INDIANA MEDICAID UPDATE

January 9, 1998

TO: Medicaid Hospice Providers

From: Office of Medicaid Policy and Planning

SUBJECT: Medicaid Hospice Billing Procedures

The Family and Social Services Administration, Office of Medicaid Policy and Planning (OMPP), previously announced the addition of the hospice benefit as a covered service under the Indiana Medicaid program. The hospice benefit was mandated by HEA 1921 and carries an effective date of July 1, 1997. Since the passage of the hospice legislation, the OMPP and our fiscal agent contractor, EDS, have been working together to add the hospice benefit to the IndianaAIM system so that hospice providers may be enrolled and hospice claims can be processed timely and accurately.

Although the OMPP and EDS have been working diligently on this benefit, reimbursement to providers will not be available systematically through the IndianaAim system until January 28, 1998. Therefore, a manual system of reimbursement has been designed for those providers, who, due to a financial hardship, cannot wait to be reimbursed until January 28, 1998. Since manual claims processing will be based on estimated rates and will require a subsequent settle-up, we recommend that providers pursue this option only if absolutely necessary.

Provider Enrollment

Hospice providers must first be enrolled in the Medicaid program before reimbursement can be made for services provided to hospice recipients.

Hospice provider participation in the Indiana Medicaid hospice program requires submission of the following documentation:

- A Provider Enrollment Agreement, which must be completed whether or not a provider currently participates as an Indiana Medicaid provider of another service; and
- A copy of the provider's Medicare Hospice Certification letter from the Health Care Financing Administration.

If you are a hospice provider and are currently not enrolled in the Medicaid program, a Provider Enrollment Agreement is available from the EDS Provider Enrollment Unit. The Provider Enrollment Unit may be contacted at the following address:

EDS Provider Enrollment Unit
10th Floor, 950 N. Meridian Street
Indianapolis, Indiana 46204

or by calling 1-800-577-1278 or locally at 655-3240.

Upon receiving the completed provider enrollment packet and copy of the provider's Medicare hospice certification, the EDS Provider Enrollment Unit will issue the provider a unique Medicaid hospice provider number.

Hospice Reimbursement Methodology

Reimbursement for the Medicaid hospice benefit follows the methodology and amounts established by the Health Care Financing Administration (HCFA) for administration of the federal Medicare Program. Medicaid hospice reimbursement rates are therefore based on Medicare reimbursement rates and methodologies, adjusted to disregard offsets attributable to Medicare coinsurance amounts. The rates are further adjusted for regional differences in wages using indices published by HCFA. The current rates to be used in billing Medicaid hospice services are attached.

The total per diem amounts reimbursed to a hospice provider are calculated according to the recipient's level of care **and** the recipient's location of care.

Reimbursable Levels of Service

The following hospice services are reimbursable by the Medicaid program.

(1) Routine Home Hospice Care Delivered in a Private Home - The hospice provider will be paid for each day the hospice recipient is in a private home, under the care of the hospice provider, and not receiving continuous home care. The hospice provider will receive the hospice per diem only.

(2) Routine Home Hospice Care Delivered in a Nursing Facility - The hospice provider will be paid for each day the hospice recipient is in a nursing facility, under the care of the hospice provider, and not receiving continuous home care. The hospice provider will receive the hospice per diem plus 95% of the nursing facility room and board per diem.

(3) Continuous Home Care Delivered in a Private Home - The hospice provider will be paid up to twenty-four (24) hours a day for providing primarily nursing care to achieve palliation and management of acute medical symptoms to hospice recipients in a private home. Continuous home care is to be provided only during a period of crisis in which a hospice patient requires continuous care. The hospice provider will receive the hospice per diem only.

(4) Continuous Home Care Delivered in a Nursing Facility - The hospice provider will be paid up to twenty-four (24) hours a day for providing primarily nursing care to achieve palliation and management of acute medical symptoms to hospice recipients in a nursing facility. Continuous home care is to be provided only during a period of crisis in which a hospice patient requires continuous care. The hospice provider will receive the hospice per diem plus 95% of the nursing facility room and board per diem.

(5) Inpatient Respite Care - The hospice provider will be paid at the inpatient respite care rate for each day that the hospice recipient, coming from his/her private home, is in an approved inpatient facility and is receiving respite care. Respite care is short term inpatient care provided to the hospice recipient only when necessary to temporarily relieve the family member or other persons caring for the hospice recipient. The hospice provider will receive the hospice per diem only.

(6) General Inpatient Hospice Care - The hospice provider will be paid at the general inpatient hospice rate for each day the hospice recipient is in an approved inpatient facility and is receiving general inpatient hospice care for pain control or acute or chronic symptom management which cannot be managed in other settings. The hospice provider will receive the hospice per diem only.

Managed Care Recipients Electing the Hospice Benefit

Recipients enrolled in any of the three Medicaid managed care programs must disenroll before hospice authorization can be completed.

Risk Based Managed Care - RBMC
Primary Care Case Management - PCCM
Managed Care for Persons with Disabilities and Chronic Illnesses - MCPD

Managed care recipients who elect to enroll in the Medicaid hospice benefit, will become eligible for hospice care the day following disenrollment from the managed care program. Providers may fax recipient enrollment information for managed care recipients to (317) 488-5061. This is to be used for managed care recipients only.

Explanation of Use of Draft Medicaid Hospice Forms

Please assure prospective hospice recipients that Medicaid has directed hospice providers to utilize forms marked DRAFT until such time as OMPP has replaced draft forms with state approved permanent forms. These forms will be made available to Medicaid enrolled hospices as soon as possible.

How To Bill For Hospice Services

Hospice providers are to bill hospice services using the UB-92 claim form. The following form indicator numbers are circled on the attached UB-92 claim form and must be completed so that proper reimbursement can be made to the hospice provider.

Form Locator	Narrative Description
1	Provider Name, Address & Telephone Number: Enter the requested information required.
4	TYPE OF BILL: Enter the code indicating the specific type of bill. (Required - use type of bill 822).
6	STATEMENT COVERS PERIOD, FROM/THROUGH: Enter the beginning and ending service dates included on this bill. For all services rendered on a single day, use both the FROM and THROUGH dates. Enter in a MMDDYY format; e.g., 122594. Required.
12	PATIENT NAME: Enter last name, first name, and middle initial of the recipient. Required.
42	REV. CD.: Enter the provided revenue code which identifies the specific hospice service. The appropriate three-digit, numeric revenue code must be entered to explain each charge entered in form locator 47. Refer to the Indiana Administrative Code (Appendices 1 and 2) for covered services and limitations and medical policy rules.

Required Hospice revenue codes are listed below.

Revenue Codes		
65X	Hospice	
	651	Routine Home Care in a private home
	652	Continuous Home Care in a private home
	653	Routine Home Care in a nursing facility
	654	Continuous Home Care in a nursing facility
	655	inpatient Respite Care
	656	General Inpatient Care
	657	Hospice Direct Care Physician Services
	659	Dual Eligibility Nursing Facility Recipients Only
	183	Therapeutic Leave Days
	185	Hospital Leave Days

43 DESCRIPTION: Enter a narrative description of the related revenue codes on this bill. Abbreviations may be used. Required.

44 HCPCS/RATES: Enter the HCPCS code applicable to the service provided. Only one service code per line is permitted. Required for Rev. Code 657 only.

45 SERV. DATE: Enter the date the indicated service was provided. Required

46 SERV. UNITS: Enter the number of units corresponding to the revenue code (or HCPCS code) billed. This form locator can accommodate seven numeric digits. Required.

UNIT OF SERVICE: Enter each date of service as a separate line item. Each different service provided on the same date should also be billed as separate line items.

Rev. Code	Unit of Measure
651	Day
652	Hour
653	Day
654	Hour
655	Day
656	Day
657	Day
659	Day
183	Day
185	Day

Note:
Partial units of service may not be billed. If a fractional unit of service is rendered, it should be billed on a separate line as one unit, but with a reduced charge to correspond to the partial unit of service rendered.

47 TOTAL CHARGES: Enter the total charges pertaining to the related revenue code for the STATEMENT COVERS PERIOD. Enter revenue code 001 to indicate totals, with the sum of all charges billed reflected in form locator 47. Nine numeric digits are allowed per line; e.g., 9999999.99. Required.

Note:
For form locators 50A, B, and C through 55A, B, and C: Medicare should always be listed first (50A), if applicable. Other insurers, such as a Medicare supplement, are then listed in the second form locator (50B), if applicable. Finally, Indiana Medical Assistance Programs information is listed last (50C).

For form locators 58A, B, and C through 62A, B, and C: enter data relative to the entries in form locators 50A, B, C; e.g., Medicare, Medicare supplement, Medicaid/spenddown.

50A PAYER: Enter the Medicare carrier's name, or other primary insurer. Required, if applicable.

50B PAYER: Enter the Medicare supplement carrier's name and additional payer names. Required, if applicable.

50C PAYER: Enter Medicaid as the program. If the recipient is in a spenddown category, enter "Medicaid/spenddown" on the same line (50C) as the applicable Indiana Medical Assistance Program; e.g., "Medicaid/spenddown". Required.

51A,B,C
PROVIDER NO.: Enter the provider number for the corresponding payer listed in form locators 50A, B, and C. Your Medical Assistance Programs' provider number is required; others optional.

Note:
A complete Indiana Medical Assistance Programs provider number should have nine numerical digits and one alpha character for the service location code; for example, 123456789X.

54A,B,C
PRIOR PAYMENTS: Enter the amount paid by the carrier entered in form locators 50A and B, as applicable. The spenddown deductible from the DFC Form 8A is entered in form locator 54C for Medicaid spenddown recipients. Required, if applicable.

Note:
Always attach a Medicare and/ or TPL denial to any claim.

55C EST. AMOUNT DUE: Enter the amount billed. This amount is calculated by form locator 47 Revenue Code 001 TOTAL CHARGES entry minus form locators 54A, B, and C PRIOR PAYMENTS entries minus form locator 57 DUE FROM PATIENT entry equals the EST. AMOUNT DUE. This form locator accommodates nine numeric digits; i.e., 9999999.99. Required.

57 DUE FROM PATIENT: Enter the amount due from the patient for personal convenience and other non-covered items requested by the recipient (see Section 4-4, Charging for Services). Required, if applicable.

58A,B,C
INSURED'S NAME: Enter recipient's LAST NAME, FIRST NAME, and MIDDLE INITIAL. Medical Assistance Programs' recipient information is required. Enter third party liability information; required, if applicable.

60A,B,C
CERT. - SSN - HIC. - ID NO.: Enter the recipient's identification number for the respective payers entered in form locators 50A, B, and C. The 12-digit recipient ID (RID) number is required in form locator 60C (see form locator 50C) for the Medical Assistance Programs; other carrier information is required, as well.

61A,B,C

GROUP NAME: Enter the name of the group or plan through which the insurance is provided to the recipient by the respective payers entered in form locators 50A, B, and C. Required, if applicable.

62A,B,C

INSURANCE GROUP NO.: Enter the identification number(s), control number(s), or code(s) assigned by the carrier or administrator to identify the group(s) under which the individual is covered (see form locators 50 A and B). Enter the policy number(s), as well. Required, if applicable.

65A,B,C

EMPLOYER NAME: Enter the name of the employer that may or does provide health care coverage for the insured individual identified in form locator 58. Required, if applicable.

66A,B,C

EMPLOYER LOCATION: Enter the specific location of the employer identified in form locators 65A, B, C. Required, if applicable.

67 PRIN. DIAG. CD.: Enter the ICD-9-CM code describing the principal diagnosis (i.e., the diagnosis that is determined to be chiefly responsible for the admission of the patient.) Required.

68-75 OTHER DIAG. CODES: Enter the ICD-9-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay. Required.

85 PROVIDER REPRESENTATIVE: An authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of the bill. A stamped signature is acceptable; however, a typed signature is not. Required.

86 DATE: Enter the date the bill is submitted. Enter in a MMDDYY format. Required.

Hospice Billing Revenue Codes

- **Revenue Code 651**: Routine Home Care delivered in a private home. The hospice will be paid at the routine home care rate for each day the recipient 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.

- **Revenue Code 652**: Continuous Home Care delivered in a private home. Continuous home care is to be 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 (8) hours of care must be provided during a twenty-four (24) hour day that begins and ends at midnight. A registered nurse or a licensed practical nurse 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 recipient to remain at home, this is covered as routine home care. The continuous home care per diem rate is divided by twenty-four (24) hours in order to calculate an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice provider for up to twenty-four (24) hours a day.

- **Revenue Code 653**: Routine Home Care delivered in a nursing facility. The hospice provider will be paid at the routine home care rate for each day the recipient is in a nursing facility 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 service on any given day. In addition, the hospice provider will be paid 95% of the lowest nursing facility per diem to cover room and board costs incurred by the contracted nursing facility.

- **Revenue Code 654**: Continuous Home Care delivered in a nursing facility. As in the private home setting, the continuous home care rate is divided by twenty-four (24) hours in order to calculate an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice provider up to twenty-four (24) hours a day. All of the limitations listed for the private home setting also apply in the nursing facility setting. In addition, the hospice will be paid 95% of the lowest nursing facility per diem to cover room and board costs incurred by the contracted nursing facility.

- **Revenue Code 655**: Inpatient Respite Care. The hospice provider will be paid at the inpatient respite care rate for each day that the recipient is in an approved inpatient facility and is receiving respite care. Respite care is short-term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient. Respite care may be provided only on an occasional basis. Payment for respite care may be made for a maximum of five (5) 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 recipients who normally reside in their <u>private</u> homes.

- **Revenue Code 656**: General Inpatient Hospice Care. The hospice provider will be paid at the general inpatient hospice rate for each day the recipient 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.

- **Revenue Code 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 will be reimbursed outside of the per diem rate, on a fee-for-service basis. These services will be billed by the hospice provider under the hospice provider number.

- **Revenue Code 659**: Dual Eligibility Nursing Facility Recipients Only. This revenue code will be utilized for dually eligible recipients residing in a nursing facility. This code will represent the room and board portion of the hospice per diem. The hospice provider will be paid 95% of the lowest nursing facility per diem to cover room and board costs incurred by the contracted nursing facility.

- **Revenue Code 183**: Nursing facility bed hold for hospice therapeutic leave days. The hospice provider will receive 50% of the 95% nursing facility per diem room and board rate associated with therapeutic leave of absence days. A total of 18 therapeutic leave of absence days is allowed per patient per calendar year.

- **Revenue Code 185**: Nursing facility bed hold policy for hospitalization for services unrelated to the terminal illness of the hospice recipient. The hospice provider will receive 50% of the 95% nursing facility per diem rate associated with each hospitalization up to 15 days per occurrence.

Reimbursement for Physician Services

Physician Services under Revenue Codes 651 - 655: The basic payment rates for Medicaid 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 made with, the hospice provider. The physician who serves as the 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 plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care [revenue code 651 or 653], continuous home care [revenue code 652 or 654], and inpatient respite care [revenue code 655].

Physician Services Under Revenue Code 657: Reimbursement for a hospice-employed physician's direct patient services, which are not rendered by a hospice physician volunteer, will be billed as an additional payment by the hospice provider under the hospice provider number. The only physician services to be billed by a hospice provider for such services are direct patient care services. Laboratory and x-ray services are included in the hospice daily rates.

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 Indiana Medicaid reimbursement methodology for physician services. **Accordingly, these services should not be billed by the hospice provider under the hospice provider number.**

The only services to be billed by an attending physician are the physician's personal professional services. Costs for services such as laboratory or x-rays are not to be included on the attending physician's billed charges to the Medicaid program. These costs are included in the daily hospice care rates paid and are expressly the responsibility of the hospice provider.

Volunteer Physician Services: Volunteer physician services are excluded from Medicaid reimbursement. However, a physician who provides volunteer services to a hospice may be reimbursed for non-volunteer services provided to hospice patients. In determining which services are furnished on a volunteer basis and which are not, a physician must treat Medicaid patients on the same basis as other hospice patients. For example, a physician may not designate all physician services rendered to non-Medicaid patients as volunteered and at the same time seek payment for all physician services rendered to Medicaid patients.

Requesting a manual payout for services provided prior to IndianaAIM implementation

Once the hospice provider is enrolled in the Medicaid program and has provided services to a Medicaid recipient who has elected the hospice benefit, the provider may submit claims with a payment agreement to notify EDS to begin the manual payout process. A copy of the payment agreement is attached to this bulletin and must be submitted with each batch of claims submitted to EDS for manual reimbursement. Claims are to be sent to the Prior Authorization Unit at P.O. Box 68763 Indianapolis, IN. 46268-0763.

Once the claims and payment agreement have been received and reviewed by EDS, the payment agreement will be sent to the EDS Finance Department, which will then establish an accounts receivable specific to the hospice's Medicaid provider number. The hospice provider's accounts receivable will remain open until such time as the IndianaAIM system can formally process the hospice provider's claims.

Emergency Services

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

If the emergency services are unrelated to the terminal illness, Medicaid will pay the transportation and hospital claims associated with the emergency services.

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Further inquiries regarding the hospice benefit, or questions regarding this bulletin, may be directed to the EDS Provider Assistance Unit at 1-800-577-1278.