Indiana Title XIX

**M E D I C A I D  B U L L E T I N**

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**To:** **Medicaid-Enrolled Hospice and Nursing Facility Providers**

**Subject:** **Treatment for Non-Terminal Conditions for Hospice Recipients Admitted to a Nursing Facility After a Hospital Stay**

## Overview

Medicaid payment for services provided to hospice recipient in a nursing facility for conditions unrelated to the terminal illness will depend upon one of the following two scenarios:

1. The hospice recipient is a dually-eligible Medicare/Medicaid recipient discharged to a nursing facility after a three day Medicare qualifying hospital stay for ongoing treatment of the non-terminal condition.
2. The Medicaid-only hospice recipient is discharged to a nursing facility following an inpatient hospitalization for the non-terminal condition.

This bulletin provides clarification about the following issues:

- Whether the hospice patient must choose hospice care or nursing facility care after he or she is discharged from the hospital to a nursing facility for treatment of the terminal condition.
- Payment parameters for treatment of non-terminal conditions for a dually-eligible Medicare/Medicaid hospice recipient who is discharged from a hospital to a nursing facility for treatment of a non-terminal condition.
- Payment parameters for treatment of non-terminal conditions for a Medicaid-only hospice recipient who is discharged from a hospital to a nursing facility for treatment of a non-terminal condition

## Hospice Patient's Decision to Choose Hospice Care or Nursing Facility Care Under Medicare or Medicaid

There are situations when a Medicaid-only hospice recipient or dually-eligible Medicare/Medicaid hospice recipient residing in his or her own private home must be admitted to a hospital for treatment of a non-terminal condition and then discharged to a nursing facility for further treatment of that non-terminal condition.

The nursing facility and hospice provider must advise the hospice recipient of his or her options with nursing facility care and hospice care, the services offered under each option, and the consequences of selecting either option from a patient care, insurance coverage, and billing perspective.

## Use of Condition Code 07 By Non-Hospice Providers Billing Medicare For Non-Terminal Conditions For A Medicare Hospice Beneficiary

The Office of Medicaid Policy and Planning (OMPP) reminds hospice and nursing facility providers that for Medicare beneficiaries, the Medicare program specifies that non-hospice providers may bill Medicare directly by using condition code 07 when that non-hospice provider delivers Medicare covered services to treat the non-terminal condition of a Medicare hospice beneficiary. This policy also applies to dually-eligible Medicare/Medicaid hospice recipients since Medicaid is the payer of last resort.

The non-hospice provider must bill Medicare by using Condition Code 07 in fields 24-30 on the UB92 claim form. The Medicare program stipulates to non-hospice providers that non-hospice providers will be subject to recovery of overpayments and possible referral of fraud and abuse investigation if a pattern of incorrect use of Condition Code 07 is determined.

If hospice providers or nursing facility providers have further questions regarding the proper use of Condition Code 07 or a case-specific question involving a Medicare hospice beneficiary (whether the individual is Medicare only or dually-eligible Medicare/Medicaid hospice recipient), then the OMPP recommends that Palmetto, the Medicare Intermediary for Indiana, be contacted at 1-803-736-4730, for case-specific direction and for a copy of Medicare Advisory Hospital #97-03 or SNF 97-01 for future reference. Since Medicaid is the payer of last resort, hospice providers and nursing facilities serving dually-eligible Medicare/Medicaid hospice recipients must bill

Medicare first for non-hospice services according to the parameters established by the Medicare program.

## Indiana Payment Parameters For Treatment of Non-Terminal Conditions For Medicaid-Only Hospice Recipients

If a Medicaid-only hospice recipient receives nursing facility care for treatment of a non-terminal condition, payment to the nursing facility must be made in compliance with the parameters outlined in *405 IAC 1-16-4*. This applies even though the nursing facility stay is for treatment of the non-terminal condition.

This payment provision applies in the following situations:

- The hospice recipient resides in his or her private home and is admitted to the nursing facility for rehabilitation and recovery after release from a hospital.
- The nursing facility resident is under hospice care and is admitted to the hospital for an inpatient hospital stay and then is re-admitted to the nursing facility for rehabilitation and recovery after release from the hospital.

## Completion of the IPAS and 450B For Hospice Patients Admitted to a Nursing Facility

Both state and federal law require that a person applying for admission to a nursing facility must be shown to have a need for nursing facility care prior to the onset of any Medicaid reimbursement for nursing facility care. There are no exceptions to this requirement; therefore, the existing Indiana Pre-admission Screening (IPAS) and federal Pre-admission Screening and Resident Review (PASRR) requirements for nursing facility admissions apply to individuals under hospice care who are being admitted to a nursing facility. The nursing facility must follow the current IPAS and PASRR requirements for taking nursing facility applications and forwarding the applications to the local Area Agency on Aging IPAS Agency for processing.

No Medicaid reimbursement is available for nursing facility care until the nursing facility has received a Form 450B (or Form 450B SA/DE) from the OMPP authorizing admission and a Medicaid effective reimbursement date.

Hospice and nursing facility providers are reminded that for a dually-eligible Medicare/Medicaid hospice recipient entering a nursing

facility under Medicare coverage following a hospitalization, the OMPP will not complete the Form 450B until the Medicare skilled days have been exhausted. The nursing facility will need to submit the Form 450B to the OMPP for approval of the Medicaid only reimbursed institutionalization if the individual remains in the facility following the Medicare coverage.

### *Procedures For Dually-Eligible Medicare/Medicaid Hospice Recipient Residing in His or Her Private Home Who is Admitted to the Nursing Facility For Treatment of Non-Terminal Condition*

The following issues arise when a dually-eligible Medicare/Medicaid hospice recipient is admitted to the hospital with a three day qualifying stay and must be discharged to a nursing facility for continuation of the care provided in a hospital. The common example raised by hospice providers involve a dually-eligible Medicare/Medicaid hospice recipient residing in his or her home who falls and breaks his or her hip and is then admitted to the nursing facility for rehabilitation and recovery after release from a hospital.

The hospital and the hospice provider have the following notification and billing responsibilities when a dually-eligible Medicare/Medicaid hospice recipient is admitted under a three day Medicare qualifying hospital stay:

- The hospice provider must notify both Medicare and Medicaid that the dually-eligible Medicare/Medicaid hospice recipient has been hospitalized since the hospitalization constitutes a change in hospice patient status. The Indiana Medicaid program requires the hospice provider to send a Change in Medicaid Hospice Patient Form to the Health Care Excel (HCE) Prior Authorization Unit. This form must also be completed when a dually-eligible Medicare/Medicaid hospice recipient is discharged from the hospital and transferred to a nursing facility for treatment of the non-terminal condition.
- The hospice provider must bill Medicare Part A for hospice services for the dates of service that the hospice patient is hospitalized.
- The hospital must bill Medicare for treatment of the non-terminal condition using condition code 07 on field 24-30 of the UB92 claim form as outlined in Medicare Advisory Hospital #97-03.

The hospice and nursing facility have the following notification and billing responsibilities when a hospice patient must be transferred to a nursing facility for treatment of a non-terminal condition after a three day Medicare qualifying hospital stay:

- The hospice provider must notify Medicare and Medicaid programs that this individual has been transferred from a hospital to a nursing facility. The Indiana Medicaid program requires the hospice provider to send a Change in Medicaid Hospice Patient Status Form to the HCE Prior Authorization Unit.
- The hospice provider continues to bill Medicare Part A for the hospice services. The nursing facility is responsible for billing Medicare for treatment of the non-terminal condition using condition 07 on field 24-30 on the UB92 claim form as outlined in Medicare Advisory SNF #97-01.
- While the dually-eligible hospice recipient is receiving treatment for the non-terminal condition, the hospice provider must NOT bill Indiana Medicaid for nursing facility room and board using revenue code 659 since Medicare is paying the nursing facility directly for treatment of the hospice recipient's non-terminal condition.
- Once a nursing facility has completed treatment for the hospice patient's non-terminal condition, the hospice patient is discharged to his or her private home. The hospice provider must notify Indiana Medicaid by submitting a Change in Hospice Patient Status Form to HCE Prior Authorization Unit. The hospice provider must notify Medicare according to Medicare program guidelines.
- There may be rare occasions when a nursing facility may request durable medical equipment (DME) for a hospice patient, such as a customized wheelchair. On those rare occasions, Indiana Medicaid will require a nursing facility to submit a request for prior authorization to the HCE Prior Authorization Unit. This request for prior authorization must include a copy of Medicare's denial for this durable medical equipment.

### *Procedures for Medicaid-Only Hospice Recipient Residing in his or her Private Home Who is Admitted to the Nursing Facility for Treatment of Non-Terminal Condition*

- The hospice provider must complete a Change in Hospice Patient Status Form to notify Indiana Medicaid that the hospice recipient has been admitted to the hospital by submitting the form to the HCE Prior Authorization Unit.
- The hospice provider must continue to bill Indiana Medicaid for hospice services using revenue code 651 (routine home care delivered in a private home) or revenue code 652 (continuous home care delivered in a private home) while the hospice patient is in the hospital.

- When the hospice patient is discharged from the hospital to the nursing facility, the hospice provider must complete and submit a Change in Hospice Patient Status form to the HCE Prior Authorization Unit.
- State and federal law require that the nursing facility complete a Pre-Admission Screening (PAS) form. A 450B must be submitted to:

  Level of Care Unit
  MS07
  Office of Medicaid Policy and Planning
  402 West Washington Street
  Indianapolis, IN 46204

  Hospice and nursing facility providers are reminded that Medicaid cannot reimburse hospice claims for nursing facility room and board services until the nursing facility has an approved 450B from the OMPP Level of Care (LOC) Unit. In short, hospices must wait until the nursing facility has an approved 450B before the hospice may bill Medicaid for the hospice and nursing facility room and board add-on using either hospice revenue codes 653 or 654.
- Unlike Medicare, Indiana Medicaid does not permit a nursing facility to bill Indiana Medicaid directly for treatment of the non-terminal condition. As outlined in *405 IAC 1-16-4*, the hospice provider must bill Indiana Medicaid for nursing facility care. The OMPP will pay the hospice provider 95 percent of the nursing facility case mix rate and the hospice must reimburse the nursing facility per their contract. If the nursing facility fails to comply with *405 IAC 1-16-4* and bills the OMPP directly, the nursing facility will be subject to recoupment by the OMPP of any Medicaid overpayments.
- When a hospice patient is discharged from the nursing facility to his or her private home, the hospice provider must complete and submit a Change in Hospice Patient Status form to the HCE Prior Authorization Unit.
- When the hospice patient has resumed residence in his or her private home, the hospice provider must bill Indiana Medicaid using hospice revenue code 651 (routine home care delivered in a private home) or hospice revenue code 652 (continuous home care delivered in a private home) for those dates of service following the discharge from the nursing facility.

## *Procedures For Hospice and Nursing Facility Staff When A Dually-Eligible Medicare/Medicaid Hospice Recipient Must Remain In the Nursing Facility After the Non-Terminal Condition Has Been Treated*

The purpose of this section is to address procedures that the hospice and nursing facility provider must follow when a dually-eligible Medicare/Medicaid hospice recipient must remain in a nursing facility because the hospice patient has experienced a general worsening of his or her overall condition. At this point, the hospice patient's non-terminal condition has been treated and paid for by Medicare.

If nursing facility care becomes appropriate for a hospice patient after a non-terminal condition has been treated, it is important that hospice and nursing facility providers ensure that the nursing facility has initiated the appropriate paperwork to ensure ongoing approval for Medicaid nursing facility level of care. If the nursing facility does not have a Form 450B (or Form 450B SA/DE) authorizing long term nursing facility placement, a Form 450B and supporting medical documentation must be submitted to:

Level of Care Unit
MS07
Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204

Hospice and nursing facility providers are reminded that Medicaid cannot reimburse hospice claims for nursing facility room and board until the nursing facility has an approved 450B from the OMPP LOC Unit. The OMPP LOC Unit will complete processing of a Form 450B once Medicare days for nursing facility days have been exhausted.

Once the Form 450B is approved for a hospice recipient residing in the nursing facility, the hospice provider may start billing Indiana Medicaid for nursing facility room and board services using hospice revenue code 659.

Further inquiries regarding the Medicaid hospice benefit, or questions regarding this bulletin, may be directed to the EDS Customer Assistance Unit at (317)-655-3240 or 1-800-577-1278.