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CHAPTER 509–COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS FOR HOSPICE SERVICES

INTRODUCTION

West Virginia Medicaid Hospice Services is an optional Medicaid program. It offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible beneficiaries. Authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in this manual must be presumed non-covered unless informed otherwise, in writing, by the Bureau for Medical Services (BMS).

The WV Medicaid Program is administered pursuant to Title XIX of the Social Security Act and Chapter 9 of the Public Welfare Law of West Virginia. The Bureau for Medical Services in the WV Department of Health and Human Resources (DHHR) is the single state agency responsible for administering the WV Medicaid Program.

This chapter sets forth requirements of the Bureau for Medical Services regarding payment and processing for Hospice Services provided to eligible WV Medicaid beneficiaries.

509.1 PROVIDER PARTICIPATION

In order to participate in the WV Medicaid Program and receive payment from the Bureau for Medical Services, hospice providers must:

- Meet and maintain applicable licensures, accreditation, and certification requirements, including the Certificate of Need
- Meet and maintain all BMS enrollment requirements listed in Chapter 300.
- Meet and maintain conditions of participation in Medicare

For provider enrollment application forms or additional information regarding provider participation requirements, please refer to Chapter 300 or contact the Provider Enrollment Unit.

509.2 COVERED SERVICES

Services that are covered by the hospice program are those that are related to the terminal condition and are palliative in nature. An interdisciplinary plan of care must be established before care begins and must detail the type, scope and frequency of those services to address the needs of the member and the member's family. All care must be planned, delivered and coordinated in accordance with 42 CFR 418 Hospice Care. Hospice services are of two types:

Core hospice services are to be provided directly by hospice employees:

- Nursing Care must be provided by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse.
- Medical Social Services must be provided by a licensed social worker working under the supervision of a physician
- Physician Services by a professional who is acting within the scope of the physician's license, who is either a doctor of medicine, of osteopathy, of podiatry, of dentistry, of optometry, or a chiropractor. The medical director of the hospice or the physician member of the IDT must be a doctor of medicine or of osteopathy.
- Counseling Services, provided to the member and the member's family for up to a year after the member's death. This service is not reimbursable.

Other services the hospice must make available may be provided by the provider or they may be arranged by contractual agreement. They include:

- Drugs and Biologicals are covered only if used for the relief of pain or control of symptoms related to the terminal condition or disease.
- Durable Medical Equipment and Supplies are to be available for comfort or self-help related to the palliation of the terminal condition or disease
- Short term inpatient care is to be provided either to provide respite for family or other persons caring for the member at home, or for control of pain or symptoms arising from the terminal condition or disease and that are not possible in any other setting.
- Home health and homemaker services must meet the specifications of 42 CFR 484.36, and be provided under the supervision of an RN. Home health aides and homemaker service providers may provide personal care services and household services for safety and sanitation of the member, appropriate for the plan of care.
- Rehabilitation Services include physical and occupational therapies and speech pathology used for symptom control or to maintain activities of daily living and functional skills.

509.3 BENEFIT PERIODS

Hospice care services are provided in a series of four benefit periods. The first and second benefit periods are each for 90 days, the third period is 30 days, and the fourth benefit period is of indefinite length, and may last as long as the member's lives. Members enrolling in the Hospice Services Program may revoke hospice coverage. In that event, the remainder of that benefit period is forfeited. If the member then re-enrolls, coverage begins under the next benefit period.

> Example: a member enrolls in hospice services on January 1. For whatever reason, he revokes his hospice coverage on February 15, after 46 days. The remainder of the 90 days of that first period is forfeited. Should circumstances lead him to enroll again even the next day, February 16, he is now in the second benefit period. If he revokes again before that 90 day period is concluded, he also forfeits the remainder of that second period. A third enrollment will be for the 30 day period. If that period is revoked the remainder is forfeited and only the fourth, indefinite period remains. If he elects that period it will continue for as long as he lives, unless he revokes the fourth time. The member who revokes West Virginia Medicaid Hospice Services four times is not eligible to enroll again.

Enrollment in the Hospice Services Program can and will continue through the initial election period and through all subsequent benefit periods without a break in care, for as long as he or she lives, if the member remains in the care of the hospice and does not revoke the program coverage and remains eligible for Medicaid benefits.

509.4 HOSPICE ENROLLMENT

Enrollment in the West Virginia Medicaid Hospice Services Program requires the following from the three parties involved. First, a physician determines that the member has a life expectancy of six months or less in the normal course of the disease or condition from which he or she suffers, and certifies that assessment in writing. Second, the hospice provider must draw up a plan of care, inform the enrolling member of what hospice services will be provided, document his or her informed consent, and complete a West Virginia Medicaid Hospice Election Form (HEF-01). The provider must also describe how the member may disenroll from hospice care, and how to choose another hospice. Third, after the Hospice Services Program has been explained thoroughly to the member by the hospice provider, the member must give consent, including signing the completed HEF-01.

To complete the enrollment of the member in hospice services, the provider must give the member the following:

- A copy of the completed and signed HEF-01
- A copy of the Plan of Care, with descriptions of the nature and scope of the services to be provided, and a schedule for providing them. Also a telephone number for contacting the hospice.
- Member's responsibility for reporting other insurance
- Member's responsibility for obtaining health care not related to the terminal condition or disease

509.4.1 PHYSICIAN CERTIFICATION

To enter into the Hospice Services Program for the first time, the attending physician and the medical director of the hospice, or physician member of the Interdisciplinary Team (IDT) must certify that the member is terminally ill. Terminal illness is defined as having a life expectancy of six months or less if the disease or condition from which the member suffers runs its normal course. The hospice must obtain a copy of this written certification no later than two (2) days after hospice care is initiated. If certification is verbal, oral certification must be obtained no later than two (2) days after hospice care is initiated.

The Bureau for Medical Services has no standard form for physician certification. Documents of physician certification to be used must contain the statement that the member's life expectancy is six months or less and must be signed and dated by the attending physician, the hospice medical director or the physician member of the IDT. If the original certification was oral, the document must also contain the name of the individual receiving that certification and the date of the oral

certification, as well as the physician's own dated signature. The finalized physician certification must be received by the BMS within 7 days of the initiation of hospice care.

For subsequent benefit periods, the medical director or physician member of the IDT must certify that the member's life expectancy is six months or less given the course of the member's disease or condition. These certifications are the same as for the first period, but need not be submitted to the Bureau for Medical Services. Hospice staff must keep a record of written and verbal certifications of later benefit periods.

509.4.2 ENROLLING THE MEMBER IN HOSPICE CARE

The hospice is responsible for enrolling the WV Medicaid member who is certified as eligible for hospice care, and who gives consent to enter the program. Enrollment must be voluntary and without regard to age, sex, race, creed, color, physical or mental handicap, national origin, marital status, or sexual preference.

The provider must draw up a Plan of Care designed to meet that member's individual needs. The member must be led to understand that by electing West Virginia Hospice Services he or she must waive Medicaid coverage of the following services if they are related to the member's terminal condition:

- Hospice care from other hospices unless provided under agreement with the hospice named in the election form
- Services of the member's attending physician unless he or she is a hospice employee,
- Medicaid services equivalent to hospice services described at 42 CFR 418

509.4.3 INFORMED CONSENT OF THE MEMBER

The provider must assure that the consent to enroll in Hospice Services is informed consent. An informed consent form detailing the type and scope of the care is to be given to the member or the member's representative to be read and signed.

The provider must complete the Hospice Election Form HEF-01 and have the member or the member's legal representative sign and date it.

509.5 NOTIFICATION OF ENROLLMENT

The signed and dated physician certification and the signed and dated HEF-01 must be received by the Bureau for Medical Services within seven days of the initiation of hospice care. If both are not received within that time, the date of the second of the two documents to be received will be used as the initial date of service of hospice care.

509.6 TERMINATION OF HOSPICE SERVICES

Hospice services may be terminated for any of the following reasons:

- The member chooses to revoke hospice care
- The hospice chooses to terminate their provision of services
- The member no longer meets enrollment criteria
- The member dies

When a member revokes hospice services or is discharged by the hospice provider, the hospice provider must send a copy of the signed and dated HEF-01 that had been signed by the member at enrollment, with the date of the termination of services written in the box marked Revoked, to the Bureau for Medical Services. This must be received by the Bureau for Medical Services within five (5) days of revocation to allow the member to resume Medicaid benefits waived upon election of hospice care.

Also, the hospice provider must send a copy of the HEF-01 to the Bureau for Medical Services following the death of the member with the date of death noted in the appropriate box.

509.7 REIMBURSEMENT

Reimbursement by the West Virginia Bureau for Medical Services for covered hospice services will be at rates set annually or semi-annually by the Centers for Medicare and Medicaid Services (CMS) for the following levels of care:

509.7.1 ROUTINE HOME CARE

To be billed under Medicare Revenue Code 0651: Unit equals one day.
This level of care consists of providing hospice services as described under §515 Covered Services, except for those referring to Inpatient Care, or when the member's needs are not so intensive as to require continuous care. The hospice is paid the Routine Home Care rate for each day the patient is under the care of the hospice and not receiving one of the other three more specialized categories of hospice care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day, and is also paid when the patient is receiving hospital care for a condition unrelated to the terminal condition.

509.7.2 CONTINUOUS HOME CARE

To be billed under Medicare Revenue Code 0652: Unit equals one hour. This code is billable for a minimum of eight hours on a given day, and up to 24 hours a day.
Continuous home care is provided to the member during brief periods of crisis. Either homemaker or home health services may be provided for up to 24 hours, but these services must be predominantly nursing services.

509.7.3 INPATIENT RESPITE CARE

To be billed under Medicare Revenue Code 0655: Unit equals one day.
This code is limited to a maximum of five consecutive days.

An inpatient respite care day is a day on which the individual who has elected hospice care receives care in an approved facility on a short term basis to provide respite to family or other persons who are involved in daily care of the member. If the facility is a Medicaid-certified nursing facility, medical necessity NF criteria do not need to be evaluated, i.e. no PAS-2000 is required.

509.7.4 GENERAL INPATIENT CARE

To be billed under Medicare Revenue Code 0656: Unit equals one day.
This level of care is provided to members whose symptoms cannot be controlled at home, or in settings other than in an inpatient facility.

509.8 INPATIENT CARE PROVIDED DIRECTLY BY THE HOSPICE

The participating hospice that provides inpatient care directly must comply with all of the following standards for nursing, for patient care, for disaster preparedness

- Nursing services must be provided 24 hours a day
- Each shift must provide an RN who provides direct patient care
- Nursing care must be sufficient to meet any Plan of Care

509.9 REIMBURSEMENT PROCEDURES

Hospice services are billed using the UB-92. Only one level of care under one Medicaid Revenue Code may be billed for a given day. Reimbursement is made for each day an eligible Medicaid member is under hospice care. Inpatient rates for Codes 655 and 656 are paid for the date of admission and all subsequent inpatient days with the exception of the date of discharge. The date of discharge will be paid at the Routine Home Care rate. If the member dies an inpatient, then the date of death will be reimbursed at the inpatient rate, if the inpatient care was related to the terminal condition.

509.10 NURSING FACILITY RESIDENTS

West Virginia Medicaid maintains a separate program of Hospice Services for members who are residents of nursing facilities. If a member electing hospice care is a resident of a West Virginia Medicaid certified nursing facility, the nursing facility may contract with a Medicare/ Medicaid certified hospice agency to provide room and board for dually eligible individuals and for individuals who are Medicaid –only who qualify medically for both the hospice benefit and Medicaid nursing facility benefits. Medicare certification of a nursing facility is not a requirement of this program. The hospice agency must enroll with the Medicaid agency to be a provider of this benefit in nursing facilities.

The room and board component provided by the nursing facility shall include the provision of a living space, nutrition, and ancillary services normally provided for residents. Ancillary services may include, but are not limited to the basic activities of daily living, social and activity programs, laundry and housekeeping.

The hospice provider is responsible for specialized services covered by Medicare or Medicaid including but not limited to, medications associated with the terminal illness and assistance with care planning, emotional support for the member and the member's family. The hospice must bill Medicare/ Medicaid for all covered services, as well as nursing facility room and board

509.11 DOCUMENTATION REQUIREMENTS FOR NF AUTHORIZATION

For each individual who applies for hospice coverage in a nursing home, election of services and physician certification are required. The hospice provider must submit to the Bureau for Medical Services for review the following information:

- An agreement between the specific nursing facility and the hospice provider that each will provide its appropriate services to members who qualify, and
- Documentation to support the medical necessity of the individual for each covered service and the financial eligibility documentation for the specific individual regarding the Medicare and the Medicaid programs.

As with hospice services provided in other settings, those provided in nursing facilities apply only to the terminal condition or disease. For health needs not related to the terminal diagnosis, ordinary West Virginia Medicaid policies and procedures are to be followed.

The authorization information must be submitted with the first claim for payment.

509.12 NURSING FACILITY REIMBURSEMENT

To be billed under Medicare Revenue Code 0658:
The WV Medicaid Program will remit to the hospice provider 95 percent of the daily rate which would have been paid to the nursing facility for care of this member had they not elected hospice coverage. The hospice will then reimburse the nursing facility for the cost of room and board, as identified in their contract. The amount of reimbursement will be based on the nursing facility base per diem rate with the Medicaid adjustment for the acuity of the beneficiary. The claim form for billing is the UB-92. A printout of the computerized report identifying the specific case mix class of the individual must be attached.

The hospice should mail all of the claim information to the Bureau for Medical Services for authorization and pricing at the following address:

The Bureau for Medical Services
Policy Units-LTC Division
350 Capitol Street, Room 251
Charleston, WV 25301-3707

CHAPTER 509
HOSPICE SERVICES
JULY 1, 2004

ATTACHMENT 1

HOSPICE ELECTION FORM

HEF-01

HOSPICE ELECTION FORM

West Virginia Department of Health and Human Resources
Bureau for Medical Services
Policy Units
350 Capitol Street, Room 251
Charleston, West Virginia 25301-3707

I. HOSPICE

HOSPICE NAME:	
ADDRESS:	
	PROV. NO.:
PERSON COMPLETING FORM:	
TELEPHONE:	**FAX:**

II. ACTION

ELECTION:	**FIRST**	**SECOND**	**THIRD**	**LATER**
EFFECTIVE DATE:				

DATE RECIPIENT EXPIRED:	**DATE SERVICES REVOKED:**

III. RECIPIENT

NAME: **(Sex: M F)**		
ADDRESS:		
(County:)		
MEDICAID NUMBER:	**DATE OF BIRTH:**	**TELEPHONE:**
SOCIAL SECURITY NO:	**DIAGNOSIS NAME:**	**DIAGNOSIS CODE:**
AUTHORIZED REPRESENTATIVE:		
ADDRESS:		
TELEPHONE:		

Completion of this form is required by Federal regulation. Failure to complete will result in non-payment of Medicaid Hospice benefits. Return completed form to address above or FAX to Policy Units at (304) 558-4398.

Call (304) 558-5962 with any questions.

IV. ATTENDING PHYSICIAN

NAME:
ADDRESS:
TELEPHONE: **PROVIDER NO.:**
HOSPICE EMPLOYEE? **YES**_____ **NO**_____

V. SIGNATURES

- **FOR ELECTION ONLY:**

I certify that I have read (or had read to me) and understand the conditions of enrollment in West Virginia Medicaid Hospice. All questions I had about these provisions of my hospice care were answered by a hospice representative.

I hereby elect West Virginia Medicaid Hospice Program:

_____

RECIPIENT OR REPRESENTATIVE **DATE**

_____

HOSPICE REPRESENTATIVE **DATE**

- **FOR REVOCATION ONLY:**

I certify that I have read (or had read to me) and understand a statement of revocation. All questions I had about revocation of my hospice care were answered by a hospice representative.

I hereby revoke my participation in the West Virginia Medicaid Hospice Program:

_____

RECIPIENT OR REPRESENTATIVE **DATE**

_____

HOSPICE REPRESENTATIVE **DATE**