

HOSPICE

Provider Manual
Volume II

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New Hampshire
Medicaid

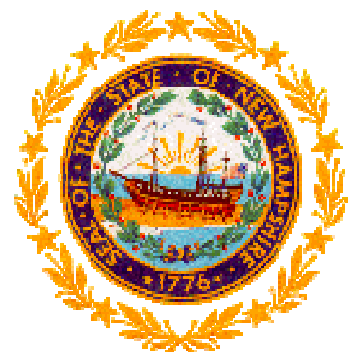


Table of Contents

1. NH MEDICAID PROVIDER BILLING MANUALS OVERVIEW	1-1
Intended Audience	1-1
Provider Accountability	1-1
Document Disclaimer/Policy Interpretation.....	1-1
Notifications & Updates.....	1-2
Description of Change Log	1-2
Contacts for Billing Manual Inquiries.....	1-2
2. PROVIDER PARTICIPATION & ONGOING RESPONSIBILITIES	2-1
Election (or Discharge Due to Death) of Hospice Care	2-1
Hospice Election Periods	2-2
Certification of Terminal Illness	2-2
Change in Designated Hospice Provider.....	2-3
Revocation of Hospice Care.....	2-3
3. COVERED SERVICES & REQUIREMENTS	3-1
Coverage for Adults (age 21 and over).....	3-1
Coverage for Children (under age 21).....	3-1
Covered Services.....	3-2
Dually Eligible Medicare/Medicaid Population.....	3-3
4. NON-COVERED SERVICES	4-1
5. SERVICE AUTHORIZATIONS (SA).....	5-1
6. DOCUMENTATION.....	6-1
7. SURVEILLANCE AND UTILIZATION REVIEW (SURS) – PROGRAM INTEGRITY.....	7-1
8. ADVERSE ACTIONS	8-1
9. MEDICARE/THIRD PARTY COVERAGE	9-1
10. PAYMENT POLICIES	10-1
Hospice Payment Limitations and Adjustments	10-2
Hospice Payment for Members in Nursing Facilities	10-2
Payment for Physician’s Services	10-2
11. CLAIMS.....	11-1
Timely Filing.....	11-2
Diagnosis & Procedure Codes.....	11-3
Required Claim Attachments	11-3
Claim Completion Requirements for Hospice Services.....	11-3
12. TERMINOLOGY	12-9

Change Log

The Change Log is used to track all changes within this manual. Changes are approved by the State of NH. The column titles and descriptions include:

- Date Change to the Manual Date the change was physically made to the manual.
- Effective Date Date the change goes into effect. This date may represent a retroactive, current or future date. This date is also included in the text box located on the left margin where the content change was updated.
- Section/Sub-Section Section/Sub-Section number(s) to which the change(s) are made.
- Change Description Description of the change(s).
- Reason A brief explanation for the change(s) including rule number if applicable.
- Related Communication References any correspondence that relates to the change (ex: Bulletin, Provider Notice, Control Memo, etc.).

Date Change to Manual	Effective Date	Section/Sub-Section	Change Description	Reason	Related Communication
12/2017	1/1/2018		Rebrand Document	Remove actual name of fiscal agent; replace with “fiscal agent”	

1. NH Medicaid Provider Billing Manuals Overview

New Hampshire (NH) Medicaid Provider Billing Manuals include two volumes which must be used in conjunction with each other. Policies and requirements detailed in these manuals are established by the NH Department of Health and Human Services (DHHS), also referred to as the Department.

It is critical that the provider and the provider's staff be familiar with, and comply with, all information contained in the General Billing Manual – Volume I, and this Provider Specific Billing Manual – Volume II.

- The **General Billing Manual – Volume I:** Applies to every enrolled NH Medicaid provider (hereinafter referred to as the provider) who submits bills to NH Medicaid for payment. It includes *general policies and procedures* applicable to NH Medicaid such as provider responsibilities, verification of member eligibility, covered and non-covered services, service authorizations, medical necessity, third party liability, surveillance and utilization review/program integrity, access to fee schedules, claims processing, and obtaining reimbursement for providing services. This manual also includes general information on how to enroll as a NH Medicaid provider. The Appendices section encompasses a wide range of supplemental materials such as Fee Schedules, Contact Information, Provider Type List, Sample Forms and Instructions, as well as other general information.
- The **Provider Specific Billing Manual – Volume II:** Specific to a provider type and designed to guide the provider through *specific policies applicable to the provider type*.

Intended Audience

The General Billing Manual - Volume I, and the Provider Specific Billing Manual – Volume II, are designed for health care providers, their staff, and provider-designated billing agents.

These manuals are *not* designed for use by NH Medicaid members (hereinafter referred to as members).

Provider Accountability

Providers should maintain both billing manuals, make them available to their staff and authorized billing agents, and be aware of all policies and procedures, as well as any changes to policies and procedures, that relate directly or indirectly to the provision of services and the billing of services for members.

Document Disclaimer/Policy Interpretation

It is our intention that the provider billing manuals, as well as the information furnished to providers by the staff of the Department's fiscal agent, be accurate and timely. However, in the event of

inconsistencies between fiscal agent and the Department regarding policy interpretation, the Department's interpretation of the policy language is question will control and govern.

Notifications & Updates

Providers are notified of NH Medicaid changes and any other changes applicable to participating providers through several types of media, including provider bulletins, provider notices, memos, letters, web site updates, newsletters and/or updated pages to the General Billing Manual and/or the Provider Specific Billing Manual. It is important that providers share these documents with their billing agents and staff.

Billing Manual updates are distributed jointly by the Department and the fiscal agent. Providers receive notification of manual updates through a message sent to each provider's message center inbox via the web.

Description of Change Log

All changes made to this manual are under change control management and are approved by Department and/or its associated organizations. The change log is located at the front of this document.

Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the fiscal agent's Provider Relations Unit (refer to General Billing Manual – Volume I Appendices Section for all Contact Information).

Questions relating to policy issues outlined in this manual may be directed to the fiscal agent's Provider Relations Unit for referral to the appropriate Department contact.

2. Provider Participation & Ongoing Responsibilities

Each participating hospice provider must:

- Be Medicare certified as a hospice provider;
- Be a NH enrolled NH Medicaid provider; and
- Hold a current NH state license as a home hospice care provider or hospice house in accordance with RSA 151:2 and He-P 823 or He-P 824, or be licensed as such by the state in which they practice;

Federal regulations at 42 CFR Section 418.56 specify that the “hospice provider” is the professional manager of the hospice recipient’s hospice care. As such, the hospice provider’s responsibility includes coordinating the plan of care and ensuring that the plan of care is consistent with the hospice philosophy of care.

Election (or Discharge Due to Death) of Hospice Care

In accordance with He-W 544, if a member seeks to elect hospice care, the hospice provider shall obtain an election statement via the hospice care provider’s hospice care election form, signed and dated by the member or his or her agent or legal guardian, indicating the member’s election of hospice care. The election statement must:

1. Specify the hospice provider designated by the member to provide care;
2. Specify the effective date of the election, which shall not be earlier than the date the member or his or her agent or legal guardian signs the election statement; and
3. Specify that by waiving rights in accordance with He-W 544, the member or the member’s agent or legal guardian acknowledges 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 member’s terminal illness specified on the form. (See “Covered Services” – “Coverage for Children” for further information on waiving rights.)

If a member elects hospice care, the designated hospice provider shall notify the Department of the effective date of the election by submitting Form 282A, “Medicaid Hospice Care Notification Form,” within 5 state business days of the election.

Each hospice provider shall notify the Department of a member’s discharge from the hospice due to the member’s death, within 5 state business days of the member’s death, via Form 282A, “Medicaid Hospice care Notification Form.”

These and other forms can be found on the NH MMIS Health Enterprise portal at www.nhmmis.nh.gov.

Hospice Election Periods

The member shall be allowed hospice coverage divided into election periods as follows:

1. An initial 90-day period;
2. A subsequent 90-day period; and
3. An unlimited number of subsequent 60-day periods.

Election of hospice care shall be considered to continue through the election periods specified above without a break in care if the member:

1. Remains in the care of the hospice provider; and
2. Does not revoke the election under the provisions of He-W 544.

Certification of Terminal Illness

The hospice provider shall obtain certification of terminal illness as follows:

1. For the first 90-day election period, the hospice provider shall obtain, within 2 calendar days after hospice care is initiated, written certification of terminal illness signed and dated by:
 - a. The medical director of the hospice provider or the physician member of the hospice interdisciplinary group; and
 - b. The member's NH Medicaid enrolled, attending physician, if the member has an attending physician. An APRN shall not be allowed to sign;
2. For subsequent election periods of coverage, the hospice provider shall obtain, within 2 calendar days after the beginning of each election period, a written certification of terminal illness that has been signed and dated by the medical director of the hospice provider, or the physician member of the hospice interdisciplinary group;
3. If the written certification in (1) or (2) above cannot be obtained within 2 days, a verbal certification shall be:
 - a. Obtained within 2 days;
 - b. Documented in the member's medical records; and
 - c. Followed by a written certification pursuant to (1) or (2) above within 30 calendar days; and
4. No NH Medicaid payment shall be made for days prior to the certification(s) specified in (1)–(3) above.

Change in Designated Hospice Provider.

A member or his or her agent or legal guardian may change the designated hospice provider once in each of the election periods specified above.

The member or his or her agent or legal guardian shall complete the hospice care provider's change of designated provider form, and provide it to the current hospice provider and the newly designated hospice provider.

The member's current hospice provider shall provide written notification to the Department within 5 state business days of a member changing his or her designated hospice provider by submitting a completed Form 282A, "Medicaid Hospice Care Notification Form" (found on the NH MMIS Health Enterprise portal at www.nhmmis.nh.gov).

The member's current hospice provider shall forward the following to the newly designated hospice provider:

1. A copy of the election statement obtained by the current hospice provider; and
2. A copy of the certification of terminal illness obtained by the current hospice provider.

The newly designated hospice provider shall comply with all requirements of He-W 544, except that the forms forwarded by the member's current hospice provider, as described above, may be used in place of completing new documents.

Revocation of Hospice Care

The member or his or her agent or legal guardian may revoke the member's election of hospice care at any time by completing and signing the hospice care provider's hospice care revocation form.

If the revocation form cannot be signed at the time of revocation, the following shall occur:

1. The member or his or her agent or legal guardian shall verbally revoke the member's election of hospice care, the date of which shall be documented in the member's medical record; and
2. The member or his or her agent or legal guardian shall complete and sign the revocation form described above.

The member or his or her agent or legal guardian shall not designate a revocation effective date earlier than the date the revocation is made as described above.

The designated hospice shall submit a completed Form 282A, "Medicaid Hospice Care Notification Form" (found on the NH MMIS Health Enterprise Portal at www.nhmmis.nh.gov), specifying the date that the revocation is to be effective, to the Department within 5-calendar days of a member revoking his or her election of hospice care.

Effective with the revocation date specified, the member shall no longer be covered under the hospice benefit, and shall resume eligibility for all NH Medicaid benefits previously waived.

A member who revokes his or her election of hospice care shall be eligible to elect hospice care for any remaining election periods.

3. Covered Services & Requirements

Members must meet certain eligibility requirements in order to be eligible for the covered services described below.

Hospice recipients can be either Medicaid only eligible or Medicare and Medicaid dually eligible. However, all members must be certified as terminally ill. A member is considered terminally ill if the medical prognosis suggests a life expectancy of six months or less if the illness runs its normal course.

Coverage for Adults (age 21 and over)

To receive NH Medicaid hospice benefits, members who are age 21 and over, terminally ill, and who elect hospice care must agree to waive all rights to the following NH Medicaid services:

- Hospice care provided by a hospice provider other than the one designated by the member on the hospice care provider's hospice election form, unless provided under arrangements made by the designated hospice;
- NH Medicaid services that are (a) related to the treatment of the terminal illness for which hospice care was elected; (b) related to the treatment of a condition or complication related to the terminal illness for which hospice care was elected; or (c) equivalent to, or duplicative of, hospice services
- NH Medicaid home and community-based care waiver services that are equivalent to, or duplicative of, hospice services.

Coverage for Children (under age 21)

To receive NH Medicaid hospice benefits, members who are under the age of 21 must be terminally ill and elect hospice care.

Section 2302 of the Affordable Care Act, entitled "Concurrent Care for Children" amends sections 1905 (o)(1) and 2110 (a)(23) of the Social Security Acts, to remove the prohibition of receiving curative treatment upon the election of the hospice benefit by or on behalf of a Medicaid eligible child.

Members under the age of 21 are not required to waive rights to NH Medicaid services that are related to the treatment of the member's condition for which a diagnosis of terminal illness has been made. These services and supports may include pain and symptom management and family counseling provided by specially trained hospice staff

Covered Services

The designated hospice provider shall create a plan of care for the member in accordance with 42 CFR 418.56 a.2.(b) that specifies the services to be provided to the member, which are reasonable and necessary for the palliation or management of the symptoms of the terminal illness and conditions or complications related to the terminal illness.

Pursuant to He-W 544, services covered as part of the hospice benefit include:

- Nursing care provided by or under the supervision of a registered nurse;
- Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician;
- Counseling services, including dietary counseling, provided to the member, family members, and others caring for the member for the purpose of training the member's family or caregivers to provide care;
- Durable medical equipment and supplies for self-help and personal comfort related to the palliation or management of the member's terminal illness or conditions related to the terminal illness while the member is under hospice care;
- Drugs for the palliation and management of the member's terminal illness or conditions related to the terminal illness;
- Home health aide and homemaker services;
- Physical therapy, occupational therapy, and speech language pathology services for the purpose of symptom control or to enable the member to maintain activities of daily living and basic functional skills;
- Ambulance and wheelchair van transportation;
- Any other service that is specified in the member's plan of care as reasonable and necessary for the palliation and management of the member's terminal illness and related conditions;
- Services performed by a hospice physician as follows:
 - General supervisory services of the medical director;
 - Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group; and
 - Physician services that are related to the treatment of the terminal illness (such services are part of the per diem rate);
- General inpatient care, which is hospice care provided in an inpatient facility for pain control or symptom management and that cannot be managed in an outpatient setting, provided as follows:
 - The care is provided in a NH Medicaid enrolled hospice house, licensed in accordance with RSA 151 and He-P 824, a hospital, or a nursing facility that meets the requirements in 42 CFR 418.110 regarding staffing and patient areas;
 - Federal hospice regulations at 42 CFR 418.110 for inpatient care specify the conditions of participation (COP) for general inpatient care and should be reviewed in their entirety;
- Continuous home care to maintain the member at home as follows:

- The care is provided only during a period of crisis, which is a period during which the member requires continuous care to achieve palliation or management of acute medical symptoms;
 - The continuous home care must be for a minimum of eight hours of care during a 24-hour day, which need not be consecutive hours. The 24-hour day begins at midnight and ends at 11:59 p.m.;
 - The continuous care is primarily nursing care with more than half of the eight hours of the period of care being provided by a registered nurse (RN) or licensed practical nurse (LPN). Home health aides may supplement the nursing care in the total continuous care hours; and
 - The hospice provider must maintain documentation that clearly indicates the nature of the medical crisis and the need for skilled intervention, including the level of staffing and the services that were provided both hourly and daily.
- Inpatient Respite Care which is short-term inpatient care provided to a member who does not reside in a nursing facility, and is used only when necessary to relieve the family members or other persons caring for the member when provided as follows:
 - Inpatient Respite Care cannot be used for more than one period of 5 consecutive days at a time per election period, except that the sixth and any subsequent consecutive days shall be covered and paid at the routine home care rate.
 - Inpatient respite hospice care may only be provided in intermediate care facilities that meet the requirements of 42 CFR 418.100 (a) and (e) regarding 24-hour nursing and patient areas.

The member's plan of care shall include bereavement counseling for the member's family after the member's death. Bereavement counseling shall not be billable to NH Medicaid nor to the member's family.

Pursuant to He-W 544, a member is not required to waive rights to the following services, which shall be covered in addition to hospice services:

1. Services provided by the member's NH Medicaid attending physician if that physician is not an employee of the designated hospice, or is not receiving compensation from the hospice for those services; and
2. Room and board services provided by a nursing facility if the member meets nursing facility level of care.

Dually Eligible Medicare/Medicaid Population

Individuals eligible for both Medicare Part A and Medicaid receive hospice services through the Medicare system. NH Medicaid does reimburse for certain services not covered under the Medicare hospice benefit, such as co-pays for respite care and deductibles for drugs. Accordingly, NH Medicaid requires recipients residing in nursing facilities who have elected hospice to change their addresses. The dual eligible member can be enrolled under both the Medicaid and Medicare programs at the same time.

4. Non-covered Services

Non-covered services are services for which NH Medicaid will not make payment.

There may be non-covered services directly associated with your provider type (such as those listed below or those for which there is no medical need), but some non-covered services cannot be directly associated with a specific provider category. Therefore, providers should review the list of other examples of non-covered services in the “Non-Covered Services” section of the General Billing Manual – Volume I.

If a non-covered service is provided to a member, the provider must inform the member, **prior to** delivery of the service, that it is non-covered by NH Medicaid, and that, should the member still choose to receive the service, the member will be responsible for payment. If this occurs, the Department recommends that the provider maintain in their files a statement signed and dated by the member that indicates that the member understands that the service is non-covered and that s/he agrees to pay for the service.

Upon election of hospice care the member agrees to waive all rights to the following Medicaid Services:

1. Hospice care provided by a hospice other than the one designated by the member on the hospice care provider’s hospice election form, unless provided under arrangements made by the designated hospice;
2. NH Medicaid services that are:
 - a. Related to the treatment of the terminal illness for which hospice care was elected;
 - b. Related to the treatment of a condition or complication related to the terminal illness for which hospice care was elected; or
 - c. Equivalent to, or duplicative of, hospice services; and
3. NH Medicaid Home and Community-based Care Waiver Services that are equivalent to or duplicative of, hospice services.

Members under the age of 21 are not required to waive rights to Medicaid services related to treatment of the member’s condition for which a diagnosis of terminal illness has been made.

5. Service Authorizations (SA)

A Service Authorization (SA), also known as a Prior Authorization (PA), is an advanced request for authorization of payment for a specific item or service.

Service authorizations are not required for hospice services.

6. Documentation

Hospice providers must maintain supporting documentation, including copies of forms submitted to the Department, for each service for which a claim has been submitted to NH Medicaid for reimbursement. Please see the “Record Keeping” section of the General Billing Manual – Volume I, for documentation requirements.

Providers must maintain clinical records to support claims submitted for reimbursement for a period of at least six years from the date of service or until resolution of any legal action(s) commenced in the six year period, whichever is longer.

As described under “Covered Services” above, continuous home care requires documentation that clearly indicates the nature of the medical crisis and the need for skilled intervention, including the level of staffing and the services that were provided both hourly and daily.

Hospice providers’ records shall include forms created by the provider, which address the following and includes the required elements (as noted in this billing manual and the rules at He-W 544):

1. A member’s election of hospice care;
2. The provider’s certification of terminal illness;
3. A change in designated hospice providers if applicable; and
4. A revocation of hospice care if applicable.

The hospice provider shall notify the Department by completing and submitting a Form 282A, “Medicaid Hospice Care Notification Form” (found on the NH MMIS Health Enterprise portal at www.nhmmis.nh.gov) to the Department when any of the following occur:

1. A member elects hospice care;
2. A member changes his or her designated hospice provider;
3. A member revokes his or her election of hospice care;
4. A member is discharge from the hospice provider due to the member’s death.

Within 30 days following the end of each quarter, for each member who died within that quarter, the hospice provider shall notify the Department of hospice service utilization by completing and submitting a Form 282B, “Service Utilization within Hospice by Recipient,” found on the NH MMIS Health Enterprise portal at www.nhmmis.nh.gov. This form is not required for dual-eligible hospice members who reside in a nursing facility.

Hospice providers shall submit to the Department a copy of the provider’s annual Medicare Cost Report, by November 30th of each year.

7. Surveillance and Utilization Review (SURS) – Program Integrity

The purpose of a Medicaid Surveillance and Utilization Review (SURS) program which, in NH, is administered by the Department's Program Integrity Unit is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse. These utilization review activities are required and carried out in accordance with Federal regulations at 42 CFR 455 and 42 CFR 456, and they are done to ensure that accurate and proper reimbursement has been made, for care, services and/or supplies that have been provided to a member, and for which a provider has received payment.

Utilization review activities may be conducted prior to payment, following payment, or both. These activities include, but are not limited to, conducting provider reviews. These reviews may be selected at random, generated from member complaints, other providers, anonymous calls, or from the SURS reporting system.

There are various outcomes that may result from Program Integrity review activities. They include, but are not limited to:

- Recovery of erroneous and improper provider payments;
- Provider education regarding appropriate documentation to support the submission and payment of claims;
- Ensuring that the provider has developed a corrective action plan based on the findings of the review. This includes conducting follow-up reviews to verify that the provider is complying with the corrective action plan, and continues to provide and bill for services provided to members, in accordance with the rules and regulations governing the NH Medicaid Program;
- Potential referral to appropriate legal authorities – including the NH Medicaid Fraud Control Unit (MFCU) and the Federal Office of Inspector General (OIG);
- Potential termination from the NH Medicaid Program; or
- Other administrative actions.

If a provider is found to have abused the NH Medicaid Program requirements, the provider may be restricted, through suspension or otherwise, from participating in the NH Medicaid Program for a reasonable period of time. In addition, the provider may also have their claims placed on a prepayment pend or hold status for additional review by the Program Integrity Unit.

For additional information regarding utilization review, please refer to the SURS – Program Integrity section of the General Billing Manual – Volume 1.

8. Adverse Actions

An adverse action may be taken by the Department due to a provider's non-compliance with Federal regulations, State laws, or Department rules, policies or procedures. Refer to the "Adverse Actions" section of the General Billing Manual – Volume I – regarding the types of adverse actions the Department is authorized to take against non-compliant providers.

9. Medicare/Third Party Coverage

Under federal law, the Medicaid Program is the *payer of last resort*. All third party obligations must be exhausted before claims can be submitted to the fiscal agent in accordance with 42 CFR 433.139, except for Medicaid only services and claims for prenatal care of pregnant women or claims for preventive pediatric services, including EPSDT (this includes dental and orthodontic services in New Hampshire). Additional information on exclusions is outlined in this section or in the General Billing Manual – Volume 1. Providers who receive payment in full from a third party are not required to file zero-payment claims with the NH Medicaid Program.

A provider must first submit a claim to the third party within the third party's time limitations. If a third party or primary insurance plan does not pay at or in excess of the applicable NH Medicaid reimbursement level, a provider may submit a claim to NH Medicaid which is processed based on the applicable reimbursement rate minus any payment received from all other resources. Commercial health insurance coverage often provides a higher payment than does NH Medicaid.

When a third party denies a claim, for any reason, a copy of the notice of denial from the third party *must be included* behind the claim submitted to NH Medicaid. When Medicare denies a claim, a copy of the Explanation of Medicare Benefits must be attached behind the claim that is submitted. For claims not submitted on paper, the Medicare or third-party denial is considered a claim attachment.

Detailed Medicare/Third Party Liability (TPL) information is found in the General Billing Manual, including handling discrepancies in TPL resource information, correcting erroneous TPL information, and exceptions to third party filing requirements.

When a member is also covered by Medicare, the provider must bill Medicare for all services before billing NH Medicaid. The provider must accept assignment of Medicare benefits in order for the claim to “*crossover*” to NH Medicaid. The crossover process works only for Medicare approved services; Medicare denied services and Medicare non-covered services are addressed in this section. NH Medicaid pays crossover claims only if the service is covered by NH Medicaid.

Certain services that are not covered by Medicare *may* be covered by NH Medicaid for dually eligible members. Services identified in the Medicare billing manual and HCPCS coding manuals as non-covered by Medicare may be billed directly to NH Medicaid who will determine whether or not the service is covered and can be reimbursed by NH Medicaid.

This does not apply to QMB Only members whose benefits are limited to the Medicare premiums and payment toward the Medicare deductible and coinsurance. Therefore, if Medicare does not cover the service, there is no NH Medicaid payment available for QMB members.

When a member elects or revokes the Medicaid hospice benefit, the member shall also elect or revoke the hospice benefit under Medicare and/or other insurance, as applicable.

Detailed Medicare/Third Party Coverage guidelines are found in the General Billing Manual – Volume I.

10. Payment Policies

Reimbursement for the NH Medicaid Hospice benefit follows the methodology and levels established by the Centers for Medicare and Medicaid Services (CMS) for administration of the federal Medicare Hospice Program. NH Medicaid hospice reimbursement rates are, therefore, based on Medicare reimbursement rates and methodologies, adjusted to disregard offsets attributed to Medicare premium amounts. The rates are adjusted for regional differences in wages using indices published by the CMS.

Payment for hospice care, with the exception of physician services, shall be at a per diem rate for each day that the member is under the care of the hospice provider.

The per diem rate shall:

1. Be determined in accordance with Medicare regulations at 42 CFR 418, Subpart G;
2. For continuous home care, be calculated based upon the number of hours of continuous home care furnished to arrive at a per diem rate, in accordance with 42 CFR 418.302(e)(4); and
3. Be based upon the level of care as follows:
 - Routine home care;
 - Continuous home care;
 - Inpatient respite care; and
 - General inpatient care

Payment for inpatient respite care shall be limited to one period of no more than 5 consecutive days in each election period. Inpatient respite care provided in excess of the 5-day limit per election period shall be paid at the routine home care rate.

If there is a change in designated provider, admission status, or level of care, payment shall be made as follows:

1. If admission occurs on the same day as discharge, revocation or death, the day shall be considered a hospice care day and the hospice shall be paid in accordance with the per diem rate noted above;
2. If the level of care changes, payment shall be made for the new level of care beginning with the day it commences;
3. If a change of hospice provider occurs, payment shall not be made to the discharging hospice for the day of discharge, but payment shall be made to the newly designated hospice; and
4. If the member is discharged from an inpatient unit, the routine home care rate shall be paid, unless the member dies as an inpatient, in which case the general inpatient or respite care rate shall be paid for the discharge date.

If certification of terminal illness is not obtained as described in the “Provider Participation & Ongoing Responsibilities” section of this manual, payment shall not be made for days prior to certification.

Bereavement counseling is part of the plan of care and shall not be separately billable to NH Medicaid nor to the member’s family.

Hospice Payment Limitations and Adjustments

Hospice payments for inpatient care shall be limited and paid in accordance with Medicare regulations 42 CFR 418.302(f).

Acquired Immunodeficiency Syndrome (AIDS) cases shall be included in the limitation calculation.

On an annual basis, by November 30, hospice providers shall submit to the Department a copy of their Medicare cap report.

Hospice payments for inpatient care shall be considered to be interim payments with adjustments made during the end of the November 1 to October 31 cap period for any payments over the limit.

Hospice providers shall refund any excess reimbursement as determined and requested by the Department in accordance with above.

Hospice Payment for Members in Nursing Facilities

No NH Medicaid payments shall be made directly to a nursing facility. When hospice services are provided to a member residing in a nursing facility, the hospice provider shall:

1. Bill for, in addition to routine or continuous home care, room and board; and
2. Be reimbursed by NH Medicaid at a room and board rate, which is at least 95% of the per diem rate that would have been paid to the nursing facility for the member for the same dates of service under rates established in accordance with He-E 803.

Payment for Physician's Services

If a member's attending physician, who is not an employee of the designated hospice or providing services under arrangement with the designated hospice, provides physician services related or unrelated to the treatment of the terminal illness:

1. These physician services shall not be considered as part of the hospice per diem rate described above; and
2. The physician shall bill for these physician services separately, and be reimbursed at the regular physician services rate in accordance with the provider specific Physician Billing Manual, Volume II.

If a member's attending physician, who is not an employee of the designated hospice or providing services under arrangement with the designated hospice, requests through an order that the medical director or hospice physician provide physician services, these physician services may be billed in the same manner described above, except that the following services may not be billed:

- general supervisory services of the medical director;
- participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group; and

- physician services that are related to the treatment of the terminal illness.

If a member does not have an attending physician at the time of electing the hospice benefit, the medical director of the designated hospice provider or the physician member of the hospice interdisciplinary group shall be the member's attending physician, and bill and receive payment as follows:

1. Physician services that are related to the treatment of the terminal illness shall be considered hospice services, and be included in the hospice per diem rate described above under "Payment Policies"; and
2. Physician services that are unrelated to treatment of the terminal illness shall be considered physician services, and shall be billed separately by the physician and be reimbursed at the regular physician services rate in accordance with the provider specific Physician Billing Manual, Volume II. These services shall not be billed by the hospice provider.

11. Claims

Please Note: Until notified otherwise, hospice providers must submit claims only as paper claims and must submit the paper claims directly to the Department address noted below - not to the fiscal agent. Hospice providers are expected to comply with all requirements of this Section 11, "Claims," except for (a) requirements related to non-paper billing and (b) the submittal of claims to the fiscal agent. Hospice claims should be submitted on paper directly to :

**Department of Health and Human Services
129 Pleasant Street
Office of Medicaid Business and Policy
Brown Building
Concord, NH 03301**

Attention: Medicaid Medical Services

Once you have received notification from the fiscal agent that you can submit your claims electronically, then the below non-paper billing and claim submittal procedures in Section 11 would be in effect. Other provisions still apply.

Hospice providers shall submit claims for payment to the Department's fiscal agent.

All providers participating in NH Medicaid must submit claims to the fiscal agent in accordance with NH Medicaid guidelines. Providers should note that NH Medicaid claim completion requirements may be different than those for other payers, previous fiscal agents, or fiscal agents in other states.

Providers participating in NH Medicaid are responsible for timely and accurate billing. If NH Medicaid does not pay due to billing practices of the provider which result in non-payment, the provider cannot bill the member.

Claim completion guidelines in this manual should be followed for instructions on specific fields. The NH Specific Companion Guide, which can be found at www.nhmmis.nh.gov, (see provider manuals under the provider tab) should be used for electronic claim filing instructions. While field-by-field requirements are shown for paper claims; the same required data is captured through web portal claim entry and through electronic submissions to EDI. Web portal submissions feature step-by-step claim completion instructions as well as tools such as Online Help to assist providers in correct claim completion.

Regardless of the method claims are submitted, information submitted on the claim by the provider represents a legal document. Neither the fiscal agent nor State staff can alter any data on a submitted claim.

The following claim-related topics are found in the General Billing Manual – Volume I:

- Claims Submission via EDI, web portal, paper
- Claims processing – edits & audits, transaction control numbers, line item vs. header processing, claim status, remark/EOB codes
- Claim Resubmission

- Claim adjustments and voids
- Medicare cross-overs
- Claims payment
- Remittance Advice

Providers will be notified of payment or denial via a Remittance Advice, usually received in electronic format or via the web portal.

Denied claims should be resubmitted only if the reason for the denial has been corrected.

Paid claims cannot be resubmitted; resubmission of a paid claim will result in a denial as a duplicate. Paid claim corrections must be made through the adjustment process. If a paid claim has a line item denial, the individual line charge can be resubmitted.

Corrected claims and denied line items can be resubmitted only if the denial was due to erroneous, updated or missing information which is now corrected. Providers should never resubmit claims that are currently in process (suspended).

Any claim denied for failure to be submitted or resubmitted in accordance with timely filing standards will not be paid. Denied claims that have been corrected must be resubmitted as a new claims transaction on paper, via the web portal, or electronically via EDI.

Timely Filing

In accordance with federal and state requirements, all providers must submit all initial claims within one year following the earliest date of service on the claim.

Except as noted below, NH Medicaid will **not** pay claims that are **not** submitted within the one-year time frame.

Claims that are beyond the one-year filing limit, that have previously been submitted and denied, must be resubmitted on paper along with Form 957x, "Override Request" located on the NH MMIS Health Enterprise Portal web site at www.nhmmis.nh.gov. A copy of the RA with the original billing date and the denial circled must also be attached. This resubmission **must** be received **within 15 months** of the date of service. If this time frame is not met, the claim will be denied.

The only other circumstance eligible for consideration under the one-year override process is for claims for NH Medicaid covered services for clients whose NH Medicaid eligibility determination was delayed. The claim should be submitted as detailed above.

Diagnosis & Procedure Codes

All NH Medicaid services must be billed using the appropriate industry-standard diagnosis and procedure codes. One procedure code must be provided for each charge billed.

For medical services, the NH Medicaid Program requires the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes and modifiers.

The most current version of the ICD-CM diagnosis code series should be utilized. Claims without the required diagnosis or procedure codes will be denied.

Before submitting a claim, the hospice provider must submit, as applicable, 282 A “ Medicaid Hospice Care Notification Form,” which can be found on the NH MMIS Health Enterprise portal at www.nhmmis.nh.gov, to the Office Of Medicaid Business and Policy (OMBP) by either mail or fax, as follows:

Mail to: Department of Health and Human Services
129 Pleasant Street
Office of Medicaid Business and Policy
Brown Building
Concord, NH 03301
Attention: Medicaid Medical Services

Fax to: (603) 271-8194
Attention: Medicaid Medical Services

Claims for hospice services should be submitted on a UB 04 claim form. Hospice providers must report the level of hospice care and details of the visits provided with appropriate revenue and HCPCS codes.

Required Claim Attachments

No special claims attachments are required.

Claim Completion Requirements for Hospice Services

UB04 Paper Completion Instruction for – Hospice Services

- Box 1** Enter the name of the hospice provider, address, city/town, zip and phone number.
- Box 2** Not applicable
- Box 3a** Patient Control Number – optional
- Box 3b** Medical Record Number – optional

Box 4 Type of Bill - required

- 1st Digit: Type of Facility
Choose “8” to designate Special (Hospice)
- 2nd Digit: Classification (Special Facility)
Choose “1” to designate Hospice (Non-hospital based); or
Choose “2” to designate Hospice (Hospital based)
- 3rd Digit Frequency

Choose 3rd digit based on Table 1, below **TABLE 1 - “FREQUENCY”**

Frequency (3 rd Digit)	Description
0	<u>Nonpayment/Zero Claims</u> - Use when no payment from Medicare is anticipated.
1	<u>Admit thru Discharge Claim</u> - Use for a bill encompassing an entire course of hospice treatment for which the provider expects payment from the payer, i.e. no further bills will be submitted for this patient.
2	<u>Interim - First Claim</u> - Use for the first of an expected series of payment bills for a hospice course of treatment.
3	<u>Interim – Continuing Claim</u> - Use when a payment bill for a hospice course of treatment has already been submitted, and further bills are expected to be submitted.
4	<u>Interim – Last Claim</u> - Use for a payment bill that is the last of a series for a hospice course of treatment. The “through” date of the bill is the discharge date, transfer date, or date of death.
5	<u>Late Charges</u> - Use this code for late charges that need to be billed. Late charges can be submitted only for revenue codes not on the original bill.
7	<u>Replacement of Prior Claim</u> - Use when the provider wants to correct a previously submitted bill. Use this code on the “new” bill.
8	<u>Void/Cancel of a Prior Claim</u> -Use to cancel a previously processed claim.

Box 5 Federal Tax Number

Box 6 Statement of Covered Period - enter the beginning and ending service dates included on this bill. For all services rendered on a single day, use both the from and through dates. Indicate dates in MMDDYY format.

Box 7 Not applicable

Box 8a Patient Identifier – Not applicable

Box 8b Patient Name – Last name, first name, and middle initial of the member.

Box 9a Patient Address – street

Box 9b Patient Address – city

Box 9c Patient Address – state

Box 9d Patient Address – zip code

- Box 9e** Patient Address – country code (optional)
- Box 10** Birthdate – entered in the MMDDYY format
- Box 11** Sex – enter M for male and F for female
- Box 12** Admission Date – enter the date that the member entered hospice care.
- Box 13** Admission Hour – optional
- Box 14** Admission Type – Not applicable
- Box 15** Admission SRC – Not applicable
- Box 16** Discharge Hour – Not applicable
- Box 17** Member Status Codes – Refer to Table 2 below to enter the status code indicating the members discharge status as of the ending of the service date period covered on this bill

TABLE 2 – “MEMBER STATUS CODE”

Member Status Codes	Description
01	Discharged to home or self-care, routine discharge
02	Discharged or transferred to another short term general hospital for inpatient care
03	Discharged or transferred to skilled nursing facility (SNF)
04	Discharged or transferred to an intermediate care facility (ICF)
05	Discharges or transferred to a designated cancer center or children’s hospital
06	Discharged or transferred to home under the care of a home health agency
07	Left against medical advice or discontinued care
08	Discharged or transferred to home under the care of a home infusion provider
20	Expired
30	Still a hospice member
40	Expired at home
41	Expired in a medical facility, such as a hospital, SNF, ICF or free standing hospice house
50	Discharged to hospice - home
51	Discharged to hospice – medical facility
62	Discharged or transferred to another rehabilitation facility
63	Discharged or transferred to a long-term care hospital
64	Discharged or transferred to a Medicaid certified nursing facility but not Medicare certified
65	Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
70	Discharged or transferred to another type of healthcare institution not defined

Member Status Codes	Description
	elsewhere in the code list

Boxes 18 – 37 Not applicable

Box 38 Unlabeled

Boxes 39- 41 Medicare value codes – Not applicable

Box 42 Revenue Codes –Refer to Table 3 below. Use the specific revenue code that identifies the level of care and the detail of the visits type. The appropriate three-digit numerical revenue code must be entered to explain each charge entered. Refer to the section of the manual that outlines covered services, description of the level of care, limitations and Medicaid rules

TABLE 3 – “REVENUE CODES”

Revenue Code	Description of Care	Units Reported In
421	Physical Therapy	Number of visits
431	Occupational Therapy	Number of visits
441	Speech Therapy	Number of visits
551	Skilled Nursing Visit	Number of visits
561	Medical Social Worker Visit	Number of visits
569	Other Medical Social Worker Service	Per time of the phone call
571	Home Health Aide	Number of visits
651	Routine Home Care	Per day
652	Continuous Home Care	Per hour
655	Inpatient Respite Care	Per day
656	General Inpatient Care	Per day
657	Hospice Physician	Number of Procedure Codes performed by the physician

Box 43 Description – enter a narrative description of the related revenue code or procedure code.

Box 44 HCPCS – Use the Healthcare Common Procedure Coding System (HCPCS) code applicable to the service provided. See Table 4 for commonly used HCPCS codes.

TABLE 4 – COMMON HCPCS CODES

Service	HCPCS	Required Detail
Physical Therapy	G0151	Each visit is identified on a separate line with the appropriate line item, date of service and the charged amount. The units are reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
Occupational Therapy	G0152	Each visit is identified on a separate line with the appropriate line item, date of services and the charged amount. The units are reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
Speech Therapy – Language Pathology	G0153	Each visit is identified on a separate line item with the appropriate line item, date of service, and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
Skilled Nursing	G0154	Each visit is identified on a separate line item with the appropriate line item, date of service, and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description.
Medical Social Worker	G0155	Each visit is identified on a separate line item with the appropriate line item, date of service, and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description
Other Medical Social Worker Services	G0155	Each visit is identified on a separate line item with the appropriate line item, date of service, and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description
Home Health Aide	G0156	Each visit is identified on a separate line item with the appropriate line item, date of service, and a charge amount. The units reported on the claim are the multiplier for the total time of the visit defined in the HCPCS description

Box 44 Location - This field is also used to indicate where the hospice services were provided. All hospice levels of care must be reported with a HCPCS code that identifies the location where that level of care was provided. If there are different, or multiple locations where the care was provided, each location is to be identified with the corresponding HCPC code as a separate and distinct line item.

Code	Short Description
Q5001	Hospice care provided in a member's home
Q5002	Hospice care provided in assisted living facility
Q5003	Hospice care provided in long term care nursing facility (LTC) or non-skilled nursing facility
Q5004	Hospice care provided in skilled nursing facility (SNF)
Q5005	Hospice care provided in inpatient hospital
Q5007	Hospice care provided in long term care facility (LTCH)
Q5008	Hospice care provided in inpatient psych
Q5009	Hospice care provided in a place not otherwise specified

- Box 45** Service Date – provide the date that the service was rendered.
- Box 46** Service Units – provide the number of units corresponding to the revenue code or procedure code. Units must be billed using whole numbers.
- Box 47** Total Charges – enter the total charges pertaining to the related revenue code for the statement coverage period.
- Box 48** Non-Covered Charges – Not applicable
- Box 49** Unlabeled Field – Not applicable
- Box 50** Payer Name – enter the applicable payor name
- Box 51** Health Plan ID- enter the provider ID number
- Box 52** Rel Info – Not applicable
- Box 53** Assignment of Benefits – Not applicable
- Box 54** Prior Payments – Not applicable
- Box 55** Estimated Amount Due – Not applicable
- Box 56** NPI – enter the 10-digit NPI for the billing provider
- Box 57** Other Provider ID – Not applicable
- Box 58** Insured Name – enter the member's last name, first name and middle initial
- Box 59** P. Rel – Not applicable
- Box 60** Insured's Unique ID – enter the member's 11-digit identification number
- Box 61** Group Name – Not applicable
- Box 62** Insurance Group Number – Not applicable
- Box 63** Treatment Authorization Codes – Not applicable
- Box 64** Document Control Number – Not applicable
- Box 65** Employer Name – Not applicable
- Box 66 - 67** Diagnosis Codes – provided the ICD-9 CM code corresponding to the condition

Boxes 68-75	Admit Diagnosis, Patient Reason Diagnosis, PPS Code, Principal Procedure Code, and Other Procedure - <u>Not applicable</u>
Box 76	Attending Physician ID – enter the attending physicians 10-digit numeric NPI number, physicians last name and first name
Box 77	Operating Physician ID - enter the operating physicians 10-digit numeric NPI number, physicians last name and first name
Box 78	Other – enter other physician’s (referring/ PCP physician) 10-digit numeric NPI number, physicians last name and first name
Box 80	Remarks – use this field for claim note text
Box 81CC	Additional Codes – <u>Not applicable</u>

12. Terminology

Agent: An adult to whom authority to make health care decisions is delegated under an activated durable power of attorney for health care executed in accordance with RSA 137-J.

Attending physician: The doctor of medicine or osteopathy or the advance practice registered nurse who is identified by the member, at the time of election of hospice care, as having the most significant role in the determination and delivery of medical care to the member.

Bereavement counseling: Emotional, psychosocial, and spiritual support and services provided before and after death of the member to assist with issues related to grief, loss, and adjustment.

Continuous home care: Hospice care consisting of primarily nursing care provided by hospice personnel on a continuous basis at home.

Day: The 24-hour period starting at 12:00 AM and ending at 11:59 PM of the same day.

Department: The New Hampshire Department of Health and Human Services.

Dietary counseling: Education and interventions provided to the patient and family regarding appropriate nutritional intake as the patient’s condition progresses and provided by qualified individuals including a registered nurse, dietician, or nutritionist, when identified in the member’s plan of care.

Election period: One or more periods for which a member may elect to receive Medicaid coverage for hospice care, as follows:

1. Two 90-day periods; and
2. An unlimited number of subsequent 60-day periods.

Employee:

1. An employee of the hospice;
2. If the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is appropriately trained and assigned to the hospice unit; or

3. A volunteer under the jurisdiction of the hospice.

General inpatient care: Hospice care received in an inpatient facility for pain control or symptom management, which cannot be managed in other settings.

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

Medicaid: The Title XIX and Title XXI programs administered by the Department which makes medical assistance available to eligible individuals age 19 and over.

Member: Any individual who is eligible for and receiving medical assistance under programs entitled Medicaid. Used interchangeably with “recipient”.

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: “Physician” as defined in 42 CFR 410.20.

Quarter: One of four calendar periods ending March 31, June 30, September 30, and December 31.

Recipient: Any individual who is eligible for and receiving medical assistance under programs entitled Medicaid. Used interchangeably with “member”.

Respite care: Short-term inpatient care provided to the member only when necessary to relieve the family members or other persons caring for the individual.

Room and board services: Includes performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident’s room, and supervision and assistance in the use of durable medical equipment and prescribed therapies.

Routine home care: Hospice care received at the place of residence and is not continuous home care as defined in this Terminology section.

Terminally ill: A condition for which the member has a medical prognosis of a life expectancy of 6 months or less if the illness runs its normal course.

Title XIX: The joint federal-state program described in Title XIX of the Social Security Act and administered in New Hampshire by the Department under programs entitled Medicaid.

Title XXI: The joint federal-state program described in Title XXI of the Social Security Act and administered in New Hampshire by the Department under programs entitled Medicaid