Hospice Services

PURPOSE

ND Medicaid covers services provided by hospice providers that are certified to participate in the Medicare program, licensed and enrolled with ND Medicaid.

APPLICABILITY

ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled on the date of service with ND Medicaid. Servicing providers acting as a locum tenens provider must enroll in ND Medicaid and be listed on the claim form. Please refer to provider enrollment for additional details on enrollment eligibility and supporting documentation requirements.

ELIGIBLE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the ND Medicaid MMIS Portal or through the through the Automated Voice Response System by dialing 1.877.328.7098.

A member must be certified as terminally ill for coverage of hospice care. Hospice care may continue until a member is no longer certified as terminally ill, until the member or representative revokes the election of hospice, or until the member's date of death.

A member may live in a home in the community or in a long-term care facility while receiving hospice services. A long-term care facility is a nursing facility, swing bed facility, or intermediate care facility for the intellectually disabled.

A dually eligible member must elect or revoke hospice care simultaneously under both the Medicare and the Medicaid programs.

COVERED SERVICES AND LIMITS

GENERAL PROVIDER POLICIES

The General Provider Policies details basic coverage requirements for all services. Basic coverage requirements include:

- The provider must be enrolled in ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

HOSPICE ELECTION

A hospice election must be submitted for a member who is eligible for hospice care and who wishes to elect hospice benefit period. A client who meets the eligibility requirements must elect hospice care by filing a written election statement with a particular hospice provider.

Election statements must include the following elements:

- The effective date of the election, which may be the first day of hospice care or a later date but may be no earlier than the date of the election statement.
- Identification of the particular hospice and of the attending physician that will provide care to the individual. The individual or representative must acknowledge that the identified attending physician was his or her choice;
- The client's (or legal representative's) acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care as it relates to the client's terminal illness,
- For adult clients, acknowledgment that the client waives certain services as stated in 42 CFR 418.24(g),
- Acknowledgment that the client (or legal representative) may revoke the election of the hospice benefit at any time in the future. Adults must also acknowledge that revocation of hospice benefits will result in restoration of Medicaid benefits that were waived at the time of hospice election, and
- Signature of the client or legal representative.
- The client's date of birth

Upon certification, a client may elect to receive hospice care for an initial 90-day period. After certification, the client may elect the hospice benefit for:

- two subsequent 90-day periods; or
- an unlimited number of subsequent 60-day periods

An election to receive hospice care remains effective through the initial election period and through the subsequent election periods without a break in care as long as the patient:

- remains in the care of a hospice;
- does not revoke the election; and
- is not discharged from the hospice.

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The hospice must provide the below services on a 24-hour basis. Core services must routinely be provided directly by hospice employees. The hospice may contract for supplemental services during periods of peak patient load or for extraordinary circumstances. A written plan of care must be prepared for each patient, and services must be provided by appropriately qualified personnel.

Core Services:

- Nursing services provided by or under the supervision of a registered nurse.
- Social services provided by a social worker under the direction of a physician.
- Services performed by a physician, dentist, optometrist, or chiropractor.

- Counseling services provided to the member and family members or other persons caring for the member at the member's home to assist in minimizing the stress and problems that arise from the terminal illness, related conditions, and the dying process.

Supplemental Services:

- Inpatient hospice care including procedures necessary for pain control and acute or chronic symptom management.
- Inpatient respite care.
- Medical equipment supplies and drugs. Medical equipment including self-help and personal comfort items related to the palliation or management of the member's terminal illness must be provided by the hospice for use in the member's home. Medical supplies include supplies specified in the written plan of care. Drugs include those used to relieve pain and control symptoms for the member's terminal illness.
- Home health aide services and homemaker services which include personal care services and household services, such as changing a bed, light cleaning and laundering, necessary to maintain a safe and sanitary environment in areas of the home used by the member. Aide services must be provided under the supervision of a register nurse.
- Physical therapy, occupational therapy, and speech and language pathology services provided for symptom control or to maintain activities of daily living and basic functional skills.

Plan of Care

All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.

The hospice interdisciplinary group, in collaboration with the individual's attending physician, (if any) must review, revise and document the individualized plan as frequently as the patient's condition requires.

PHYSICIAN CERTIFICATION

For the first 90-day period of hospice coverage, the hospice provider must obtain, no later than 2 calendar days after hospice care is initiated, (that is, by the end of the third day), oral or written certification of the terminal illness by the medical director or the hospice or physician member of the hospice interdisciplinary group (IDG), and the individual's attending physician if the individual has an attending physician. The hospice must obtain certification before it submits a claim for payment. Certifications may be completed no more than 15 calendar days prior to the effective date of election and recertifications may be completed no more than 15 calendar days prior to the start of the subsequent benefit period.

Content of the Certification

The certification statement must include:

- A statement indicating the member's medical prognosis is a life expectancy of six months or less
- Clinical information and documentation that supports the medical diagnosis
- A brief narrative explanation of the clinical findings that supports the life expectancy of 6 months or less
- Physician(s) signature and the benefit period dates to which the certification or recertification applies

DOCUMENTATION REQUIREMENTS

GENERAL REQUIREMENTS

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to ND Medicaid. Records must be retained for at least 7 years after the last date the claim was paid or denied. Providers must follow the documentation requirements in the Provider Requirements Policy.

INPATIENT HOSPICE CARE

A member may need care as an inpatient on a short-term basis during a period of crisis. To meet this need, the hospice or facility under contract to provide inpatient hospice care must provide 24-hour nursing services. Nursing services must be sufficient to meet the total nursing needs and be consistent with the member's plan of care. The inpatient facility must provide treatments, medications, and diet as prescribed, and keep the

member comfortable, clean, well-groomed, and protected from accident, injury, and infection. The inpatient facility must employ a registered nurse on each shift to provide nursing care.

INPATIENT RESPITE CARE

Inpatient respite care may be provided on an occasional basis to give the member's family or caregiver a break from the full-time responsibility of providing care. Payment for inpatient respite care may not exceed five consecutive days of inpatient respite care at a time.

DISCHARGE FROM HOSPICE

Hospice may discharge a patient if:

- The patient moves out of the hospice's service area or transfers to another hospice;
- The hospice determines that the patient is no longer terminally ill;
- The member passes away.

BEREAVEMENT COUNSELING

The hospice must make bereavement services available to the member's family for at least one year after the member's death. Family includes persons related to the member or those considered by the member to be family because of close association. No Medicaid payment is made for bereavement counseling.

PAYMENT FOR PHYSICIAN SERVICES

Daily hospice care rates include payment for the administrative and general supervisory activities performed by the medical director or a physician member of the interdisciplinary team. These activities include participation in establishment of plans of care, supervision of care and service, periodic review and updating plans of care, and establishment of governing policies. The cost of these activities may not be billed separately.

The hospice may be paid at the current Medicaid rate for physician services provided for purposes other than those listed above if the physician is an employee of the hospice or provides services under arrangement with the hospice. Payment is not available for donated physician services.

Payment may be made for personal professional services provided by a member's attending physician, if the physician is not an employee of the hospice, not providing services under arrangement with the hospice, or does not volunteer services to the hospice. Costs for services other than personal professional services, such as lab or x-ray, may not be included on the attending physician's bill and may not be billed separately.

ROOM AND BOARD PAYMENT FOR MEMBERS IN LONG-TERM CARE FACILITY

The hospice is responsible for paying room and board when providing care for a member residing in a long-term care facility. In this situation, payment to the long-term care facility by ND Medicaid is no longer available. The hospice is responsible for including the room and board charges on the claim for the amount equal to the Medicaid rate payable to the long-term care facility at the time the services are provided. The hospice may not negotiate a room and board rate with the long-term care facility except for payment for private room accommodations. No additional payment will be made to the hospice for negotiated private room rates.

If a member has a recipient liability, the amount will be shown on a remittance advice. The hospice is responsible for collection of this amount from the member. The hospice may arrange with the long-term care facility to collect the recipient liability. ND Medicaid will not reimburse the hospice for any uncollected recipient liability.

A hospice claim must be submitted for all members electing hospice who reside in a long-term care facility even if no payment is due from ND Medicaid and payment is made entirely by Medicare, insurance, or any other payment source.

SERVICE AUTHORIZATION REQUIREMENTS

No service authorization required.

NON-COVERED SERVICES

GENERAL NON-COVERED SERVICES

The Noncovered Services Policy contains a general list of services that are not covered by North Dakota Medicaid.

REIMBURSEMENT METHODOLOGY AND CLAIM INSTRUCTIONS

TIMELY FILING

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The Timely Filing Policy contains additional information.

THIRD-PARTY LIABILITY

Medicaid members may have one or more additional source of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources. The Third Party Liability Policy contains additional information.

CLIENT SHARE (RECIPIENT LIABILITY)

Client share (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The Client Share Policy contains additional information.

REIMBURSEMENT

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

The hospice provider will be reimbursed at one of four predetermined rates for each day a member is under the care of the hospice. The four rates exclude payment for physician services that are separately paid.

The hospice provider will be reimbursed an amount applicable to the type and intensity of services provided each day to the member. The four levels of care into which each day of care is classified are:

Routine Home Care – This level of care is used for each day the member is

under the care of the hospice and the member is not classified at another level of care. This level of care is paid without regard to the volume or intensity of services provided.

Continuous Home Care – This level of care is used for each day the member receives nursing services on a continuous basis during a period of crisis in the member's home. The hospice is paid an hourly rate for every hour or part of an hour of continuous care furnished up to a maximum of 24 hours a day.

Inpatient Respite Care – This level of care is for each day a member is in an inpatient facility and receiving respite care. Payment for inpatient respite care is limited to 5 consecutive days beginning with the day of admission but excluding the day of discharge. Any inpatient respite care days in excess of 5 consecutive days must be billed as routine home care. Inpatient respite care may not be paid when a member resides in a long- term care facility.

General Inpatient Care – This level of care is for each day the member receives inpatient hospice care in an inpatient facility for control of pain or management of acute or chronic symptoms that can't be managed in the home. The day of admission to the facility is general inpatient care and the day of discharge is not general inpatient care unless the member discharged is deceased. Payment for general inpatient care may not be made to a long-term care facility when that facility is considered the resident's home; however, payment for general inpatient care can be made to another long-term care facility.

Payment for inpatient care days will be limited according to the number of days of inpatient care furnished to members by the hospice in a year. The maximum number of payable inpatient respite and general inpatient days may not exceed twenty percent of the total number of days of hospice care provided to all members by the hospice. If the maximum number of days exceeds twenty percent of total days, an adjustment will be made to pay the excess days at the routine home care rate, and the difference will be recovered from the hospice provider. The limitation on inpatient care days does not apply to members diagnosed with acquired immunodeficiency syndrome (AIDS).

CLAIM FORM

Hospice services must be billed using the UB 04 claim form or 837i. Detailed claim instructions are available on the ND Medicaid Provider Guidelines, Policies & Manual webpage.

DEFINITIONS

Attending physician - Identified by the individual, at the time the member elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care and can be a:

- Doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs that function or action; or
- Nurse practitioner who meets the training, education, and experience requirements as described in § 410.75(b) of this chapter; or
- Physician assistant who meets the requirements of § 410.74(c) of this chapter.

Bereavement counseling -emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment.

BFCC-QIO - Beneficiary and Family Centered Care Quality Improvement Organization.
Cap period means the twelve-month period ending September 30 used in the application of the cap on overall hospice reimbursement specified in § 418.309.

Clinical note - a notation of a contact with the patient and/or the family that is written and dated by any person providing services and that describes signs and symptoms, treatments and medications administered, including the patient's reaction and/or response, and any changes in physical, emotional, psychosocial or spiritual condition during a given period of time.

Comprehensive assessment - a thorough evaluation of the patient's physical, psychosocial, emotional and spiritual status related to the terminal illness and related conditions. This includes a thorough evaluation of the caregiver's and family's willingness and capability to care for the patient.

Dietary counseling - education and interventions provided to the patient and family regarding appropriate nutritional intake as the patient's condition progresses. Dietary counseling is provided by qualified individuals, which may include a registered nurse,

dietitian or nutritionist, when identified in the patient's plan of care.

Employee - a person who:

- Works for the hospice and for whom the hospice is required to issue a W-2 form on his or her behalf;
- If the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice; or
- Is a volunteer under the jurisdiction of the hospice

Hospice - a public agency or private organization or subdivision of either of these that is primarily engaged in providing hospice care as defined in this section.

Hospice care - a comprehensive set of services described in 1861(dd)(1) of the Act, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.

Initial assessment - an evaluation of the patient's physical, psychosocial and emotional status related to the terminal illness and related conditions to determine the patient's immediate care and support needs.

Licensed professional - a person licensed to provide patient care services by the State in which services are delivered.

Multiple location - a Medicare-approved location from which the hospice provides the same full range of hospice care and services that is required of the hospice issued the certification number. A multiple location must meet all of the conditions of participation applicable to hospices.

Palliative care - patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

Physician - an individual who meets the qualifications and conditions as defined in section 1861(r) of the Act and implemented at § 410.20 of this chapter.

Physician designee - a doctor of medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available.

Pseudo-patient - a person trained to participate in a role-play situation, or a computer-based mannequin device. A pseudo-patient must be capable of responding to and interacting with the hospice aide trainee and must demonstrate the general characteristics of the primary patient population served by the hospice in key areas such as age, frailty, functional status, cognitive status and care goals.

Representative - an individual who has the authority under State law (whether by statute or pursuant to an appointment by the courts of the State) to authorize or terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill patient who is mentally or physically incapacitated. This may include a legal guardian.

Restraint - Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of:

- Conducting routine physical examinations or tests or to protect the patient from falling out of bed, or
- To permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort); or
- A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Seclusion - the involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving.

Simulation - a training and assessment technique that mimics the reality of the homecare environment, including environmental distractions and constraints that evoke or replicate substantial aspects of the real world in a fully interactive fashion, in order to teach and assess proficiency in performing skills, and to promote decision making and critical thinking.

Terminally ill - that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

REFERENCES

- North Dakota Administrative Code
- North Dakota Century Code
- Code of Federal Regulations

CONTACT

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POLICY UPDATES

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Section	Summary
	Multiple clarifications and format changes added throughout.