also submit the Change in Status of Medicaid Hospice Patient State Form 48732 (4/98)/OMPP 0010 to the ADVANTAGE Health Solutions-FFS to inform the IHCP that the member is Medicare eligible.

In this example, July 15 is the date the individual is considered dually eligible Medicare and IHCP for billing purposes by both programs. The hospice provider plans to bill IHCP for the entire month of July using the following calculations:

1. From July 1 to July 14, the hospice member was an IHCP-only member so the hospice provider must bill IHCP using revenue codes 653 or 654 for those dates of service. Revenue codes 653 and 654 include the additional room and board per diem to cover costs incurred by the contracted NF.

2. From July 15 to July 31, the hospice member is considered dually eligible Medicare and IHCP, and the hospice provider must bill the IHCP using revenue code 659 for the additional room and board per diem for those dates of service. The hospice provider must bill Medicare for the hospice services.
Dually Eligible Medicare and IHCP in a Nursing Facility Becomes IHCP-Only

The following example provides guidelines for the completion of the UB-04 claim form for this scenario. The hospice provider must complete the Change in Status of Medicaid Hospice Patient State Form 48732 (4/98)/OMPP 0010 to inform the IHCP that the individual is no longer Medicare-eligible. The hospice provider must submit the Change in Status of Medicaid Hospice Patient State Form 48732 (4/98)/OMPP 0010 and the required IHCP hospice forms for IHCP-only members to the ADVANTAGE Health Solutions-FFS.

In this example, July 15 is the date the individual is IHCP-only by both programs. The hospice provider plans to bill the IHCP for the entire month of July using the following calculations:

1. From July 1 through July 14, the hospice member is dually eligible Medicare and IHCP. The hospice provider must bill IHCP using revenue code 659 for the room and board per diem for these dates of service. The hospice provider must bill Medicare for the hospice services.

2. From July 15 through July 31, the hospice member is IHCP-only. The hospice provider must bill the IHCP for the hospice services and the additional room and board per diem for these dates of service. The hospice provider must use revenue codes 653 or 654 for those dates of service. Revenue codes 653 and 654 include the additional room and board per diem to cover costs incurred by the contracted NF.

Payment for Diapers for Hospice Patients in Nursing Facilities

Diapers are and have been included in the room and board portion of the Medicaid hospice program since 1997. Hospice providers have long expressed concerns to the ISDH and Family and Social Services Administration (FSSA) that providing diapers for care related to the terminal illness or related conditions for hospice patients in a nursing home could be construed as fraud or kickback as diapers are considered part of the room and board per diem of the Medicaid hospice program; however, some hospices do provide diapers for care of the terminal illness for ALL hospice patients regardless of payer source as a matter of their policy.

Representatives from CMS Baltimore on the Medicare and Medicaid Hospice Operations indicated in January 2008 the following clarification:

If the diapers etc. are used as an inducement i.e. to obtain referrals, it would not comply with Medicare requirements and should be referred to the State OIG. If it is a practice and part of the hospice’s policy to provide diapers, etc. to ALL patients regardless of payer source or as a response to referrals, there doesn’t appear to be anything that affects the Medicare hospice benefit’s statute or regulations.

One additional point, my response pertained ONLY to the Medicare hospice benefit. In other words, if a patient is a resident of the nursing home and is receiving Medicare hospice care and if the terminal or related condition requires diapers and the hospice provides diapers for ALL patients that require diapers regardless of payer source or where the care is provided, there does not appear to be a prohibition, even though diapers are not considered a covered item under Medicare. However, it would seem that diapers would be part of room and board and thus covered under Medicaid in a nursing home or by the patient in his/her home.

If diapers are supplied by a hospice to only nursing home patients in return for referrals, that would be prohibited.
Section 8: IHCP Recoupment

Overview

The Indiana Health Coverage Programs (IHCP) currently has different methods to recoup IHCP overpayments as they relate to the IHCP hospice benefit. The first recoupment process is coordinated by the Office of Medicaid Policy and Planning (OMPP) with the HP Claims Adjustment Unit to recoup IHCP overpayments from nursing facility providers due to noncompliance with 405 IAC 1-16-4. The second recoupment process was the IHCP Hospice Agency Review conducted by the HP hospice team within the HP Long Term Care Unit. This process ended effective December 31, 2003, as the IHCP has opted to develop hard edits and other monitoring tools to deny claims before payment is made.

OMPP Recoupment from Nursing Facilities

The IHCP provider bulletin BT199919, describes the new effective date for the OMPP recoupment based on noncompliance with 405 IAC 1-16-4. Hospice providers should refer to this bulletin for more information about this recoupment. See Appendix B for a complete list of referenced IHCP banner pages, bulletins, and newsletters.

The quarterly notification and recoupment process is as follows:

- The OMPP sends two different letters to nursing facility (NF) providers about the recoupment process:
  - A letter providing written notification of the names of hospice members who are identified as hospice on the quarterly minimum data set (MDS), but who are not enrolled in the IHCP hospice benefit. The letter should also indicate the estimated amount of the overpayment.
  - A letter that indicates an individual who is identified as hospice on the quarterly MDS, and who is enrolled in the IHCP hospice benefit. The letter should also identify the amount of the IHCP overpayment that the NF billed the IHCP for the dates of service that the NF resident was under hospice care.

- The NF is given 30 calendar days from receipt of the letter to respond to the OMPP in writing by letter or fax.

- When the response time has elapsed, the OMPP proceeds with the formal recoupment process by coordinating with the HP Claims Adjustment Unit.

- If there is not a recoupment issue based on the response received from the NF, the OMPP faxes a written notice to the NF provider so that the NF provider has a copy for its reimbursement records.

- If there is an IHCP recoupment from the NF, the OMPP mails a formal notice to the NF provider referencing the original letter and specifying the name and member identification number (RID) of the member who received the IHCP overpayment. The hospice provider also receives a copy of this notice.

End of the Hospice Agency Review Process

The IHCP initiated a comprehensive audit process for the IHCP hospice benefit in January 2000, which the IHCP ended effective December 31, 2003, as the IHCP has opted to develop hard edits and other monitoring tools to deny claims before payment is made. The following sections outline the
information previously published in the IHCP provider bulletin BT200365 Pharmacy Hard Edits and Hospice Review Process and supply documentation requirements to which hospice providers should adhere, because all IHCP providers can be subject to Surveillance and Utilization Review (SUR) on-site visits, investigation by the Indiana Medicaid Fraud Unit, or postpayment reviews by Medicare. See Appendix B for a complete list of referenced IHCP banner pages, bulletins, and newsletters.

**Pharmacy Hard Edits and the Hospice Review Process**

This information was previously published in the IHCP provider bulletin BT200365. Pharmacy overpayments accounted for 95 percent of the overpayments duplicative of hospice care in the hospice review process. Despite extensive education to hospice and pharmacy providers about coordination of care, duplicate billing continues.

In an effort to eliminate these overpayments before billing occurs, the Office of Medicaid Policy and Planning (OMPP) is developing a list of the most common medications used by hospice providers to treat terminal illnesses. The Long Term Care Pharmacy Alliance, the Indiana Hospice and Palliative Care Organization, and the Indiana Association for Home and Hospice Care are working with the OMPP to provide identification of medications on this list. The hard edit list will be updated on a regular basis as new medications are approved for use by the Federal Drug Administration (FDA) and approved for use by the IHCP. Prior to implementation, the OMPP and Division of Aging (DA) staff will convene with the above trade associations to identify any implementation concerns.

The IHCP is also developing other monitoring tools to monitor duplicate payment and billing regarding transportation and hospital stays. It was determined that Medicare is not being billed for hospice members admitted for Medicare hospital qualifying stays.

This reminds hospice providers that the IHCP could perform postpayment review that retrospectively audits hospice services including a review for medical necessity.

The IHCP will rely on current professional guidelines, including the Medicare Local Coverage Determination (LCD) for hospice services when performing hospice authorization reviews on each hospice member. Hospice providers are reminded that the IHCP recognizes the LCD is only a guide in determining if the patient is appropriate for hospice care. It is not meant to replace the overall clinical evaluation by the hospice provider or by the IHCP, and its contractor, in evaluating the unique clinical condition of each hospice member.

While the IHCP requires hospice providers to request hospice authorization for the IHCP-only members at the beginning of each hospice benefit period, the IHCP or its contractors is not prevented from requesting medical documentation about any hospice member at any point during the members’ enrollment in the IHCP. This practice is consistent with the hospice provider’s IHCP agreement.

**Recognition of Hospice Review Process at 405 IAC 5-34-4.2**

Changes to the Hospice Benefits Rule included the addition of 405 IAC 5-34-4.2, which recognizes this review process and specifies that the audit of hospice services shall include review of the medical record to determine the medical necessity of services based on applicable current professional standards, including the local Medicare Medical Review Policies for hospice services. While the IHCP has ceased the HP Hospice Review Process, the IHCP still has the right to review medical necessity and will continue to do so through the ADVANTAGE Health Solutions-FFS hospice authorization process, Medicaid Surveillance and Utilization Review Process, and follow-up on any reported cases of program misutilization from other State agencies.
According to Palmetto Government Benefits Administrators (GBA), the Part A Medicare Administrative Contractor (MAC) for Indiana, Medicare coverage for hospice care depends on a physician’s certification of an individual’s prognosis for a life expectancy of six months or less. Recognizing that the determination of life expectancy during the course of the terminal illness is difficult, the Part A MAC has established medical criteria for determining prognosis for noncancer diagnoses. These criteria for a reasonable approach to the determination of life expectancy are based on research, and can be revised as more research is available, particularly because remedial care is a new and changing field. The Medicare program indicates that coverage of hospice care for patients not meeting the criteria under a specific LCD could be denied. However, some patients may not meet the criteria, yet still be appropriate for hospice care because of other diseases or rapid decline. Coverage for these patients can be approved individually.

The IHCP recognizes that the LCD is only a guide to assist providers in determining if a patient is appropriate for hospice care and is not meant to replace the overall clinical evaluation either by the hospice provider or by the IHCP and its contractor in evaluating the unique clinical condition of each hospice member. Each hospice authorization is reviewed as a stand-alone request and should take into consideration the hospice member’s unique clinical history.

Hospice providers must adhere to the LCD published by the Part A MAC for the state of Indiana when evaluating an IHCP-only hospice member for hospice care appropriateness.

Medical Records Review

The hospice provider is required to submit specific paperwork to the ADVANTAGE Health Solutions-FFS for each hospice benefit period to obtain IHCP hospice authorization for those dates of service as described in Section 6: Hospice Authorization Process in this manual.

The IHCP hospice forms are legal documents. Hospice providers must adhere to the same medical records standards required for the completion of the hospice agency’s form. Hospice providers must use these forms to document the medical necessity of the IHCP member’s hospice care.

It is the hospice provider’s responsibility to place the authorized hospice forms in the hospice member’s medical chart at the hospice agency and at the contracted NF. The inclusion of the IHCP hospice forms in the NF chart is important when a member elects, revokes, or is discharged from hospice care.

The hospice provider must have the forms listed in Table 8.1 available in the patient’s medical chart to demonstrate compliance with IHCP hospice authorization, including ADVANTAGE Health Solutions-FFS hospice authorization for that benefit period, and IHCP program compliance standards.

Changes to the IHCP hospice rule became effective July 5, 2003, and included language that specified the forms required at the hospice agency or the contracted NF. The hospice provider is required to keep all IHCP hospice forms that were submitted or should have been submitted to the ADVANTAGE Health Solutions-FFS. This documentation should be kept in the hospice member’s clinical chart at the hospice agency. The IHCP also expects hospice providers to include the same documentation in the hospice member’s clinical chart at the nursing home.
Although the IHCP expects these forms to be in the member’s clinical chart, the review process does not include any penalty if the forms are not located in the chart during the review. The hospice provider is instructed in the summary of findings letter to correct the documentation discrepancy to make sure the hospice member’s clinical records reflect accurate documentation of the member’s enrollment in the IHCP hospice benefit.

Table 8.1 lists the documentation requirements for hospice providers to include in the patient’s clinical record at the hospice agency for IHCP-enrolled only members and those having dual eligibility with Medicare.

### Table 8.1 – Documentation Requirements for Hospice Providers

<table>
<thead>
<tr>
<th>Form</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Authorization Notice for Dually Eligible Medicare/Medicaid Nursing Facility Residents 51098/OMPP 0014</td>
<td>Dually eligible Medicare/IHCP Hospice members residing in nursing homes</td>
</tr>
<tr>
<td>Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005</td>
<td>One-page hospice authorization notification with corresponding hospice agency form reflecting Medicare hospice election date. Resident is required to sign the Medicaid hospice election form to be compliant with OBRA 89.</td>
</tr>
<tr>
<td>Medicaid Hospice Physician Certification State Form 48736 (R/12-02)/OMPP 0006</td>
<td>Hospice agency physician certification form no longer required for IHCP post payment review process, but still required for state hospice survey process</td>
</tr>
<tr>
<td>Medicaid Hospice Plan of Care State Form 48731 (R2/11-04)/OMPP 0011</td>
<td>The IHCP requires the hospice provider to meet the documentation requirements under 42 CFR 418.112 to reflect a coordinated plan of care between hospice and NF agencies that demonstrates the hospice care philosophy supersedes in the care of the NF resident. The plan of care should be updated to reflect appropriate changes in the member’s medical condition regarding the terminal illness and related conditions.</td>
</tr>
<tr>
<td>Medicaid Hospice Revocation State Form 48735 (4/98)/OMPP 0007</td>
<td>Medicaid Hospice Revocation Form</td>
</tr>
<tr>
<td>Medicaid Hospice Discharge State Form 48734 (R/12-02)/OMPP 0008</td>
<td>Medicaid Hospice Discharge Form</td>
</tr>
<tr>
<td>Hospice Provider Change Request Between Indiana Hospice Providers State Form 48733 (R/12-02) OMPP 0009</td>
<td>Medicaid Change of Provider Form</td>
</tr>
<tr>
<td>Change in Status of Medicaid Hospice Patient State Form 48732 (4/98)/OMPP 0010</td>
<td>Medicaid Change in Status of Hospice Member</td>
</tr>
</tbody>
</table>

Hospice providers must provide the same services to a hospice member residing in an NF that it would provide had the hospice member been residing in his or her private home as governed by federal regulations at 42 CFR Part 418.112 Condition of Participation: Hospices That Provide Care in SNF/NF or ICF/MR. This section states that the plan of care must describe, to the extent possible, the participation of the hospice, the NF, and the patient. The hospice and the NF must communicate with each other when any changes are included in the plan of care, and each provider must be aware of the other’s responsibilities for implementing the plan of care. **Evidence of this coordinated plan of care must be present in the clinical records of both providers. All aspects of the plan of care must**
reflect the hospice care philosophy. Failure to meet this medical documentation and charting criteria for a hospice patient at the NF is a violation of the Medicare Conditions of Participation of Hospice Care and State hospice licensure.

Because the IHCP is the payer of last resort, the IHCP hospice benefit has unique reimbursement issues and patient coordination issues that are different from the Medicare program. For this reason, the IHCP recommends that hospice providers include the above-mentioned forms in a hospice member’s NF chart. The inclusion of the listed forms permits the NF staff to understand that a particular member is enrolled in the IHCP hospice benefit or that an individual’s hospice status has changed due to hospice election, revocation, or discharge. This goal cannot be accomplished if only a coordinated plan of care is included in the hospice member’s NF medical record chart.

Hospice Plan of Care Review

The following criteria are used when evaluating the plan of care:

• Does the hospice plan of care show that all services were delivered at the appropriate IHCP hospice LOC?
• Is the plan of care updated to show the most recent hospice benefit period?
• Does the plan of care received by the ADVANTAGE Health Solutions-FFS match the plan of care in the member’s medical records?
• Do the member’s medical records support that all services in the plan of care have been delivered?
• Does the plan of care show coordinated care between the hospice and the NF for members residing in an NF as described in CMS Publication 21 and State Operations Manual, Section 2082A?

Other Hospice Review Criteria

The following is outlined in the IHCP provider bulletin BT200331. See Appendix B for a complete list of referenced IHCP banner pages, bulletins, and newsletters.

The following criteria is also used when a hospice review is conducted at the hospice agency and includes all services billed to the IHCP by hospice and nonhospice providers for the specified review time period:

• The medical documentation of the hospice and nonhospice providers must support the services billed to the IHCP.
• The services must be IHCP benefits.
• The services must be reasonable and medically necessary to treat the terminal condition and related illnesses.
• The services must be billed in the quantities ordered and documented in the medical records as provided.
• The services must be specifically identified on either the provider’s itemized statements of the charge receipt maintained by the facility.
• The services must be billed to the IHCP only after other medical insurance has been exhausted.
• The services must be billed in accordance with established IHCP policy.
• The physician must order the services in writing as indicated in the medical documentation.
The following documentation is not acceptable legally or from a patient care perspective under the IHCP guidelines, and would subject the hospice and nonhospice providers to recoupment:

- Failure to document the IHCP member’s name on each page of the service record is not acceptable. A patient’s name is essential to ensure that the documentation is returned to the correct record, and that the record pertains to the member being reviewed.
- Scratch-outs, whiteouts, alterations, missing dates, and missing signatures are not acceptable. All documentation errors should be corrected using the following universally accepted medical records method: draw a line through the entry in ink, and do not obliterate the word, enter the correct information, initial, and date the change.
- Failure to include signatures to authenticate all documentation of services rendered is not acceptable. It is recommended that a full signature be used for each entry and each individual entry must be signed, including at a minimum, the first initial and last name.
  - If a first initial and last name is used, a master signature file must be maintained. The file should contain a complete (first and last name) signature and the corresponding initial and last name to be used for documentation purposes.
  - If a service requires a certain licensure level, that individual should include his or her title or credential in the signature.

Hospice providers are reminded that prior authorization is not a guarantee of payment. Therefore, if the hospice review team or SUR Department identifies an overpayment issue that requires recoupment, the fact that the provider has prior authorization does not keep the IHCP from initiating the recoupment process.

**IHCP Recommendations for Hospice Provider Coordination**

Hospice providers must ensure the hospice agency is not involved with another healthcare provider that submits claims for any services not reimbursable by Medicare or the IHCP based on the following program guidelines:

- Standard Medicare or IHCP benefits for treatment of the terminal illness
- Treatment by another hospice not arranged for by the patient’s hospice
- Care from another provider that duplicates care the hospice is required to furnish

The hospice provider must work with other nonhospice providers to coordinate care and ensure appropriate billing when these situations occur.

**IHCP Recommendations for Nursing Facility Resident Coordination**

The majority of IHCP hospice benefit members reside in NFs. The majority of these NF residents under hospice care are dually eligible Medicare and IHCP residents. Medicare Part A pays for the hospice per diem for these members. Regardless of whether the NF resident is dually eligible Medicare and IHCP, or IHCP-only, the IHCP must not be billed by nonhospice providers for any services covered under the Medicare or IHCP hospice per diem.

Pharmacy providers can bill the IHCP directly for medications for an NF resident. The IHCP has the following recommendations to minimize the occurrences of pharmacy providers and other nonhospice providers from billing the IHCP directly:
Hospice providers and NF providers must address this coordination and notification process in their standard contracts. Specifically, the contract must do the following:

- Identify nonhospice providers who provide services to the NF resident.
- Establish a mechanism to notify nonhospice providers that the NF resident has elected hospice.
- Indicate what services and medications are included in the hospice plan of care and covered by the hospice per diem. Follow-up procedures should be identified to address those updates to the hospice plan of care for any changes to the hospice member’s medications.
- Indicate the name and address of the contact person to send this information so the appropriate individual in the nonhospice provider’s billing department is notified that the individual is a Medicare and IHCP hospice member or an IHCP member.

Hospice providers who have a contract with a particular pharmacy to provide medications for the treatment of the terminal illness should ensure that the contract specifies coordination responsibilities between the hospice and pharmacy provider. This ensures that Medicare or the IHCP is not inappropriately billed for medications identified in the hospice plan of care for treatment of the terminal illness. The contract must include the name and address of the contact person for each provider.

Hospice providers should ensure that the coordination efforts are documented if the nonhospice provider contacts the hospice provider for reimbursement of the IHCP overpayment.

IHCP Recommendations for IHCP-only Member Residing in Private Home Coordination

The following recommendations help ensure that nonhospice providers are notified that the individual is an IHCP-only hospice member:

- Instruct the hospice member, or member’s representative, of the services covered under the IHCP hospice per diem during the admission process.

- Instruct the hospice member, or representative, of the nonhospice providers who provide noncore hospice services under contract with the hospice agency. Also notify the hospice member that the hospice member is required to use these services while under hospice care with that agency.

- Educate the hospice member, or representative, that failure to follow the hospice care philosophy or to use a provider not under contract with the hospice makes the hospice member liable for all charges resulting from the noncompliance as specified by Medicare and the IHCP.

Note: It is the hospice provider’s responsibility to ensure that nonhospice providers bill neither Medicare nor the IHCP when the hospice member is noncompliant. Refer to Section 5: Election, Discharge, and Revocation in this manual for guidelines about hospice revocation versus hospice discharge.

- Provide the hospice member, or representative, with a list of covered medications under the hospice per diem. A new list should be provided each time the covered medications are revised per the updated hospice plan of care.

- Provide the hospice member, or representative, with the patient care coordinator’s business card, or the business card of an appropriate hospice agency staff person. This card can be used to remind nonhospice providers that the member is under hospice care.

- Ensure that the contract specifies coordination responsibilities between the hospice and pharmacy provider so that Medicare or the IHCP is not inappropriately billed for medications in the hospice plan of care used for treatment of the terminal illness. The contract must specify the name and
address of the contact person for the hospice and the pharmacy provider so the pharmacy provider can contact the hospice provider about which medications the pharmacy provider must bill.

- Hospice providers who contract any part of the hospice noncore services for treatment of the terminal illness must ensure that the contractor bills the hospice provider directly for those services. Medicare or the IHCP must not be billed directly by these nonhospice providers because these services are covered under the hospice per diem and are under the supervision of the hospice provider.

- As part of the admissions process and subsequent hospice visits, ask the patient or the patient’s representative whether any new provider or staff person is coming to see the patient since the last visit so that the hospice provider may follow up to develop a coordinated plan of care with that entity.
**Section 9: Hospice Care in Nursing Facilities**

This chapter provides an overview of hospice care in nursing facilities because the majority of enrollees in the Indiana Health Coverage Programs (IHCP) hospice benefit reside in nursing facilities. This chapter provides an overview of level-of-care requirements for billing for room and board under the IHCP hospice benefit, an explanation of payment, and billing parameters for hospice and nursing facilities based on a member’s election, discharge, and revocation of hospice services, and discussion of hospice care and nursing facility room and board services based on the Centers for Medicare & Medicaid Services (CMS) clarification regarding nutritional supplements.

**Hospice Conditions of Participation**

Effective December 2, 2008, the hospice conditions of participation codified the care standards in nursing facilities by incorporating 42 CFR Section 418.112: Condition of Participation: Hospices That Provide Hospice Care in NFs and ICF/MRs. The care expectations are consistent with the information in this section of the *Hospice Provider Manual*.

**Level-of-care Requirements for Hospice Billing**

The member must have hospice level of care and Medicaid nursing facility level of care for service dates that the hospice must bill for nursing facility room and board services under the IHCP hospice benefit. The Family Social Services Agency (FSSA) Division of Aging has noted the following issues with regard to nursing facility level of care for hospice members:

- Nursing facility staff submits a new request for IHCP nursing facility level of care when a nursing facility resident revokes hospice or the resident is discharged from hospice care. If the resident has a current Medicaid nursing facility level of care for Medicaid reimbursement, the nursing facility does not need to resubmit a request for nursing facility level of care.

- The hospice is required by federal law to notify the State Medicaid agency when a member elects, revokes, is discharged, or changes providers under the Medicare and Medicaid programs. The hospice must submit a Medicaid revocation form or Medicaid hospice discharge form to the Medicaid prior authorization contractor so that the hospice level of care can be updated with these changes. If a hospice fails to submit the Medicaid hospice revocation form or the Medicaid hospice discharge form, then nursing facility claims will deny for service dates following the hospice revocation or discharge because the member will still be identified as a hospice member in the IHCP eligibility system.

**B98 Autoclosures**

When a hospice provider receives a claims denial for edit 2026 – *Member does not have Medicaid nursing facility level of care*, it can possibly be related to a B98 autoclosure as a direct result of prior nursing facility provider billing or the hospice provider inappropriately billing patient status.

In those circumstances, it is the responsibility of the nursing facility to provide the necessary documentation to the designated staff person at the HP Health Services Unit. This individual may be reached at (317) 488-5094. The hospice will continue to receive a denial under edit 2026 until the B98 autoclosure.
Payment and Billing Parameters for Hospice and Nursing Facilities

The following is a chart to assist hospice and nursing facilities regarding when nursing facility billing stops and when nursing facility billing resumes for nursing facility care based on a member’s enrollment in the IHCP Hospice Program.

<table>
<thead>
<tr>
<th>Hospice Enrollment Status</th>
<th>Hospice Billing</th>
<th>Nursing Facility Billing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Election</td>
<td>Hospice bills for room and board starting the date of hospice election</td>
<td>Nursing facility must stop billing Medicaid the date of hospice election</td>
</tr>
<tr>
<td>Hospice Revocation</td>
<td>Hospice bills Medicaid for room and board the date of hospice revocation</td>
<td>Nursing facility resumes direct Medicaid billing the day after the hospice revocation</td>
</tr>
<tr>
<td>Hospice Discharge</td>
<td>Hospice bills Medicaid for room and board the date of hospice discharge</td>
<td>Nursing facility resumes direct Medicaid billing the day after the hospice discharge</td>
</tr>
<tr>
<td>Nursing facility date of death or date of resident’s physical discharge from facility</td>
<td>Hospice must not bill date of death or date of resident’s physical discharge</td>
<td>Nursing facility regulations do not permit payment for date of death or date of resident’s physical discharge from facility</td>
</tr>
</tbody>
</table>

Frequently Asked Questions about the Medicaid Hospice Benefit and Long Term Care

This section is meant to provide a high level of the questions posed to the IHCP about hospice care in nursing facilities.

**Question 1: What is included in the IHCP Hospice Per Diem?**

**Response to Question 1:** Hospice providers are required to provide in frequency and scope the hospice covered services to treat the patient’s terminal illness and related conditions. Hospice covered services are listed in federal regulations at 42 CFR Part 18 and state regulations at 405 IAC 5-34-8.

- Nursing care provided by or under the supervision of a registered nurse
- Medical social services provided by a social worker who has at least a bachelor’s degree and who is working under the supervision of a physician
- Physician services provided by the Medicaid director or a physician member of the interdisciplinary team that may be characterized as follows:
  - General supervisory services, participation in the establishment of the plan of care, supervision of the plan of care, periodic review, and establishment of governing policies
  - Direct care patient services
- Counseling services provided to the member and the member’s family or other person caring for the member
- Short-term inpatient care provided in a hospice inpatient unit, participating hospital, or nursing home subject to the limitations outlined in 405 IAC 1-16-3
• Medical appliances and supplies, including palliative drugs, which are related to the palliation or management of the member’s terminal illness
• Home health services furnished by qualified aides
• Homemaker services that assist in providing a safe and healthy environment
• Physical, occupational therapy, and speech-language pathology services provided for purposes of symptom control

Question 2: Why do hospice providers have to bill for the nursing facility room and board under the IHCP hospice benefit?

Response to Question 2: Federal mandate under OBRA 89 requires that in states that have a Medicaid hospice benefit, the state Medicaid agency must pay the hospice a pass-through for nursing facility room and board under the hospice benefit. The hospice then pays the nursing facility according to their contract. The IHCP pays 95 percent of the nursing facility daily rate for room and board to the hospice. The hospice then pays the nursing facility 95 percent to 100 percent of the nursing facility daily rate for room and board according to their contract.

Question 3: What is included in the room and board per diem under the IHCP hospice benefit?

Response to Question 3: Room and board under the IHCP hospice benefit is outlined at 405 IAC 1-16-4:

• Performing personal care activities (not otherwise performed by the hospice provider)
• Assisting with activities of daily living (ADL)
• Administering medication
• Socializing activities
• Maintaining the cleanliness of a patient’s room
• Supervising and assisting in the use of durable medical equipment and prescribed therapies
• While not explicitly listed at 405 IAC 1-16-4, the nursing facility should continue to provide all dietary and laundry services for care of the nursing facility resident who elected hospice.

• Skilled nursing facility or nursing facility (SNF/NF) services offered to a patient or resident should be the same whether or not he or she has elected hospice.

1. This means that if the member has a diagnosis or condition that is unrelated to the terminal illness, the nursing home must still provide that service.
2. It is the responsibility of the hospice as the manager for the patient’s end-of-life care to indicate in the coordinated plan of care that the service is unrelated to the terminal illness. If the documentation does not support this distinction between terminal and nonterminal illness, the hospice is subject to recoupment by Medicare or Medicaid.

Question 4: Is there any possibility that a hospice can pay the nursing facility more than 100 percent of the nursing facility daily rate for room and board?

Response to Question 4: The following box reflects comments from the Centers for Medicare & Medicaid Services (CMS).

Note from the CMS to the OMPP: Amounts paid to the nursing facility above 100 percent of the Medicaid daily rate should be limited to nonroutine equipment, supplies, and therapies that are related to the patient’s terminal illness and paid to the nursing home or an affiliated supplier at cost or obtained from an independent supplier.
Question 5: Is a hospice responsible for providing nutritional supplement or Ensure as tolerated for the terminal illness, such as hospice failure to thrive, and paying for it out of the hospice per diem?

Response to Question 5: According to representatives from CMS, nutritional supplements, necessary as a result of the terminal illness, would be the financial responsibility of the hospice. It would be viewed as above and beyond the dietary services an NF traditionally provides – even though some NFs would be required to provide nutritional supplements for nonhospice participants, the election of hospice transfers the payment obligation to hospice, for those services related to the terminal illness.

Question 6: Who is responsible for providing diapers for the nursing facility resident who elects hospice?

Response to Question 6: Diapers are and have been included in the room and board portion of the Medicaid hospice program since 1997. Hospice providers have long expressed concerns to the ISDH and Family and Social Services Administration (FSSA) that providing diapers for care related to the terminal illness or related conditions for hospice patients in a nursing home could be construed as fraud or kickback as diapers are considered part of the room and board per diem of the Medicaid hospice program; however, some hospices do provide diapers for care of the terminal illness for all hospice patients regardless of payer source as a matter of their policy.

Representatives from CMS Baltimore on the Medicare and Medicaid Hospice Operations indicated in January 2008 the following clarification:

If the diapers etc. are used as an inducement i.e. to obtain referrals; it would not comply with Medicare requirements and should be referred to the State OIG. If it is a practice and part of the hospice’s policy to provide diapers, etc. to ALL patients regardless of payer source or as a response to referrals, there doesn’t appear to be anything that affects the Medicare hospice benefit’s statute or regulations.

One additional point my response pertained ONLY to the Medicare hospice benefit. In other words, if a patient is a resident of the nursing home and is receiving Medicare hospice care and if the terminal or related condition requires diapers and the hospice provides diapers for ALL patients that require diapers regardless of payer source or where the care is provided, there does not appear to be a prohibition, even though diapers are not considered a covered item under Medicare. However, it would seem that diapers would be part of room and board and thus covered under Medicaid in a nursing home or by the patient in his/her home. If diapers are supplied by a hospice to only nursing home patients in return for referrals, that would be prohibited.

Question 7: What should hospices address in the hospice contracts with nursing facilities?

Response to Question 7: It is important that the hospice consult with an attorney for all contractual issues and to ensure that the contracts are compliant with the safe harbor laws. Hospice providers can address the following issues in their contracts:

- Specification of what is included in room and board services and whether the hospice pays 95 percent or 100 percent of the nursing home daily rate
- Specification of any additional hospice noncore services and the rates the hospice will pay for each
- Specification whether the hospice is the manager of the resident’s hospice care and as such the nursing facility must seek authorization from the hospice provider for any change to the agreed-upon plan of care
- Procedures for hospice to provide regular in-service training to the nursing facility staff regarding the hospice care philosophy
- Notification sections that specify the name of the contact person for each entity
• Specification that room and board under the Medicaid hospice benefit cannot be made for date of service that the resident was ineligible for the Medicaid hospice benefit, did not have Medicaid nursing facility level of care, or the nursing facility was decertified from the Medicaid program

• Notification procedures for the nursing facility to inform the hospice when there is an approved Office of Medicaid Policy and Planning (OMPP) 450B form (nursing facility level of care)

• Notification procedures that a nursing facility must follow to inform the hospice about Medicaid decertification as a result of State Department of Health survey, which may also include hospice participation in the discharge/transfer of a resident to another Medicaid-certified facility

• Attendance of appropriate hospice staff at nursing facility interdisciplinary team meetings and attendance of appropriate nursing facility staff at hospice interdisciplinary meetings

• Billing and payment parameters between hospice and nursing facility

• Specification of the respective care responsibilities of hospice and nursing facility staff based on a detailed description of the hospice level of care and the nursing facility room and board services under the Medicaid hospice benefit

• Procedures that must be followed by hospice and nursing facility staff when a resident is under hospice care requires hospitalization for either the terminal illness or the nonterminal illness; for example, nursing facility must contact hospice for authorization, determination of which hospital the resident will be admitted, the billing and payment parameters, and so forth

• Procedures for the disposal of medications once the hospice member dies

**Question 8: Can a Medicare beneficiary who elects hospice remain in a Medicare-certified bed in the nursing facility?**

**Response to question 8:** No. The IHCP is paying for a room and board pass-through to the hospice; therefore, the member must be in a Medicaid-certified bed.
This appendix lists copies of the forms referenced in this manual. Table A.1 is a complete list of the forms with the corresponding Web address, link, or information about obtaining copies of the forms.

<table>
<thead>
<tr>
<th>Form</th>
<th>Web Address and Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Hospice Plan of Care State Form 48731 (R2/11-04)/OMPP 0011</td>
<td><a href="http://www.in.gov/icpr/webfile/formsdiv/48731.pdf">http://www.in.gov/icpr/webfile/formsdiv/48731.pdf</a></td>
</tr>
<tr>
<td>Hospice Provider Change Request Between Indiana Hospice Providers State Form 48733 (R/12-02) OMPP 0009</td>
<td><a href="http://www.in.gov/icpr/webfile/formsdiv/48733.pdf">http://www.in.gov/icpr/webfile/formsdiv/48733.pdf</a></td>
</tr>
<tr>
<td>Medicaid Hospice Discharge State Form 48734 (R/12-02)/OMPP 0008</td>
<td><a href="http://www.in.gov/icpr/webfile/formsdiv/48734.pdf">http://www.in.gov/icpr/webfile/formsdiv/48734.pdf</a></td>
</tr>
<tr>
<td>Medicaid Hospice Physician Certification State Form 48736 (R/12-02)/OMPP 0006</td>
<td><a href="http://www.in.gov/icpr/webfile/formsdiv/48736.pdf">http://www.in.gov/icpr/webfile/formsdiv/48736.pdf</a></td>
</tr>
<tr>
<td>Medicaid Hospice Election State Form 48737 (R/11-04)/OMPP 0005</td>
<td><a href="http://www.in.gov/icpr/webfile/formsdiv/48737.pdf">http://www.in.gov/icpr/webfile/formsdiv/48737.pdf</a></td>
</tr>
<tr>
<td>Hospice Authorization Notice for Dually Eligible Medicare/Medicaid Nursing Facility Residents State Form 51098 (3-03)/OMPP 0014</td>
<td><a href="http://www.in.gov/icpr/webfile/formsdiv/51098.pdf">http://www.in.gov/icpr/webfile/formsdiv/51098.pdf</a></td>
</tr>
<tr>
<td>IHCP Hospital and Facility Provider Application and Maintenance Form</td>
<td><a href="http://www.indianamedicaid.com/ihcp/ProviderServices/Forms/IHCP%20Hospital%20and%20Facility%20Provider%20Application%20and%20Maintenance%20Form.dot">http://www.indianamedicaid.com/ihcp/ProviderServices/Forms/IHCP%20Hospital%20and%20Facility%20Provider%20Application%20and%20Maintenance%20Form.dot</a></td>
</tr>
<tr>
<td>Approved OMB -0938-0008 Form CMS-1500 (12/90)</td>
<td>Obtain supplies of this form from a local medical office supply store. Providers can view the form at the CMS Web site at <a href="http://www.cms.hhs.gov/">http://www.cms.hhs.gov/</a>.</td>
</tr>
<tr>
<td>Approved OMB-0938-0279 Form UB-04 CMS-1450</td>
<td>Obtain supplies of this form from a local medical office supply store. Providers can view the form at the CMS Web site at <a href="http://www.cms.hhs.gov/">http://www.cms.hhs.gov/</a>.</td>
</tr>
<tr>
<td>Nursing Facility Level of Service State Authorization and Data Entry State Form 49120 (11-98)/OMPP 450B SA/DE</td>
<td><a href="http://www.in.gov/icpr/webfile/formsdiv/49120.pdf">http://www.in.gov/icpr/webfile/formsdiv/49120.pdf</a></td>
</tr>
<tr>
<td>Form</td>
<td>Web Address and Link</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>Physician Certification for Long Term Care Services State Form 38143 (R5/6-93) Form 450B/PASRR2A</td>
<td><a href="http://www.in.gov/icpr/webfile/formsdiv/38143.pdf">http://www.in.gov/icpr/webfile/formsdiv/38143.pdf</a></td>
</tr>
<tr>
<td>Indiana Family and Social Services Administration UB-04 and Inpatient/Outpatient Crossover Adjustment Request</td>
<td><a href="http://www.indianamedicaid.com/ihcp/Publications/forms.asp">http://www.indianamedicaid.com/ihcp/Publications/forms.asp</a></td>
</tr>
</tbody>
</table>
This appendix lists the hospice-related IHCP provider bulletins, banner pages, and newsletters referenced in this manual. Bulletins, banner pages, and newsletters published after release of this manual are available on the IHCP Web site at [http://www.indianamedicaid.com](http://www.indianamedicaid.com).

**Table B.1 – Hospice-Related Bulletins, Banner Pages, and Newsletters**

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<th>Date</th>
<th>Subject</th>
</tr>
</thead>
<tbody>
<tr>
<td>E98-17</td>
<td>09/18/1998</td>
<td>Procedures to Request Hospice Forms</td>
</tr>
<tr>
<td>E98-30</td>
<td>09/18/1998</td>
<td>Reimbursement and Survey Issues Related to the Hospice Benefit</td>
</tr>
<tr>
<td>E98-37</td>
<td>11/06/1998</td>
<td>Recoupment Based on IC 405 IAC 1-16-4 (Additional per diem amount for nursing facility room and board services once nursing facility resident elects hospice)</td>
</tr>
<tr>
<td>E98-40</td>
<td>11/16/1998</td>
<td>Current Form 450B Nursing Facility Level of Service Procedures</td>
</tr>
<tr>
<td>BT199904</td>
<td>01/26/1999</td>
<td>Election of Hospice Services by Home- and Community-Based Services Waiver Recipients</td>
</tr>
<tr>
<td>BT199905</td>
<td>01/26/1999</td>
<td>Parameters and Procedures for Reimbursement for Exceptional Circumstances for Managed Care Recipients Who Elect the Medicaid Hospice Benefit</td>
</tr>
<tr>
<td>BT199919</td>
<td>06/14/1999</td>
<td>New Effective Date for OMPP Recoupment Based on Noncompliance with 405 IAC 1-16-4 and Submission of Untimely Hospice Election Forms</td>
</tr>
<tr>
<td>BT199924</td>
<td>07/30/1999</td>
<td>Treatment for Non-Terminal Conditions for Hospice Recipients Admitted to a Nursing Facility After a Hospital Stay</td>
</tr>
<tr>
<td>BT199925</td>
<td>07/30/1999</td>
<td>Policies and Procedures on Medicaid Prior Authorization and Reimbursement for the Treatment of the Medicaid Hospice Recipient’s Non-Terminal Conditions</td>
</tr>
<tr>
<td>BT200002</td>
<td>04/05/2000</td>
<td>Use of Forms 450B and OMPP 450B SA/DE</td>
</tr>
<tr>
<td>BT200011</td>
<td>02/25/2000</td>
<td>New Policy for Indiana Health Coverage Programs (IHCP) Hospice Authorization for Nursing Facility Residents Without IHCP Nursing Facility Level of Care (Pending Form 450B or OMPP 450B SA/DE) and Other IHCP Hospice Benefit Issues</td>
</tr>
<tr>
<td>BT200107</td>
<td>05/15/2001</td>
<td>Notification of Systems Issues Regarding Incorrect Payments to Hospice Providers for Room and Board Payments on Member’s Date of Death</td>
</tr>
<tr>
<td>BT200132</td>
<td>08/10/2001</td>
<td>Implementation of Prior Authorization Requirement for Brand Medically Necessary Drugs</td>
</tr>
<tr>
<td>BT200146</td>
<td>12/05/2001</td>
<td>Nursing Facility Bed Hold Days</td>
</tr>
<tr>
<td>Publication Number</td>
<td>Date</td>
<td>Subject</td>
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<tr>
<td>-------------------</td>
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</tr>
<tr>
<td>BR200329</td>
<td>05/30/2003</td>
<td>BT200335 HCPCS Changes, Restricted Card Program Changes, BT200346 Copayment Clarification, HIPAA Workshops Location Change, Omni Software HIPAA-Compliant Available, Inpatient Spend-down Claims to Written Correspondence, Hospice Verification Reminder, MAC Rate Change.</td>
</tr>
<tr>
<td>BT200331</td>
<td>05/30/2003</td>
<td>Detailed explanation of rule changes and the impact of the changes on hospice providers for IHCP hospice authorization, hospice provider enrollment, and hospice review.</td>
</tr>
<tr>
<td>BT200365</td>
<td>10/29/2003</td>
<td>Pharmacy Hard Edits and Hospice Review Process. This bulletin notifies providers about the upcoming edits and changes to the hospice review process.</td>
</tr>
<tr>
<td>BT200372</td>
<td>12/15/2003</td>
<td>Changes to the Hospice Authorization Process. The IHCP is implementing changes to IndianaAIM that will permit the hospice authorization process to mirror IHCP prior authorization for other programs.</td>
</tr>
<tr>
<td>NL200509</td>
<td>09/01/2005</td>
<td>Prenatal Risk Assessment, HIPAA Security and Privacy, Web interChange Password, Signature Stamp, Personal Injury, TPL Credit Balance, MRT and PASRR, Package E Dental, Medicare Prescription Drug, Mandatory RBMC, 3rd Qtr Workshops, Package E CDT-5, TPL Form</td>
</tr>
<tr>
<td>BT200527</td>
<td>11/15/2005</td>
<td>Automation of Spend-down</td>
</tr>
<tr>
<td>BR200547</td>
<td>11/22/2005</td>
<td>Notice to hospice providers that the IHCP may special batch hospice claims</td>
</tr>
<tr>
<td>BR200645</td>
<td>11/07/2006</td>
<td>Effective December 1, 2006, the required changes to IndianaAIM have been made to permit prior authorization (PA) reviewers at ADVANTAGE Health Solutions-FFS, to enter a hospice level of care (LOC) for dually eligible Medicare and Medicaid members residing in nursing facilities with an open-ended segment.</td>
</tr>
<tr>
<td>BT200702</td>
<td>01/30/2007</td>
<td>UB-04 paper claim completion instructions</td>
</tr>
<tr>
<td>NL200704</td>
<td>04/01/2007</td>
<td>IHCP Reimbursement Policy</td>
</tr>
<tr>
<td>BT200723</td>
<td>09/13/2007</td>
<td>Indiana Care Select – (Medicaid Care Management for Aged, Blind, Disabled) and Prior Authorization Changes</td>
</tr>
<tr>
<td>BR200739</td>
<td>09/25/2007</td>
<td>Change to Hospice Process</td>
</tr>
<tr>
<td>BR200914</td>
<td>04/07/2009</td>
<td>Revised Instructions for Medicaid Hospice Plan of Care Form</td>
</tr>
<tr>
<td>BR200917</td>
<td>04/28/2009</td>
<td>Special Processing Required for Home and Community-Based Services Overlapping Hospice Level-of-Care or Long-Term Care Discharge Dates</td>
</tr>
<tr>
<td>BT200933</td>
<td>09/21/2009</td>
<td>Hospice, Home and Community-Based Services, and Medicaid Home Health Services</td>
</tr>
<tr>
<td>BR200930</td>
<td>07/28/2009</td>
<td>Hospice Rate Update</td>
</tr>
<tr>
<td>BT200938</td>
<td>11/17/2009</td>
<td>Revised version of BT200938, Annual Hospice Rates</td>
</tr>
<tr>
<td>Publication Number</td>
<td>Date</td>
<td>Subject</td>
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<tr>
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</tr>
<tr>
<td>BR201006</td>
<td>02/09/2010</td>
<td>Leave Days Billed Without Accommodation Days Will Adjudicate Systematically</td>
</tr>
</tbody>
</table>
Appendix C: Common Error Codes

Overview

The IHCP has monitored hospice claims denial trends since the implementation of the IHCP hospice benefit. This section provides the hospice provider with the most common denials, an explanation of the denial error codes, and how the hospice provider can correct an error code.

Error codes are divided by general IHCP error codes and IHCP hospice error codes. General IHCP error codes are on the Remittance Advice (RA) when the IHCP claim does not meet general IHCP claims processing guidelines. The IHCP hospice error codes are error codes on the RA when a hospice claim does not meet required IHCP hospice claims processing guidelines.

These error codes are not an all-inclusive list nor do they serve as a replacement for information available at HP Customer Assistance at (317) 655-3240 in the Indianapolis local area, toll-free at 1-800-577-1278, or on the IHCP Web site at http://www.indianamedicaid.com.

<table>
<thead>
<tr>
<th>Error Code</th>
<th>Description</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0264</td>
<td>Date of service missing</td>
<td>This denial occurs when the date of service is missing from the UB-04 claim form. This denial is avoided if the provider ensures all dates of service are legible and complete when filing paper claims. Note: The format for dates of service is MMDDYY.</td>
</tr>
<tr>
<td>0387</td>
<td>This service is not payable. The member has not satisfied spend-down for the month.</td>
<td>This denial occurs when the member has not incurred enough medical expenses to satisfy the spend-down amount for the month. This denial also occurs when the claim is submitted to HP for processing prior to the state eligibility consultant entering the spend-down information into the ICES. This denial is avoided by taking the following steps: • Verify the recipient’s eligibility status through one of the eligibility verification systems • Verify the spend-down met date through one of the eligibility verification systems If a spend-down met date is not found through the eligibility verification systems, verify that the client has turned in all receipts for medical services to the county office for calculation of spend-down met date and eligibility activation.</td>
</tr>
<tr>
<td>Error Code</td>
<td>Description</td>
<td>Explanation</td>
</tr>
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<td>------------</td>
<td>------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>0512</td>
<td>Claim past one-year filing limit</td>
<td>This denial occurs when the date of service on the claim exceeds the one-year filing limit. The supporting documentation was either not included with the claim, or it does not support efforts to bill for these services prior to the one-year filing limit. This denial is avoided by submitting the claim to HP within one year of the date of service. It is the responsibility of the provider to monitor the RA statements to ensure the claim was received and processed. If the claim suspends, monitor the claim until adjudication. If the claim denies, take the necessary steps to correct and resubmit.</td>
</tr>
<tr>
<td>0513</td>
<td>Recipient name and number disagree</td>
<td>This denial occurs when the recipient name and recipient identification number do not match. This denial is avoided by verifying that the biller has entered the correct member identification number (RID) for the member.</td>
</tr>
<tr>
<td>0562</td>
<td>Hospice services have incompatible type of bill and revenue codes identified on the claim</td>
<td>This denial occurs when the hospice claim type of bill equals 822, but the revenue codes billed are not part of revenue code group 43. This denial is avoided by ensuring the type of bill on the claim is equal to 822 (hospice), and a revenue code from revenue group 43 is used. The hospice revenue codes are 651, 652, 653, 654, 655, 656, 657, 659, 183, and 185.</td>
</tr>
<tr>
<td>0563</td>
<td>Hospice revenue code/units mismatch</td>
<td>This denial occurs when the units billed are not in range for the revenue code billed. This denial is avoided by ensuring that the revenue code billed should have the corresponding units billed.</td>
</tr>
</tbody>
</table>

Note: Table 7.5 – Hospice Billing Revenue Codes in Section 7: Reimbursement of this IHCP Hospice Provider Manual provides the service units that should be listed in locator 46 of the UB-04 claim form.
<table>
<thead>
<tr>
<th>Error Code</th>
<th>Description</th>
<th>Explanation</th>
</tr>
</thead>
</table>
| 0564       | Revenue code/QMB eligibility invalid | This denial code occurs for the following reasons:  
  - Reason 1: A member is qualified Medicare beneficiary (QMB)-only.  
  - Reason 2: Billing a 659-revenue code for a hospice member when the eligibility is non-QMB or is QMB-Only.  
  This denial is avoided by taking the following actions:  
  - Action 1: For hospice billing, a QMB-Also member is only eligible to bill 183, 185, and 659 revenue codes.  
  - Action 2: Contact HP Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278, to verify the member is categorized as QMB-Also. This is determined by verifying if the recipient has a dual aid segment on his or her Medicare file. If an L or LP is present, then verify if the revenue code being billed is allowable for a QMB-Also member. |
| 1035       | Billing provider not member’s listed hospice provider for dates of service billed | This denial occurs when the provider is not the same provider listed in the member’s file as the member’s authorized hospice provider for the dates of service billed.  
  This denial is be avoided by verifying that the Hospice Provider Change Request Between Indiana Hospice Providers State Form 48733 (R/12-02) OMPP 0009 has been completed and submitted to the ADVANTAGE Health Solutions-FFS.  
  *Note:* This denial has also occurred when hospice providers have used the incorrect hospice provider number from another hospice office location within Indiana or a hospice agency in another state that does not correspond to the hospice provider number listed on the hospice authorization form. |
<table>
<thead>
<tr>
<th>Error Code</th>
<th>Description</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>Member not eligible for Indiana Health Coverage Programs benefits for dates of service</td>
<td>This denial occurs when the member was not eligible for benefits at the time the service was provided. This denial is avoided by verifying eligibility prior to the provision of any services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Note:</strong> It is recommended that providers check eligibility on the 1st or 15th day of the month or at least monthly using one of the IHCP eligibility verification systems and document the eligibility information in the patient’s file.</td>
</tr>
<tr>
<td>2024</td>
<td>The recipient is ineligible for hospice level of care</td>
<td>This denial occurs when the member does not have a hospice level of care on file for the dates of service billed. This denial is avoided by doing the following:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Bill only after receiving approval for the certification period from the ADVANTAGE Health Solutions-FFS.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Contacting the ADVANTAGE Health Solutions-FFS to verify that the initial election or recertification paperwork has been received and processed by an ADVANTAGE Health Solutions-FFS hospice analyst. Contact ADVANTAGE Health Solutions-FFS no sooner than 14 business days after having mailed the paperwork.</td>
</tr>
<tr>
<td>2025</td>
<td>Hospice recipient billing for nonhospice services</td>
<td>This denial occurs when the recipient’s level of care is equal to 51H, 52H, or 53H (hospice benefit periods), but the type of bill is not equal to bill type 822 (hospice), or a revenue code in revenue group 43 (hospice revenue codes 651, 652, 653, 654, 655, 656, 657, 183, and 185) is not being billed. This denial is avoided by ensuring that bill type 822 and the appropriate revenue codes are listed on the claim form.</td>
</tr>
<tr>
<td>2026</td>
<td>Recipient not eligible for this level of care for the dates of service and revenue codes billed</td>
<td>This denial occurs when a hospice recipient is billing revenue codes 653, 654, 659, 183, or 185, but a nursing home level of care is missing or not active for the dates of service being billed. This denial is avoided by ensuring that a DPW Form 450B has been submitted and approved for nursing facility level of care.</td>
</tr>
<tr>
<td>Error Code</td>
<td>Description</td>
<td>Explanation</td>
</tr>
<tr>
<td>------------</td>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>4040</td>
<td>Primary diagnosis code not on file</td>
<td>This denial occurs when hospice services are billed and the primary diagnosis code is not on the diagnosis table for claim type 822. This denial is avoided by checking that the primary hospice diagnosis is in locator 67.</td>
</tr>
<tr>
<td>5001</td>
<td>This is a duplicate of another claim</td>
<td>This denial occurs when the claim being processed is an exact duplicate of a claim(s) on the history file or another claim being processed in the same cycle. This denial is avoided by verifying previous claim denial by using the Automated Voice Response (AVR) system or calling the HP Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278, to verify previous claim payment to another provider. If a spend-down met date is not found through the Eligibility Verification System (EVS), verify that the client has turned in all receipts for medical services to the county office for calculation of spend-down met date and eligibility activation.</td>
</tr>
<tr>
<td>9069</td>
<td>Room and board not paid on date of death/discharge</td>
<td>This denial occurs when Occurrence code 51 is not used. IndianaAIM calculates the bill twice: first for the long-term care (LTC) portion and second for the hospice portion. The code is set up to deduct patient liability and apply it to the LTC portion of the bill which is paid first, by design. Consequently, there is no balance left for patient liability. IndianaAIM does not apply patient liability to the hospice routine home care portion of the claim; however, TPL is applied. If Occurrence code 51 is used for the date of death/discharge, the hospice portion of the claim is paid.</td>
</tr>
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