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**Related Clinical Coverage Policies**

Refer to <http://www.ncdhhs.gov/dma/mp/> for the related coverage policies listed below:  
9, Outpatient Pharmacy Program

**1.0 Description of the Procedure, Product, or Service**

The NC Medicaid (Medicaid) and NC Health Choice (NCHC) hospice benefit provides a coordinated and comprehensive set of services for the physical, psychosocial, spiritual, and emotional needs of terminally ill beneficiaries and their families and caregivers.

**Note:** Throughout this policy, wherever the word “family” is used, “caregivers” are included unless specifically stated otherwise.

The services are provided by a public agency or private organization that is primarily engaged in providing hospice care as directed by a care plan established by an interdisciplinary group (IDG). The IDG is a team of medical professional and social support staff employed by, or under contract with, the hospice agency, in accordance with guidelines established by the Centers for Medicare and Medicaid Services (CMS) and listed in the Code of Federal Regulations (42 CFR 418). Services are provided in private homes, hospice residential care facilities, adult care homes, nursing facilities, Intermediate Care Facilities for Mental Retardation (ICF-MR), and hospitals. The hospice and the facility or hospital shall have a written contractual agreement for services to be provided in the facility or hospital setting. Hospice participation may limit Medicaid reimbursement of other services. The hospice benefit covers all care pertaining to or resulting from the terminal illness.

Program coverage complies with North Carolina Administrative Code 10A NCAC 13K, *North Carolina Rules Governing the Licensure of Hospice*, N.C. General Statute 10 G.S. 131E-201, and Federal Code of Regulations 42 CFR 418 with citation from Authority: Sections 1102 and 1871 of the Social Security Act (42 U. S. C. 1302 and 1395hh).

**1.1 Covered Services**

A hospice agency shall routinely provide substantially all core services directly by hospice employees. Core services include nursing services, medical social services, counseling, and physician services. The hospice may contract for physician services as described in **Subsection 1.1.1**. The hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of beneficiaries under extraordinary or other non-routine circumstances as outlined in 42 CFR 418.64. The hospice shall provide hospice care that optimizes comfort and dignity and is consistent with the needs and goals of the beneficiary and family.

The hospice shall be primarily engaged in providing the following care and services and shall do so in a manner that is consistent with accepted standards of practice and in accordance with 42 CFR 418.202.

### **1.1.1 Physician Services**

Physician services are provided by a doctor of medicine or doctor of osteopathy licensed by the North Carolina Board of Medicine and as outlined in 42 CFR 410.20. The services are administrative or supervisory and include the role of medical director, participating on the IDG, assisting with the development of and approving care plans, and serving as a consultant to the hospice staff.

The physician shall be either a direct employee of the hospice or provide services under contract. The hospice medical director, physician employees, and contracted physicians are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness, in conjunction with the beneficiary's attending physician. The hospice physician or nurse practitioner may also act as the beneficiary's attending physician. Attending physician services are not considered a hospice service and are covered under the Medicaid Physician Services program.

### **1.1.2 Nursing Services**

Nursing services are provided by a registered nurse (RN) or licensed practical nurse (LPN) licensed by the North Carolina Board of Nursing and in accordance with G.S. 90-171.19-.47, *North Carolina Nursing Practice Act*, 21 NCAC 36, current standards of practice, and agency policy. The hospice shall provide nursing care and services by or under the supervision of an RN. The RN shall ensure that the nursing needs of the beneficiary are met as identified in the initial assessment, comprehensive assessment, and updated assessments. Nursing services are considered a core service that must be provided routinely by hospice employees. The hospice provider may apply for a waiver to CMS for contracting nursing services in accordance with 42 CFR 418.66. Nursing services are included as part of the IDG and provide the supervision of the hospice aide.

### **1.1.3 Medical Social Services**

Medical social services must be provided by a qualified social worker (as defined in 10A NCAC 13K and 42 CFR 418), under the direction of a physician. The social worker shall base all services on the beneficiary's psychosocial assessment and the beneficiary's and family's needs for and acceptance of these services.

### **1.1.4 Counseling Services**

The hospice shall provide counseling services to the beneficiary and family to assist with minimizing the stress and problems that arise from the terminal illness, problems related to it, and the dying process. Counseling services include the following.

#### **a. Spiritual**

1. The hospice shall designate a clergy member to be responsible for coordinating the beneficiary's and the family's spiritual care in accordance with the beneficiary's and family's acceptance of this service [per 42 CFR 418.64(d)(3)(ii)]. The clergy member is an individual who has received a degree from a school of theology and has fulfilled appropriate denominational seminary requirements, or an individual

who, by ordination or authorization from the beneficiary's denomination, has been approved to function in a pastoral capacity.

2. The hospice shall provide an assessment of the beneficiary's and family's spiritual needs and provide counseling to meet those needs in a manner consistent with the beneficiary's and family's beliefs and desires.
  3. The hospice shall make all reasonable efforts to facilitate visits by local clergy and other individuals who can support the beneficiary's spiritual needs.
- b. Bereavement
1. The hospice shall have an organized program for the provision of bereavement services, furnished under the supervision of a qualified professional with experience or education in grief or loss counseling.
  2. The hospice shall make bereavement services available to the family and other individuals in the bereavement plan of care for up to one year following the death of the beneficiary. Bereavement counseling also extends to residents of a nursing facility or ICF-MR when it is appropriate and documented in the bereavement plan of care.
  3. The hospice shall develop a bereavement plan of care that notes the kinds of bereavement services to be offered and the frequency of service delivery. The plan of care reflects the needs of the bereaved in accordance with 42 CFR 418.204(c).
- c. Dietary
- The hospice shall provide dietary counseling when it is identified in the plan of care. A qualified individual shall provide dietary counseling. A "qualified individual" is a dietitian, a nurse, or another individual who is able to address the dietary needs of the beneficiary and ensure that they are met.

### 1.1.5 Hospice Aide and Homemaker Services

The hospice shall make hospice aide and homemaker services available and adequate in frequency to meet the needs of the beneficiary. The hospice shall ensure that aide training and skills are in accordance with state licensure laws and stipulations recorded in 42 CFR 418.76. The aide is assigned to a specific beneficiary by an RN who is a member of the IDG.

- a. The hospice aide performs personal care tasks included on a plan of care developed by the IDG. The RN shall provide written instructions for patient care to be provided by the aide. All aide services are provided in accordance with 21 NCAC 36.
- b. The RN shall make an on-site visit to the beneficiary's home, at least every 14 days to assess the quality and effectiveness of the services provided by the hospice aide. Annually, the RN shall conduct the on-site visit while the aide is in the home providing care, to observe and assess the service performance of each aide. If an area of concern is noted, the hospice nurse shall make more frequent on-site visits while the aide is performing the care.
- c. The hospice aide may also perform homemaker services such as household services that assist in maintaining a safe and sanitary environment in areas of the home used by the beneficiary.

Homemaker services can be provided by staff that has not completed formal in-home aide training, but they shall complete a hospice orientation program addressing the needs and concerns of beneficiaries and families coping with a

terminal illness. A member of the IDG is required to develop written instructions to coordinate and supervise care provided by the homemaker. Homemaker services include assistance with personal care, maintenance of a safe and healthy environment, and other support services as outlined by the beneficiary's plan of care.

#### **1.1.6 Volunteer Services**

The hospice shall use volunteers in administrative or direct patient care roles and in accordance with 42 CFR 418.78. The hospice shall maintain a volunteer staff sufficient to provide the administrative or direct care to the beneficiary in an amount that, at a minimum, equals 5% of the total hours of care provided by all paid hospice employees and contract staff. The hospice shall document the level of volunteer activity on a continual basis and shall record any expansion of care and services achieved through the use of volunteers, including the type of services and the time worked.

#### **1.1.7 Medical Appliances and Supplies**

Medical supplies and appliances are provided as needed for the palliative care and management of the terminal illness and related conditions. Appliances include durable medical equipment (DME) as well as other self-help and personal comfort items. Equipment is provided for home use while the beneficiary is receiving hospice services.

#### **1.1.8 Drugs and Biologicals**

Drugs and biologicals are those used for pain relief, comfort, and symptom control related to the terminal illness. All drugs and biologicals are administered in accordance with accepted standards of practice.

#### **1.1.9 Therapy Services**

Covered therapy services include occupational therapy, physical therapy, and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

#### **1.1.10 Short-Term Inpatient Care**

The hospice shall make inpatient care available for pain control, symptom management, and respite purposes, and shall provide it in a participating Medicare or Medicaid facility and in accordance with 42 CFR 418.108.

- a. General Inpatient Care is of a short duration for either the management of symptoms or for palliative care that cannot be provided in any other setting. The hospice shall have an arrangement with the facility to provide short-term inpatient care in the hospital or nursing facility. The arrangement is described in a written agreement, coordinated by the hospice, and in accordance with 42 CFR 418.108. General Inpatient Care can also be provided in a hospice inpatient facility.
- b. Inpatient Respite Care provides inpatient care for short-term relief for the caregiver. This service is provided in a nursing facility or hospital under written agreement or in a hospice inpatient care facility.

### **1.1.11 Ambulance Services**

For Medicaid beneficiaries only, ambulance transport services are provided in relation to the palliation or management of the beneficiary's terminal illness.

### **1.1.12 Nursing Facility and ICF/MR Room and Board**

Medicaid reimburses the hospice for the room and board charge when a resident elects the Medicare or Medicaid hospice benefit or a hospice beneficiary becomes a resident of a nursing facility or an ICF/MR.

## **1.2 Levels of Care**

Each day of the beneficiary's hospice coverage is classified at one of four levels of care. The Medicaid reimbursement for the service is made at a per diem rate based on the level of care and the location of the beneficiary.

**Note:** All rules, regulations, and statutes cited in this clinical coverage policy are adopted by reference.

### **1.2.1 Routine Home Care**

Routine Home Care is the basic level of care provided to support a hospice beneficiary. It is provided in a private residence, a hospice residential care facility, a nursing facility, or an adult care home. When the care is provided in a nursing facility or adult care home, the hospice and the facility shall have a written contractual agreement for the services to be provided in the facility.

### **1.2.2 Continuous Home Care**

Continuous Home Care is provided during a medical crisis, as needed to keep the beneficiary at home and when the beneficiary's physician believes that continuous care, primarily nursing care, is needed to achieve palliation or management of acute medical symptoms. The care must be needed for a minimum of eight hours of the calendar day. The hours may be split into two or more periods during the day. An RN or LPN shall provide nursing services for at least half of the hours of care in a day. Homemaker and home health aide services may be used to supplement the nursing care for the remaining hours.

### **1.2.3 Inpatient Respite Care**

Inpatient Respite Care is short-term care to relieve family members and other unpaid caregivers who care for a beneficiary in a private residence. Respite may be provided only on an occasional basis for up to five consecutive days for each occurrence, as defined by agency policy and based on the needs of the primary caregiver. It is provided in a hospice inpatient facility, a hospital, or nursing facility under arrangement with the hospice agency. The hospital or nursing facility is required to meet the special hospice standards for staffing and patient care areas as specified in 10A NCAC 13K and 42 CFR 418. For a detailed explanation on determining annual limitations as it relates to inpatient care, refer to 42 CFR 418.

### **1.2.4 General Inpatient Care**

General Inpatient Care is for the management of symptoms or to perform procedures for pain control that cannot be performed in other settings. The care is provided in a hospice inpatient facility, a hospital, or a nursing facility under

arrangement with the hospice agency. The hospital or nursing facility is required to be in compliance with the special hospice standards for staffing and patient care areas as specified in 10A NCAC 13K and 42 CFR 418.108.

For a detailed explanation on determining annual limitations on payments to inpatient care, refer to 42 CFR 418.

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

*(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)*

- a. An eligible beneficiary shall be enrolled in either:
  1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
  2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

#### 2.1.2 Specific

*(The term “Specific” found throughout this policy only applies to this policy)*

- a. **Medicaid**  
None Apply.
- b. **NCHC**  
None Apply.

### 2.2 Special Provisions

#### 2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible,

compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**b. EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTracks Provider Claims and Billing Assistance Guide:*

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

**2.2.2 EPSDT does not apply to NCHC beneficiaries**

**2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary .

### **2.2.4 Beneficiaries with Medicaid for Pregnant Women Coverage**

Beneficiaries with Medicaid for Pregnant Women (MPW) are eligible for hospice services if the terminal illness is pregnancy related. Refer to **Subsection 5.2** for information regarding prior approval for MPW beneficiaries.

## **3.0 When the Procedure, Product, or Service Is Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### **3.1 General Criteria Covered**

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

### **3.2 Specific Criteria Covered**

#### **3.2.1 Specific criteria covered by both Medicaid and NCHC**

- a. The beneficiary shall have been certified by a physician as being terminally ill. Terminal illness is defined as having a medical prognosis for a life expectancy of six months or less if the disease follows its expected course.
- b. The beneficiary or representative shall elect the hospice benefit by signing a hospice election statement.
- c. The hospice shall provide services in accordance with 42 CFR 418.

#### **3.2.2 Medicaid Additional Criteria Covered**

None Apply.

#### **3.2.3 NCHC Additional Criteria Covered**

None Apply.

## **4.0 When the Procedure, Product, or Service Is Not Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### **4.1 General Criteria Not Covered**

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or

- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

## **4.2 Specific Criteria Not Covered**

### **4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC**

None Apply.

### **4.2.2 Medicaid Additional Criteria Not Covered**

Respite care is covered only under the contracted per diem for hospice services. Additional respite care services over and above the contracted amount are not covered.

Hospice services are not covered when the provider does not comply with all Medicaid requirements as specified in this policy.

### **4.2.3 NCHC Additional Criteria Not Covered**

- a. Respite care is covered only under the contracted per diem for hospice services. Additional respite care services over and above the contracted amount are not covered.
- b. Payment for room and board for hospice beneficiaries in nursing facilities, ICF-MR facilities, and adult care homes is not covered by NCHC.
- c. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
  1. No services for long-term care.
  2. No nonemergency medical transportation.
  3. No EPSDT.
  4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

**Note: Subsection 4.2.3(b) applies to NCHC only.**

## **5.0 Requirements for and Limitations on Coverage**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

### **5.1 Prior Approval**

Prior approval is only required for the following:

- a. Prior to the election of the fifth (5<sup>th</sup>) and each subsequent benefit period.
- b. Beneficiaries with Medicaid for Pregnant Women (MPW) coverage.

### **5.2 Prior Approval Requirements**

#### **5.2.1 General**

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and

- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy; and
- c. if the Medicaid beneficiary is under 21 years of age, information supporting that all EPSDT criteria are met and evidence-based literature supporting the request, if available.

Prior approval is requested by the hospice medical director or beneficiary's attending physician via NC Tracks, PA Type A-10 Hospice, at least ten days before the end of the current certification period. If prior approval is denied, the beneficiary will be notified of his or her appeal rights.

### **5.2.2 Specific**

None Apply.

## **5.3 Hospice Responsibility**

The hospice shall assume professional management over all of the beneficiary's medical care to ensure the continuity of care whether in the home or in inpatient or outpatient settings and shall provide services in accordance with 42 CFR 418. The hospice shall make nursing services, physician services, drugs, and biologicals routinely available on a 24-hour basis, 7 days per week. The hospice shall make other covered services available on a 24-hour basis when reasonable and necessary to meet the needs of the beneficiary and family.

## **5.4 Admission to Hospice**

The hospice agency shall admit a beneficiary to hospice only with the recommendation of the medical director in consultation with, or with input from, the beneficiary's attending physician (if the beneficiary has an attending physician) as outlined in 42 CFR 418.25. The Medical Director or physician designee, in conjunction with the beneficiary's attending physician (if any), shall complete the initial certification of terminal illness, stating in writing that the beneficiary has a medical prognosis for a life expectancy of six months or less if the disease process runs its expected course.

## **5.5 Physician Certification**

The hospice agency shall obtain written physician certification of the beneficiary's terminal prognosis for each benefit period and a copy of the signed statement is kept on file in the beneficiary's medical record.

### **5.5.1 Certification for Initial Benefit Period**

An initial written certification statement is obtained from the medical director of the hospice or the physician designee, in conjunction with the beneficiary's attending physician (when applicable) within two calendar days of the hospice election. The certification is based on the physician's or medical director's clinical judgment regarding the prognosis for the normal course of the individual's illness. The written certification follows the requirements below.

- a. The physician shall certify that the beneficiary's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.
- b. The physician shall include a brief narrative that supports the clinical justification for the medical prognosis. Refer to 42 CFR 418.22

### **5.5.2 Certification for Subsequent Benefit Periods**

Written certification of the terminal illness is required at the beginning of each benefit period no later than two calendar days after the beginning of the period. The certification of terminal illness must include a brief narrative of the beneficiary's clinical circumstance to justify the medical prognosis. The medical director or physician designee shall sign the written certification, with input from the beneficiary's attending physician, when applicable. Refer to **Attachment C** for documentation requirements.

### **5.5.3 Hospice Face-to-Face Encounter**

The hospice physician shall have a face-to-face encounter with every hospice beneficiary prior to the 3rd and subsequent benefit periods in accordance with the Patient Protection and Affordable Care Act, Section 3132. The face-to-face contact shall be done by the hospice physician or nurse practitioner (NP) to determine if the beneficiary's condition continues to meet hospice criteria. The hospice physician or NP shall attest to providing the visit, in accordance with established procedures outlined in 42 CFR 418.22. Refer to **Attachment C**.

## **5.6 Initial and Comprehensive Assessment**

### **5.6.1 Initial Assessment**

The hospice RN shall complete an initial assessment visit within 48 hours after the election of hospice care in accordance with §418.24 (unless the physician, beneficiary, or representative requests that the initial assessment be completed sooner). The visit is made to determine the appropriateness of hospice services and to gather the information needed to develop a care plan. The hospice agency shall determine if it can provide the services needed prior to accepting the beneficiary as a hospice client.

### **5.6.2 Comprehensive Assessment**

The hospice IDG, in consultation with the individual's attending physician (if applicable), shall complete the initial comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with 42 CFR 418.24. The comprehensive assessment identifies the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that the hospice shall address in order to promote the hospice beneficiary's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment includes the following factors:

- a. The nature and condition causing admission (including the presence or lack of objective data and subjective complaints).
- b. Complications and risk factors that affect care planning.
- c. Functional status, including the beneficiary's ability to understand and participate in his or her own care.
- d. Imminence of death.
- e. Severity of symptoms.
- f. A drug profile covering a review of all of the beneficiary's prescription and over-the-counter drugs, herbal remedies, and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:
  1. Effectiveness of drug therapy

2. Drug side effects
3. Actual or potential drug interactions
4. Duplicate drug therapy
5. Drug therapy currently associated with laboratory monitoring
- g. Bereavement status. An initial bereavement assessment of the needs of the beneficiary's family and other individuals, focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the beneficiary's death. The hospice shall incorporate information gathered from the initial bereavement assessment into the plan of care and shall consider it in the bereavement plan of care.
- h. The need for referrals and further evaluation by appropriate health professionals.

### **5.6.3 Assessment Updates**

The hospice IDG (in collaboration with the individual's attending physician, if applicable) shall complete an update of the comprehensive assessment and shall consider changes that have taken place since the initial assessment. It shall include information on the beneficiary's progress toward desired outcomes, as well as a reassessment of the beneficiary's response to care. The IDG shall update the assessment as frequently as the condition of the beneficiary requires, but no less frequently than every 15 calendar days.

### **5.6.4 Measuring Outcome of Care**

The hospice IDG shall ensure that the comprehensive assessment identifies data elements that allow for measurement of outcomes. The hospice shall measure and document data in the same way for all beneficiaries and shall ensure that the data used to measure these outcomes:

- a. takes into consideration aspects of care related to hospice and palliation.
- b. are an integral part of the comprehensive assessment and are documented in a systematic and retrievable way for each beneficiary.
- c. are used in individual beneficiary care planning and in the coordination of services, and are used in the aggregate for the hospice's quality improvement program.

## **5.7 Electing the Hospice Benefit**

Before the beneficiary or representative signs the election statement, appropriate hospice staff shall provide counseling. Hospice staff shall inform the beneficiary and family of the services to be provided under the hospice Medicaid and NCHC benefits and of the waiving of Medicaid and NCHC coverage for some other services. The hospice staff shall provide this information in a language and manner that the beneficiary or representative understands. The beneficiary or the beneficiary's representative shall then confirm the choice of hospice election by signing and dating a hospice election statement.

### **5.7.1 Election Statement**

The election statement form is developed by the hospice providing the service in accordance with 42 CFR 418.24. The statement may be combined with the Medicare election statement or on a separate form. The election statement is signed by the beneficiary or beneficiary representative to elect services under the hospice benefit and verify informed consent to receive services as provided under the program. The statement is effective from the initial benefit period through all

the subsequent benefit periods as long as the beneficiary does not revoke the election or change hospice agencies and is not discharged from hospice care. The election form must include:

- a. a declaration of the beneficiary's intent to receive Medicaid or NCHC hospice coverage;
- b. the identification of the particular hospice that will provide the care;
- c. the acknowledgment that the beneficiary/representative has been given a full understanding of the palliative rather than the curative nature of hospice care as it relates to the terminal illness;
- d. a listing of the Medicaid or NCHC services that are waived when electing the hospice benefit; with acknowledgement of the meaning of waiving those services;
- e. the effective date for the start of the hospice services. This date may be the first day hospice services are provided or later but can be no earlier than the date of the election statement; and
- f. the beneficiary's or representative's signature.

### **5.7.2 Waiver of Rights to Other Medicaid-Covered Services**

A Medicaid or NCHC beneficiary who elects the hospice benefit waives the rights to Medicaid or NCHC coverage of other services that replicate the services covered under the hospice benefit. The hospice shall obtain a written statement from the beneficiary or designated representative acknowledging their full understanding of the palliative rather than curative nature of hospice care. The waiver of curative services is not applicable to beneficiaries under 21 years old. Refer to **Subsection 5.8.3**. The written statement includes the waiver of coverage for certain Medicaid or NCHC covered services when they are pertinent to treatment of the terminal illness. The waived Medicaid or NCHC services are listed below.

- a. Medicaid or NCHC coverage for home health, DME, and home infusion therapy (HIT) services is not allowed for hospice beneficiaries when the service pertains to the treatment of the terminal illness or related conditions.
- b. Medicaid coverage for In-Home Care services (IHC) in the private residence is not available for beneficiaries electing hospice services.
- c. Drugs and biologicals pertaining to the terminal diagnosis are reimbursed to the hospice as part of the hospice per diem. Medicaid or NCHC will make direct reimbursement to the pharmacy for drugs used to treat illnesses or conditions not related to the terminal illness.

Refer to clinical coverage policy 9, *Outpatient Pharmacy Program*, **Attachment A, Section J**, on DMA's website at <http://www.ncdhhs.gov/dma/mp> for additional information.

### **5.7.3 Provision of Hospice Care for Children Under 21 Years Old**

Hospice services are available to Medicaid eligible children under 21 years old, and to NCHC beneficiaries age 6 -18 without requiring the waiver of any rights of the child to be provided with, or to have payment made for, services that are related to the treatment of the child's condition for which a diagnosis /of terminal illness has been made.. Concurrent care shall be made available to the child after the provision of hospice care. This provision is in accordance with Sections 1905(o)(1) and 2110(a)(23) of the Social Security Act, and Section 2302 of The Patient Protection and Affordable Care Act.

The Patient Protection and Affordable Care Act does not change the criteria for receiving hospice services. The hospice provider shall provide all services covered under the hospice benefit. Refer to **Subsection 1.1** in this policy. Concurrent care does not duplicate the services covered in the hospice benefit.

#### **5.7.4 Medicare Hospice Benefit**

The Medicare and Medicaid hospice benefit coverage is identical; beneficiaries who are dually eligible shall elect both hospice benefits simultaneously.

NCHC beneficiaries do not participate in Medicare hospice.

### **5.8 Provision of Service**

Hospice services are covered when provided in the following locations:

- a. The beneficiary's private residence.
- b. An adult care home under a written agreement with the hospice agency.
- c. A hospice residential care facility or hospice inpatient unit.
- d. A hospital, nursing facility, or ICF-MR under a written agreement with the hospice agency.

**Note:** Nursing facility or ICF-MR long-term care approval is required for a beneficiary residing or entering the facility. Nursing facility or ICF-MR approval is determined by Medicaid's fiscal agent. The hospice shall obtain a copy of the approval form (FL-2) or (MR-2) as applicable, to ensure compliance with this guideline. Nursing facility or ICF/MR room and board reimbursement cannot be made to the hospice without this approval.

### **5.9 Benefit Period**

Hospice coverage is divided into "benefit periods" for Medicare, Medicaid and NCHC. The initial hospice election statement remains valid through all the benefit periods as long as there is no break in coverage.

#### **5.9.1 Length of Benefit Period**

The benefit periods are available in an initial 90-day period, a second 90-day period, and an unlimited number of 60-day periods.

#### **5.9.2 Coordinating Medicaid and Medicare Benefit Periods**

Medicaid and Medicare benefit periods are identical and run concurrently. When the beneficiary is dually eligible, he or she shall elect the hospice benefit for both programs simultaneously. The Medicare hospice benefit covers hospice payment in full. Medicaid coverage is available only for nursing facility room and board. The benefit period for starting the Medicaid service would mirror the current Medicare benefit status when the coverage does not start concurrent. NCHC beneficiaries are not eligible for the Medicare hospice benefit.

#### **5.9.3 Medicaid Eligibility and Benefit Period Coordination**

When a beneficiary becomes ineligible for Medicaid while receiving hospice services or goes into a deductible status, the following apply:

- a. If the beneficiary remained on hospice throughout the ineligible Medicaid period, there is no change in the benefit period status. The hospice charges should be applied toward any deductible.
- b. If the beneficiary discontinues hospice coverage when becoming ineligible for Medicaid or NCHC, the situation is handled like a revocation. The beneficiary forfeits any remaining days in the current benefit period and enters the next benefit period if re-electing hospice after Medicaid or NCHC eligibility is restored.

## 5.10 Reporting Hospice Participation

The hospice agency shall report initial hospice participation to DMA's fiscal agent's prior approval unit when a beneficiary elects Medicaid or NCHC hospice benefits. The agency shall also report hospice participation for dually eligible Medicare/Medicaid beneficiaries in a nursing facility. Medicare reimbursement will be made for the hospice care, and Medicaid will make reimbursement for room and board charges. Hospice claims will not be reimbursed by DMA without this notification.

The hospice shall make the report:

- a. initially, within 6 calendar days of the election of the Medicaid or NCHC hospice benefit and start of care;
- b. within 6 calendar days of the start of the second, third, and fourth benefit period;
- c. within 6 calendar days of the start of care and the start of the second, third, and fourth benefit periods if the beneficiary resides in a nursing facility, the beneficiary is dually eligible under Medicare and Medicaid, and the hospice agency will be billing Medicaid for room and board charges;
- d. if the beneficiary transfers to another hospice agency; or
- e. if the beneficiary is discharged from or revokes hospice.

**Note:** No reporting is required at the beneficiary's death. No reporting is required for the fifth and subsequent benefit periods, as prior approval is required instead. Refer to **Attachment B** for specific information regarding the initial and continuing hospice participation reporting processes and requirements. Hospice agencies shall coordinate the reporting a transfer of hospice care from one agency to another in order to prevent duplication of dates of service and subsequent denial of payment as only one agency can be paid each day.

## 5.11 Hospice Revocations and Discharges

### 5.11.1 Revocations

A beneficiary or his or her representative may revoke the hospice election at any time by completing and signing a revocation statement. The statement indicates that the beneficiary revokes the hospice election and the effective date of the revocation. The effective date cannot be earlier than the date the beneficiary signs the revocation statement. The hospice agency shall promptly report the ending of hospice participation and the effective date of withdrawal to the prior approval unit at the fiscal agent for DMA.

By revoking hospice coverage, a beneficiary:

- a. forfeits any remaining days of coverage in the current benefit period after the revocation date, and

- b. is eligible to resume coverage of the waived benefits effective on the date of revocation.

### **5.11.2 Discharges**

The hospice agency may discharge a beneficiary in accordance with applicable law, rules and regulations, and agency policy. The agency shall promptly report the beneficiary's revocation or discharge to DMA's fiscal agent because hospice participation information may affect Medicaid or NCHC payment for other services. The agency may bill for the date of discharge or revocation.

### **5.11.3 Re-Electing Hospice after Revocation**

If a beneficiary wishes to resume hospice, he or she or the representative re-elects hospice for the next benefit period. The beneficiary is considered to be a new hospice client. A new election statement, plan of care (POC), and physician certification are required. Additionally, a participation report to DMA's fiscal agent is required, as described in **Subsection 5.10**.

## **6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service**

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

### **6.1 Provider Qualifications**

Refer to **Subsection 1.1** for provider qualification specifics relative to each service type.

### **6.2 Provider Certifications**

To qualify for enrollment as a Medicaid or NCHC hospice provider, the hospice agency shall obtain Medicare certification and licensure by the Division of Health Service Regulation to provide hospice services [licensure defined in 10 G.S.131E-201 (3)].

## **7.0 Additional Requirements**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### **7.1 Compliance**

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for

Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

## **7.2 Patient Self Determination Act**

The Patient Self Determination Act of 1990, Sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, P.L.101-508 requires that Medicaid-certified hospitals and other health care providers and organizations, give patients information about their right to make their own health decisions, including the right to accept or refuse medical treatment. Providers shall comply with these guidelines. Refer to *NCTracks Provider Claims and Billing Assistance Guide*:  
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>.

## **7.3 Coordinating Care**

The hospice provider is responsible for the professional management of the beneficiary's medical care. The hospice shall assess and coordinate any existing home care services being rendered to a beneficiary electing the hospice benefit. Additionally, to avoid duplication of services, the hospice shall coordinate with other providers any care unrelated to the terminal illness.

The hospice agency shall notify the other service providers of the beneficiary's request for hospice services prior to admitting the beneficiary for hospice care. This policy also pertains to Medicare-covered hospice benefits for dually eligible beneficiaries.

### **7.3.1 Community Alternatives Program**

If the beneficiary participates in a Community Alternatives Program (CAP), the hospice shall contact the CAP case manager. The cost of hospice care may affect the beneficiary's ability to remain on the CAP program. The hospice is responsible for the professional medical oversight of all hospice patients. CAP services should augment the care provided by the hospice and necessary to meet the beneficiary's needs. The hospice shall coordinate care with the CAP case manager to prevent duplication of service and to ensure that cost limitations are not exceeded.

**Note:** CAP participants have a two-letter code in the CAP block of the Medicaid identification (MID) card.

### **7.3.2 Providing Care to Nursing Facility Residents and Residents in an ICF/MR**

This section does not apply to NCHC beneficiaries.

Hospice services may be provided to a nursing facility or an ICF/MR resident if the hospice and the facility have a written agreement that specifies the provision of hospice services in the facility and in accordance with 42 CFR 418.112. The agreement must be signed by authorized representatives of the hospice and the facility before the provision of hospice services.

The hospice shall assume professional management of the beneficiary's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-

related inpatient care in a participating Medicaid facility according to 42 CFR418.100 and 418.108.

The hospice shall assess and coordinate the beneficiary's hospice and medical care to facilitate continuity of the care and the facility agrees to provide room and board to the individual.

The agreement includes the following provisions:

- a. Coordination of services in accordance with the plan of care developed by the IDG, and indication of the services to be provided by the facility and the services to be provided by the hospice staff.
- b. Indication of the financial arrangements involved, including the rate of reimbursement to the nursing facility and the collection of any patient monthly liability (PML) amounts.
- c. The agreement by the facility to provide room and board and related services. Room and board services include the performance of personal care services, assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room, supervising and assisting in the use of DME and prescribed therapies, and all of the requirements and services outlined in the N.C. Medicaid Nursing Facility Provider Manual (on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/>).
- d. Hospice shall have the responsibility of providing the medications and DME directly related to the terminal illness, with the exception of the DME included in the room and board as referenced above.
- e. All other details related to the provision of care and compliance with current North Carolina Rules Governing the Licensure of Hospice.
- f. Process and responsibility for changes to the plan of care. The hospice is responsible for approving changes to the plan of care. The hospice shall provide a copy of the plan of care for the facility, and the facility shall allow the hospice access to documentation on the beneficiary's care.
- g. Hospice responsibility for monitoring the care provided to ensure the adequacy of the care provision and to determine the need for any changes.

#### **7.3.2.1 Hospice Reporting and Election Statement for Dually Eligible Nursing Facility Residents**

A beneficiary who is dually eligible for Medicare and Medicaid hospice shall elect both programs simultaneously. Medicare is the primary payer and Medicaid shall reimburse the hospice for nursing facility room and board charges. The hospice shall report the beneficiary's hospice participation to Medicaid's fiscal agent if the beneficiary is dually eligible under Medicare and nursing facility room and board will be submitted to Medicaid for payment. All hospice providers shall follow all reporting requirements.

#### **7.3.2.2 Patient (Beneficiary) Monthly Liability**

The hospice agency assumes responsibility for collecting the Patient Monthly Liability (PML). The agency notifies the local department of social services (DSS) of the beneficiary's election of hospice, and DSS forwards to the hospice agency notification of the PML amount on the

Notification of Eligibility for Medicaid/Amount and Effective Date of Patient's Liability Form (DMA-5016).

The hospice shall include the collection of PML in the contractual agreement. The nursing facility may act as the hospice agent in collecting the PML if this arrangement is included in the contractual agreement.

### **7.3.2.3 Prior Approval for Level of Care**

The hospice is responsible for ensuring that the long-term-care prior approval process has been completed and that the beneficiary is approved for nursing facility or ICF/MR level of care. This process can be completed by the hospice or through arrangement with the facility, hospital discharge planner, physician, or other sources. Hospice beneficiaries in nursing or ICF/MR facilities shall meet the same level of care requirements as other Medicaid nursing facility beneficiaries. The beneficiary shall occupy a Medicare/Medicaid-certified bed if in a nursing facility. The hospice agency shall retain a copy of the FL-2 or MR-2, as applicable, in the beneficiary's records on site at the hospice agency.

### **7.3.3 Providing Care in an Adult Care Home**

Hospice services can be provided for Medicaid beneficiary residing in an adult care home (ACH) when the beneficiary elects the hospice benefit. The ACH and the hospice shall have a written contractual agreement that describes the services to be provided by each according to the plan of care. The ACH is considered the beneficiary's place of residence and the basic care is provided by the ACH staff. The hospice has the responsibility for the professional management of the beneficiary's care. The hospice is responsible for the oversight of the beneficiary's medical care and the monitoring of the care provided by the facility to ensure adequacy of care provision and the need for changes to the services and the plan of care. The plan of care includes the services provided by both the ACH and the hospice (i.e., room and board, ACH Personal Care Services). The hospice agency is responsible for coordinating all services included in the plan of care. A copy of the hospice plan of care will be provided to the ACH.

### **7.3.4 Pharmacy Services**

Drugs and biologicals pertaining to the terminal diagnosis are reimbursed to the hospice as part of the hospice per diem. DMA will make direct reimbursement to the pharmacy for ~~any~~ drugs used to treat illnesses or conditions not related to the terminal illness. The hospice provider shall supply the diagnosis and ICD-10-CM code for the terminal illness when contacted by the pharmacy. The pharmacy will need this information in order to process the claim. Refer to Clinical Coverage Policy 9, *Outpatient Pharmacy Program*, on DMA's website at <http://www.ncdhhs.gov/dma/mp/> for additional information.

## **7.4 Delivering and Supervising Care**

Delivery of care and supervision of the delivery of care shall conform to all applicable laws, rules and regulations, the current standard of practice, and agency policy. Services are provided as specified in the plan of care developed and approved by the IDG.

Core hospice services (nursing services, medical social services, and counseling) are routinely provided directly by hospice employees. Other covered services are provided by agency employees or under contractual arrangements. Contractual agreements are in writing and in compliance with 10A NCAC 13K and 42 CFR 418.

### **7.5 Monitoring Care**

Members of the hospice IDG shall monitor the beneficiary's condition and initiate changes in the plan of care as needed. The beneficiary's attending physician also participates in this process. The IDG shall complete the review and resulting updates to the plan of care every 15 calendar days to ensure that the beneficiary's needs are met and shall document each review in the beneficiary's record.

### **7.6 Changing Agencies**

A beneficiary may change hospice agencies between benefit periods and once during each benefit period. An agency change is not a revocation of hospice. When a change occurs during a benefit period, the beneficiary completes the period with the new agency.

To change agencies during a benefit period, the beneficiary gives a signed statement to both the current agency and the new agency. The statement indicates the beneficiary's intent to change agencies, provides the name of the current agency, states the name of the new agency, and identifies the effective date of the change.

The transfer is coordinated with the attending physician and any other care providers to ensure continuity of services. The current or first agency shall cease billing for services on the day prior to the effective date on the notice. The new agency assumes responsibility for the beneficiary's care on the effective date of the change and bills for that date of service. The existing plan of care can be used or the new agency may develop a new one.

The first agency shall report the transfer to DMA's fiscal agent. Payment to the new agency depends on a report of the termination of services by the first agency. The new agency shall contact DMA's fiscal agent to report the admission of the beneficiary to hospice services under the new agency. Both agencies shall report the transfer to DMA's fiscal agent no later than the 6th day after the date of transfer (day of report plus 6 previous days).

### **7.7 Electronic Signatures**

N.C. Home Care Licensure Rules provide requirements for accepting electronic signatures for documentation.

## 8.0 Policy Implementation/Revision Information

**Original Effective Date:** August 1, 1984

### Revision Information:

Date	Section Updated	Change
12/01/2006	Sections 2, 3, 5	A special provision related to EPSDT was added.
04/01/2007	Subsection 7.1.2.1	Removed statement that Medicaid reimburses for co-insurance on hospice-covered drugs and respite days
04/01/2007	Section 2.6, 3.0, 4.0, and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for beneficiaries under 21 years of age
05/01/2007	Attachment A	Added UB-04 as an accepted claims form.
08/01/2007	Section 6.0	Changed the name of Division of Facility Services (DFS) to Division of Health Service Regulation (DHSR).
08/01/2007	Subsection 2.3 and Attachment C	Medicare-AID beneficiaries are not eligible for Medicaid-covered hospice services.
08/01/2007	Attachment A, letter E	Added revenue code 658.
12/01/2009 (effective 12/02/2008)	Throughout	Updated to include DMA standard statements and incorporate requirements in changes to 42 CFR 418 and CMS Conditions of Participation, issued 10/1/2008, effective 12/2/2008.
05/11/2010	Subsection 2.2	Changed reference from Subsection 5.8.2 to Subsection 5.1.2
06/01/2011	Subsections 1.1.12, 5.7, 7.3.2, 7.3.2.2	Updated information on hospice and long term care to include ICF/MR and related MR-2
06/01/2011	Subsection 5.4.2, 5.4.3	Refer to Attachment C
06/01/2011	Subsection 5.4.3	Added information on the Face-to-Face Encounter requirements.
06/01/2011	Subsection 5.6.2	Added The waiver of curative services is not applicable to beneficiaries under 21 years old. Refer to Subsection 5.6.3.
06/01/2011	Subsection 5.6.3	Added Provision of Hospice Care for Children Under 21 Years Old. Under Provision of Hospice Care for Children Under 21 Years Old added sentence to include the complete hospice package having to be provided with the addition of a curative service
06/01/2011	Subsection 5.6.3	Clarified wording on concurrent care
06/01/2011	Subsection 7.2	Added Patient Self Determination Act information
06/01/2011	Attachment A	Updated to standard DMA policy language
06/01/2011	Attachment C	Added Attachment C
07/01/2010	Throughout	Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services.

Date	Section Updated	Change
11/01/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
11/01/2012	Subsections 5.1, 5.2	Addition of prior approval requirement prior to fifth and each subsequent benefit period.
11/01/2012	Subsection 1.1.10	Clarified that general inpatient care can also be provided in a hospice inpatient facility
11/01/2012	Subsection 5.7.2	Added reference to Outpatient Pharmacy policy regarding billing for medications for hospice beneficiaries.
11/01/2012	Subsection 5.10	Clarification that in the case of a patient transfer between hospice agencies, only one agency can be paid per day.
11/01/2012	Subsection 7.5	Changes two weeks requirement for plan of care review to 15 calendar days
11/01/2012	Attachment A	Deleted statement about non-contracting hospice agencies. Changes place of service back to "Not Applicable"
11/01/2012	Attachment C	Changed language referring to "nurse practitioners" to "Medicare officially recognized non-physician providers" Changes three days requirement in face to face encounter to seven days
07/01/2013	Subsection 5.2	Added "Prior approval is requested by the hospice medical director or beneficiary's attending physician via NC Tracks, PA Type A-10 Hospice, at least ten days before the end of the current certification period. If prior approval is denied, the beneficiary will be notified of his or her appeal rights."
07/01/2013	Subsection 5.2	Deleted "Prior approval is requested by the hospice medical director or beneficiary's attending physician as follows: a. The physician submits the request in writing using the N.C. Medicaid Hospice prior Approval Authorization Form (NC DMA-3212), which can be obtained from the DMA website ( <b>Refer to Attachment D</b> ).. b. The physician provides information detailing the complications of the pregnancy ( <b>for MPW beneficiaries only</b> ), medical necessity for hospice services, the potential impact if the service is not provided, the frequency of visits, and the anticipated duration of services. c. <b>The completed form is sent to DMA's designated fiscal agent along with the accompanying documentation listed on the form.</b> d. The prior approval request is submitted by mail at least ten days before the end of the current certification period. The fiscal agent will respond to

Date	Section Updated	Change
		the hospice provider via fax within five business days. If prior approval is denied, the beneficiary will also receive via mail notification with appeal rights.”
07/01/2013	Attachment D	Deleted outdated information to reflect current process with fiscal agent.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

## Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

**A. Claim Type**

Institutional (UB-04/837I transaction)

**B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)**

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

**C. Code(s)**

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Revenue Code	Description
<p><b>651</b> Routine Home Care</p>	<p><b>Routine Home Care</b> is the basic level of care that is provided to support the beneficiary. It may be provided in a private residence, a hospice residential care facility, or an adult care home. It may also be provided in a nursing facility if the facility has a contractual arrangement with the hospice agency. It is billed by the day and is the agency’s basic per diem rate. This service code is limited to once per day per beneficiary, same or different provider.</p> <p>Routine Home Care/Continuous Home Care/Inpatient Respite Care/General Inpatient Care is not allowed on the same day. The agency should provide and bill the appropriate level of service.</p>

<p><b>652</b> Continuous Home Care</p>	<p><b>Continuous Home Care</b> is provided during a medical crisis and is billed by the hour. This level of service is provided when the beneficiary's physician feels that continuous care, primarily nursing care, is needed. The care is given to achieve palliation or management of acute medical symptoms. It can be provided in the private residence, hospice residential care facility, adult care home, or nursing facility. The care needed shall be:</p> <ul style="list-style-type: none"><li>• continuous care for at least 8 hours of the calendar day (the hours may be split); AND</li><li>• nursing services by an RN or LPN for at least half of the hours of care in a day.</li></ul> <p>Homemaker and hospice aide services may be used to supplement the nursing care. Continuous Home Care is limited to a maximum of 24 units a day.</p> <p>Continuous Home Care is not allowed on the same day as Routine Home Care/Inpatient Respite Care/General Inpatient Care. The agency should provide and bill the appropriate level of service.</p>
<p><b>655</b> Inpatient Respite Care</p>	<p><b>Inpatient Respite Care</b> is short-term care to relieve family members or other unpaid caregivers providing care for the beneficiary in the private residence. It is provided in a hospice inpatient facility or in a hospital or nursing facility under a contractual arrangement. Hospitals or nursing facilities shall meet the special hospice standards for staffing and beneficiary areas.</p> <p>This service can be provided only on an occasional basis for up to five consecutive days at a time. If the beneficiary remains in the facility longer than five days, the extra days are billed at the routine home care rate. The date of discharge is usually billed at the routine home care rate. The inpatient respite rate may be billed if the discharge is due to the beneficiary's death.</p> <p>Inpatient Respite Care counts toward the annual limit on inpatient care. This service code is limited to once per day per beneficiary, same or different provider. Inpatient Respite Care is not allowed on the same day as Routine Home Care/Continuous Home Care/General Inpatient Care. The agency should provide and bill the appropriate level of service.</p>

<p><b>656</b> General Inpatient Care</p>	<p><b>General Inpatient Care</b> is payment made to the hospice for a beneficiary in an acute care hospital. The service is billed by the day as follows:</p> <ul style="list-style-type: none"> <li>• The number of days that a beneficiary receives general inpatient care is billed, beginning with the date of admission.</li> <li>• The date of discharge is billed at the appropriate rate. If discharge is delayed while a beneficiary awaits nursing facility placement, the general inpatient rate can be billed for up to three days. Bill any subsequent days as if the beneficiary is in a nursing facility; that is, the routine home care rate plus the appropriate long-term-care rate to cover room and board. If a beneficiary is discharged as deceased, bill the general inpatient rate for the date of discharge.</li> </ul> <p>If the beneficiary is hospitalized for a condition not related to the terminal illness, the hospital bills Medicaid for the beneficiary's inpatient care. Additionally, the hospice bills the routine home care rate during the inpatient stay.</p> <p>General Inpatient Care counts toward the annual limit on inpatient care. This service code is limited to once per day per beneficiary, same or different provider. General Inpatient Care is not allowed on the same day as Routine Home Care/Continuous Home Care/Inpatient Respite Care/General Inpatient Care: The agency should provide and bill the appropriate level of service.</p>
<p><b>658</b> Hospice Nursing Facility Room and Board (Intermediate Level of Care)</p>	<p>Refer to "Hospice Nursing Facility Room and Board," below. Revenue code 658 is used to bill this service if the beneficiary has been approved for nursing facility care at the intermediate level.</p>
<p><b>659</b> Hospice Nursing Facility Room and Board (Skilled Level of Care)</p>	<p>Refer to "Hospice Nursing Facility Room and Board," below. Revenue code 659 is used to bill this service if the beneficiary has been approved for nursing facility care at the skilled level or the approval was granted after May 31, 2004.</p>

**Hospice Nursing Facility Room and Board**

Hospice Nursing Facility Room and Board is the charge billed by the hospice agency for a beneficiary residing in a nursing facility or ICF/MR. It is billed in addition to routine home care or continuous home care, as applicable.

Medicaid reimbursement to the hospice is based on 95% of the per diem for the individual nursing facility. The amount is reduced by the amount of the PML when applicable. The hospice agency reimburses the nursing facility at the negotiated rate determined by the contractual agreement.

To bill for nursing facility room and board, enter the National Provider Identifier (NPI) number for the nursing facility where the beneficiary resides in the Attending Provider field of the UB-04 form or 837I transaction. The NPI number entered and the revenue code used correspond to the

current level of care for the beneficiary, as determined by the FL-2 approval. Use RC 658 for intermediate level of care and RC 659 for skilled level of care.

**Type of Bill**

081X Hospice—Non-hospital based

082XHospice—Hospital based

**Note:** The fourth digit in the Bill Type is the Frequency Code 0–5. Refer to XXX for the description for applicable code.

**Value Code**

Hospices billing routine home care, continuous home care, inpatient respite care, or general inpatient care (Revenue Codes 651, 652, 655, or 656) are required to enter the following information on the UB-04 form or 837I transaction:

- a. A value code of 61 or 68, as applicable, in the Value Code field.
- b. the ZIP code for the location where the service was rendered in the Facility Location field.
- c. the applicable Core-Based Statistical Area (CBSA) for the location where the care was provided (such as the beneficiary’s residence, nursing home, assisted living facility, hospital unit) in the Value Code Amount field.

**Unlisted Procedure or Service**

**CPT:** The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

**HCPCS:** The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

**D. Modifiers**

Provider(s) shall follow applicable modifier guidelines.

Not applicable.

**E. Billing Units**

The provider shall report the appropriate procedure code(s) used which determines the billing unit(s).

Revenue Code **651** unit of service = **1 day**

Revenue Code **652** unit of service = **1 hour**

Revenue Code **655** unit of service = **1 day**

Revenue Code **656** unit of service = **1 day**

Revenue Code **658** unit of service = **1 day**

Revenue Code **659** unit of service = **1 day**

Per diem rate includes all services provided directly by hospice provider and also services provided indirectly through subcontracting arrangements with other providers including all areas listed under coverage.

**F. Place of Service**

Not applicable for institutional claims.

**G. Co-payments**

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at [http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter\\_108A/GS\\_108A-70.21.html](http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html)

**H. Reimbursement**

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/> .

Payment rates for hospice services are equivalent to Medicare hospice rates, and Medicare methodology is followed. For Medicaid only, the hospice reimbursement rate for nursing facility room and board is 95% of the nursing facility rate.

The reimbursement rate for routine home care, continuous home care, inpatient respite care, and general inpatient care (Revenue Codes 651, 652, 655, or 656) is dependent on the beneficiary's location by Core-Based Statistical Areas (CBSA) on the date of service.

## Attachment B: Hospice Participation Reporting

### A. Steps for Hospice Participation Reporting

**Step 1:** Contact the prior approval unit of DMA's fiscal agent no later than 6 days after the beneficiary (or representative) elects hospice. The report is made initially and at the beginning of each subsequent benefit period.

**Note:** Do not report participation if the beneficiary is dually eligible for Medicare and Medicaid, unless the beneficiary is in a nursing facility and Medicaid will be billed. Medicare is the primary payer when there is dual coverage.

**Step 2:** Provide the following information:

- a. The beneficiary's name and MID number as it appears on the MID card/
- b. The benefit period start and end dates.
- c. The ICD-10-CM code for the primary diagnosis related to the terminal illness.
- d. The agency's Medicaid provider number and name as it appears on the Medicaid provider agreement.
- e. The name and contact number of the person making the report.

**Step 3:** Note the confirmation number given and the date of the telephone call in the beneficiary's record as the agency's proof of the contact for reporting. Medicaid's fiscal agent assigns a system-generated confirmation number that is unique to the beneficiary and the hospice agency. It is effective through the last day of the benefit period, unless the beneficiary revokes hospice, is discharged, or transfers to another agency before that date. The confirmation number, with applicable approval dates and agency provider number, is documented in the claims processing system. (Do not enter the information on the hospice claim when billing.)

**Step 4:** The hospice shall notify Medicaid's fiscal agent if the beneficiary revokes hospice, is discharged, or transfers to another agency.

### B. Reporting Hospice Participation When Medicaid Is Pending

Contact the Medicaid fiscal agent to report hospice participation for a beneficiary who has applied for Medicaid but whose approval is still pending. Medicaid-pending reporting enables the provider to receive Medicaid reimbursement for services retroactive to the election date or the date the report was made. The hospice shall document the name of the person and the date of the telephone call in the beneficiary's record as the agency's proof of the contact.

In this case, the hospice agency shall make two telephone calls for reporting:

- a. Make the initial telephone call within the six days of the beneficiary's election of hospice. Inform Medicaid's fiscal agent that the beneficiary's Medicaid is pending. Medicaid's fiscal agent will document the telephone call for later reference.
- b. Make a second telephone call when the beneficiary's pending Medicaid is approved. Inform Medicaid's fiscal agent that this beneficiary was reported previously as a pending Medicaid beneficiary. Medicaid's fiscal agent will assign and document a confirmation number, with retroactive dates, to cover services to the date of the original telephone call.

## **Attachment C: Physician Face-to-Face Encounter and Certification of Terminal Illness**

A physician face-to-face encounter is required for all Medicaid and NCHC hospice beneficiaries at the 3rd benefit period and at all subsequent benefit periods, prior to recertification of terminal illness in accordance with the Patient Protection and Affordable Care Act, Section 3132. The physician must provide a written attestation that the encounter occurred.

### **A. Timeframe Requirements**

The Affordable Care Act, Section 3132 outlines specific timeframes for the face-to-face contact to occur. Failure to meet the face-to-face encounter requirements and time frames results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement and the patient would cease to be eligible for the hospice benefit.

#### **1. Timeframe of the Encounter**

- a. The encounter must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to every subsequent benefit period thereafter.
- b. The encounter can be done by the hospice physician or Medicare officially recognized provider.

#### **2. Timeframe Exceptions**

- a. Exceptions to timeframe guidelines are permitted for admission of new hospice beneficiaries in the third or later benefit period. Exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period in cases where a hospice newly admits a Medicaid or NCHC beneficiary who is in the third or later benefit period. The face-to-face encounter must occur no later than the 7 days after the admission for these beneficiaries. The exceptional circumstance that prevented the face-to-face encounter from being conducted in a timely way must be documented in the beneficiary's medical record.
- b. Exceptions to the timeframe are permitted when the hospice may be unaware that the patient is in the third benefit period. In such documented cases, a face-to-face encounter which occurs within 7 days after admission will be considered to be timely. Hospice must document the circumstances for the exception.

### **B. Physician and Non-Physician Practitioners Allowed To Provide The Face-to-Face Encounter**

The hospice medical director or hospice physician is responsible for providing and documenting the encounter. Please note the following:

1. A hospice physician is described as a physician who is employed by the hospice or working under contract with the hospice.
2. Non-Physician Practitioners allowed to provide the Face-to-Face Encounter include those officially recognized by Medicare

## **C. Documentation Requirements**

### **1. Face-to-Face Encounter**

A hospice physician or other Medicare recognized provider who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter. Please note the following:

- a. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled.
- b. Documentation will be required for any exceptional circumstance that prevented the face-to-face encounter from being conducted in a timely way.

### **2. Attestation Statement for Nurse Practitioner**

- a. Where a Medicare recognized non-physician provider performed the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the beneficiary continues to have a life expectancy of 6 months or less, should the illness run its normal course.
- b. Medicare recognized non physician hospice providers may conduct face-to-face encounters as described in as part of the certification process, but are still prohibited by statute from certifying the terminal illness. In the event that a beneficiary's attending physician is a Medicare recognized non-physician provider, the hospice medical director and/or physician designee may certify or re-certify the terminal illness.

## **D. Certification and Recertification of Terminal Illness**

The certifications or re-certification must include a brief narrative describing the clinical basis for the patient's terminal prognosis. The hospice must retain all certification statements and attestations of face-to-face encounter. Please note the following:

1. The certification or recertification must contain the following:
  - a. Physicians must briefly synthesize the clinical information supporting the terminal diagnosis, and attest that they composed the narrative after reviewing the clinical information, and where applicable, examining the patient. The narrative must reflect the patient's individual clinical circumstances.
  - b. The certification or recertification must include the benefit period dates to which it applies, and be signed and dated by the certifying or recertifying physician
  - c. Initial certifications may be prepared no more than 15 calendar days prior to the effective date of election.
  - d. Recertification may be prepared no more than 15 calendar days prior to the start of the subsequent benefit period.
2. Narratives associated with the third and later benefit period must also include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.