



CHAPTER 509 HOSPICE SERVICES

TABLE OF CONTENTS

SECTION	PAGE NUMBER
Background	3
Policy	3
509.1 Provider Participation Requirements	3
509.1.1 Hospice Staff Fingerprint-Based Background Check Requirements, Restrictions, and Medicaid Exclusion List	3
509.1.2 Hospice Staffing Requirements	4
509.1.3 Hospice Interdisciplinary Team (IDT)	5
509.1.4 Hospice Service Requirements	5
509.1.5 Hospice Service Exceptions	7
509.1.6 Hospice Physician Services Staffing	7
509.1.7 Hospice Volunteers	7
509.1.8 Hospice Employee Training Requirements	8
509.2 Benefit Periods	8
509.3 Hospice Enrollment	9
509.3.1 Physician Certification	10
509.3.2 Physician Certification Timeline.....	10
509.3.3 Enrolling the Member in Hospice Care.....	11
509.3.4 Informed Consent of the Member.....	12
509.4 Notification of Enrollment.....	12
509.5 Termination of Hospice Services.....	12
509.5.1 Transfer of Member to another Hospice Provider	13
509.6 Billing and Reimbursement.....	13



CHAPTER 509 HOSPICE SERVICES

509.6.1	Routine Home Care	13
509.6.2	Continuous Home Care	13
509.6.3	Inpatient Respite Care	14
509.6.4	General Inpatient Care	14
509.7	Reimbursement Procedures	14
509.8	Inpatient Care Provided Directly by the Hospice	14
509.9	Nursing Facility Residents	15
509.9.1	Documentation Requirements for Nursing Facility Authorization	16
509.9.2	Billing and Reimbursement for Nursing Facility Hospice	16
509.10	Care Plan Oversight	16
509.11	How to Obtain Information	17
	Glossary	17
	Change Log	19

CHAPTER 509 HOSPICE SERVICES

BACKGROUND

Hospices provide a continuum of care, directed by professionals, designed to optimize the comfort and functionality of terminally ill members for whom the possibilities of curative medicine have been exhausted. Hospice emphasizes relief from distress for the member without actively shortening or prolonging life. Relief from distress includes palliation of physical, psychological and psychosocial symptoms of distress and a regular regimen for alleviation of physical pain. All efforts are directed to enriching life during the member's final days and to the provision of ongoing opportunities for the member to be involved in life.

Hospice services are defined as reasonable and medically necessary services, palliative and supportive in nature, provided to the terminally ill for the management of the terminal illness and related conditions.

This chapter sets forth requirements of the Bureau for Medical Services regarding coverage under and payment for Hospice Services provided to eligible West Virginia Medicaid members.

POLICY

509.1 PROVIDER PARTICIPATION REQUIREMENTS

In order to participate in the West Virginia Medicaid Program and receive payment from the Bureau for Medical Services (BMS), hospice providers must:

- Meet and maintain applicable licensures, accreditation, and certification requirements, including the Certificate of Need (CON);
- Meet and maintain all BMS enrollment requirements listed in [Chapter 300, Provider Participation Requirements](#);
- Be physically located within the state of WV;
- Meet and maintain Medicare enrollment conditions. *(In accordance with [42 CFR §418 Hospice Care](#), [West Virginia State Plan Supplement 2 to Appendix 3.1-A & 3.1-B page 6 on Hospice services](#), and [§1905\(o\) of the Social Security Act](#).);*
- Ensure that all required documentation is maintained at the agency on behalf of the State of West Virginia and accessible for state and federal audits.

Additional information concerning enrollment can be found on the [BMS Hospice Services](#) website.

509.1.1 Hospice Staff Fingerprint-Based Background Check Requirements, Restrictions, and Medicaid Exclusion List

At a minimum, a state level fingerprint-based background check must be conducted by the West Virginia State Police initially and again every three years for all hospice providers staff providing direct care services to members. If a prospective or current employee has lived out of state within the last five years, an FBI fingerprint-based background check must also be conducted.

Prior to providing hospice services, required fingerprint-based checks must be initiated. Hospice providers **may** do a preliminary check utilizing on-line internet companies and use these results until the

CHAPTER 509 HOSPICE SERVICES

fingerprint results are received. An individual who is providing direct care services through a hospice provider cannot be allowed to provide services if ever convicted of the following:

- A. Abduction
- B. Any violent felony crime including but not limited to rape, sexual assault, homicide, felonious physical assault or felonious battery
- C. Child/adult abuse or neglect
- D. Crimes which involve the exploitation, including financial exploitation, of a child or an incapacitated adult
- E. Any type of felony battery
- F. Felony arson
- G. Felony or misdemeanor crime against a child or incapacitated adult which causes harm
- H. Felony drug related offenses within the last 10 years
- I. Felony DUI (Driving Under the Influence) within the last 10 years
- J. Hate crimes
- K. Kidnapping
- L. Murder/ homicide
- M. Neglect or abuse by a caregiver
- N. Pornography crimes involving children or incapacitated adults, including but not limited to, use of minors in filming sexually explicit conduct, distribution and exhibition of material depicting minors in sexually explicit conduct or sending, distributing, exhibiting, possessing, displaying or transporting material by a parent, legal representative or custodian, depicting a child engaged in sexually explicit conduct
- O. Purchase or sale of a child
- P. Sexual offenses including but not limited to incest, sexual abuse, or indecent exposure
- Q. Healthcare fraud
- R. Felony forgery

Fingerprint-based background check results, other than those listed above, which may place a member at risk of personal health and safety or have evidence of a history of Medicaid fraud or abuse, must be considered by the licensed hospice provider before placing an individual in a position to provide services to the member.

If aware of a recent conviction or change in status of an agency staff member providing hospice services, the hospice provider must take appropriate action, including notification to the BMS Hospice Program Manager.

The OIG Exclusion List must be checked for every agency employee who provides Medicaid services prior to employment and monthly thereafter. Persons on the OIG Exclusion List cannot provide Medicaid services. This list can be obtained at <http://exclusions.oig.hhs.gov>.

All payments for services provided by excluded providers or employees will be recovered by BMS.

509.1.2 Hospice Staffing Requirements

In accordance with [42 CFR §418.62](#) and [§418.64](#), hospice staffing involves employing, contracting and otherwise obtaining the services of individuals who provide core services, supplemental services and physician services.

CHAPTER 509 HOSPICE SERVICES

- Federal regulations require that core hospice functions and services be performed only by employees of the hospice or by volunteers under the supervision of hospice employees.
- Supplemental services may be provided by individuals who are either employed, or contracted by the hospice, or who are volunteers.

509.1.3 Hospice Interdisciplinary Team (IDT)

Each hospice must have an Interdisciplinary Team (IDT) composed of individuals who provide or supervise the care and services offered by the hospice. Each IDT must include at least the following individuals in accordance with [42 CFR §418.56](#) and [§418.64](#)):

1. A doctor of medicine or osteopathy;
2. A registered nurse;
3. A licensed social worker and
4. A (pastoral or other) counselor.

The registered nurse, the licensed social worker and the (pastoral or other) counselor must be employees of the hospice, or volunteers under the supervision of designated employees of the hospice.

The physician member of the IDT may be a volunteer or a hospice employee, or the hospice may contract with the physician.

The hospice must designate a registered nurse who is a member of the IDT to provide coordination of care and to ensure continuous assessment of each member's and family's needs and implementation of the interdisciplinary plan of care.

If the hospice has more than one IDT, it must identify a specifically designated IDT to establish policies governing the day-to-day provision of hospice care and services.

There must be a continuous and identifiable relationship between each member and his or her IDT.

The hospice must try to provide consistent IDT membership and assignment of hospice members to an IDT.

509.1.4 Hospice Service Requirements

Services that are covered by the hospice program are those that are reasonable and necessary for the palliation and management of the terminal illness and related conditions. 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 §418.56](#) and [§418.200](#).

Hospice services are of two types:

- I. Core Hospice Services are to be provided directly by hospice employees/contractors/volunteers. These include:

CHAPTER 509 HOSPICE SERVICES

- Nursing Care: must be provided by a registered nurse (RN), or by a licensed practical nurse (LPN) under the supervision of a registered nurse.
 - Medical Social Services: must be provided by a licensed social worker (LSW) working under the direction of a physician.
 - Physician Services: must be provided by a professional who is acting within the scope of the physician's license, who is either a doctor of medicine (MD), of osteopathy (DO), of podiatry (DPM), of dentistry (DDS), of optometry (OD), or a chiropractor (DC). The medical director of the hospice or the physician member of the IDT must be a licensed doctor of medicine or of osteopathy.
 - Counseling Services: must be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the member's family or other caregivers to provide care, and for the purpose of helping the member and those caring for him or her to adjust to the member's approaching death. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable. (See [West Virginia State Plan Hospice Services Appendix 3.1-C](#)).
- II. Other Hospice Services: the hospice provider must make available services that are not considered "core" services. These may be provided by the employees of the hospice provider or they may be arranged by contractual agreement. They include:
- Drugs and Biologicals: drugs and biologicals must be identified as those documented in the hospice plan of care and provided by the hospice while the member is under hospice care. Hospice covered drugs are those related to the palliation and management of the terminal illness and related conditions necessary to meet the needs of the member. (In accordance with [West Virginia State Plan Appendix 3.1-A](#) & [3.1-B](#) and [42 CFR §418.56\(c\)\(4\)](#), [§418.106](#), and [§418.202 \(f\)](#)).
 - Management, ordering, dispensing, administration, labeling, disposition, and storing of drugs and biologicals must follow the policies and procedures in accordance with [42 CFR §418 Hospice Care](#);
 - Home Health Program services, drugs and biologicals obtained through the West Virginia Medicaid Pharmacy Program for the palliation and management of symptoms related to the member's terminal illness;
 - Coverage of medications to control pain and nausea unless justified by pre-existing conditions;
 - Durable Medical Equipment and Supplies: are to be available for comfort or self-help related to the palliation of the terminal illness and related conditions. (In accordance with [West Virginia State Plan Appendix 3.1-A](#) & [3.1-B page 7](#) and [42 CFR §418.56](#), [§418.202 \(f\)](#), and [§418.106](#)).
 - 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 illness and related conditions that is not possible in any other setting. (In accordance with [West Virginia State Plan Appendix 3.1-A](#) & [3.1-B page 7](#) and [42 CFR §418.202 \(e\)](#)).

CHAPTER 509 HOSPICE SERVICES

- Home health and homemaker services: must meet the specifications of [42 CFR §484.36](#), and must 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. (In accordance with [West Virginia State Plan Appendix 3.1-C pages 2 & 3 on Hospice Services](#) and [42 CFR §418.202](#)).

When a hospice contracts or arranges for any service, the hospice must maintain professional, financial, and administrative responsibility for the services and must ensure that all staff members meet the regulatory qualification requirements.

509.1.5 Hospice Service Exceptions

Hospice services may be provided to children under age 21 concurrently with curative treatment. (In accordance with the [Affordable Care Act 2302 Concurrent Care for Children](#)).

509.1.6 Hospice Physician Services Staffing

The following functions may be performed by a physician designee including a physician employee, volunteer physician, or a contracted physician:

1. Hospice medical director services (must be a doctor of medicine (MD) or osteopathy (DO));
2. Physician services related to the palliation and management of the member's terminal illness and related conditions;
3. Care for general medical needs when the attending physician is not available (if the member has an attending physician); and
4. Physician participation in the IDT (must be a doctor of medicine (MD) or osteopathy (DO)).

The hospice or the physician member of the Interdisciplinary Team (IDT) may designate another physician or other physicians to be "on call" during the hours the IDT assigned physician is not on duty.

1. The on-call physician may assist with urgent, emergency or otherwise unscheduled plan of care revisions.
2. The hospice or the IDT assigned physician member of the IDT may not designate substitute physicians to routinely assist with initial plans of care and scheduled plan of care reviews and revisions.
3. When the "on call" physician provides a service to a member, it must be documented in that member's health record.

509.1.7 Hospice Volunteers

A hospice provider uses volunteers in defined roles and under the supervision of designated hospice employees. Volunteers may perform administrative functions or direct care services as outlined in the Federal Regulations. In the Hospice Program, "employee" also refers to a volunteer under the jurisdiction of the hospice. All use of volunteers must be in accordance with [42 CFR §418.78](#) and [§418.304 \(b\)](#).



CHAPTER 509 HOSPICE SERVICES

Volunteer hours of service must equal at least five percent of the hours of direct member care furnished by paid personnel, employed or contracted.

If a physician volunteers some services and is reimbursed by the hospice for other services, the terms and conditions of such service must be described in a written agreement or contract between the physician and the hospice.

Services provided by volunteers may not be billed to Medicaid when those services are provided at no charge for members who are not eligible for Medicaid.

Examples of equitable ways for physicians to donate or volunteer services may include:

- a) Donating a percentage of their time; or
- b) Providing a particular service (e.g., treatment of decubitus ulcers or psychotherapy) or a particular occurrence of a service (donating one visit per week/month, etc. to each member in their care).

509.1.8 Hospice Employee Training Requirements

A hospice must provide orientation that includes explaining the hospice philosophy to all employees, including contracted and volunteer staff who have member and family contact.

A hospice must provide an initial orientation for each employee, including contracted and volunteer staff that addresses the employee's specific job duties.

A hospice must assess the skills and competence of all employees furnishing care, including contracted and volunteers furnishing services, and, as necessary, provide in-service training and education programs where required.

A hospice must provide ongoing educational opportunities for all employees, including contracted and volunteer staff.

A hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months. (In accordance with [42 CFR §418.78\(a\)](#) and [§418.100\(g\) 1-3, p. 122](#)).

509.2 BENEFIT PERIODS

In accordance with [42 CFR §418.21](#), a member may elect to receive hospice care during one or more of the following election periods:

1. An initial 90-day period;
2. A subsequent 90-day period;
3. An unlimited number of subsequent 60-day periods that will continue as long as the member lives unless he or she revokes hospice care or is discharged from hospice care.

CHAPTER 509 HOSPICE SERVICES

The periods of care are available in the order listed and may be elected separately at different times. Having once elected hospice, it is not necessary for a member to elect hospice again after the initial election unless he or she revokes hospice care or is discharged from hospice care.

- Members who have elected hospice care may revoke hospice coverage. In that event, the remainder of that benefit period is forfeited. If the member then re-enrolls, coverage begins immediately under the next benefit period.
- Members who revoke West Virginia Medicaid hospice services four times are not eligible to enroll again.

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 60-day period. If that period is revoked, the remainder is forfeited and only the unlimited 60-day periods remain. If he elects again during a subsequent 60-day period, he may continue to receive hospice services 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.

509.3 HOSPICE ENROLLMENT

Enrollment in the West Virginia Medicaid Hospice Services Program requires the following from the three parties involved:

- **Physician** – must determine that the member has a life expectancy of 6 months or less if the illness runs its normal course and certifies that assessment in writing;
- **Hospice Provider** - must complete a plan of care, inform the enrolling member of what hospice services will be provided, document the member's informed consent, and complete a [West Virginia Medicaid Hospice Election Form \(HEF-01\)](#). The provider must also inform the member how to disenroll from hospice care, change providers, and transfer services to another hospice;
- **Member/Legal Representative** - After explanation of hospice services by the hospice provider, the member/legal representative must sign and date consent on the completed [HEF-01](#).

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

- A copy of the completed and signed [HEF-01](#)
- A copy of the Plan of Care upon member's and/or the member's legal representative's request, 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;
- A copy of the conditions of enrollment in West Virginia Medicaid Hospice explained to the member/legal representative by the provider and signed by the member/legal representative;
- A copy of the terms of revocation explained to the member/legal representative by the provider and signed by the member/legal representative.

CHAPTER 509 HOSPICE SERVICES

The member is responsible for reporting other insurance and obtaining health care that is not related to the terminal illness or disease.

509.3.1 Physician Certification

For the first 90-day election period of hospice coverage, the hospice medical director or IDT assigned physician and the attending physician (if the member has an attending physician) must certify and document the member's diagnosis and that the member has a terminal illness which is defined as having a life expectancy of 6 months or less if the illness runs its normal course. (In accordance with [42 CFR §418.22](#)).

509.3.2 Physician Certification Timeline

The hospice must obtain a copy of this written certification no later than 2 calendar days after hospice care is initiated.

- For the initial 90-day period, if the hospice cannot obtain a written certification within 2 calendar days, it must obtain oral certifications within 2 calendar days and written certification no later than 8 calendar days after the period begins (See [West Virginia State Plan Appendix 3.1-A](#) & [3.1-B](#)).

If these requirements are not met within the set timeline, the provider is not eligible for reimbursement of hospice services furnished before the date on which written certification is obtained.

For Subsequent Recertification Periods:

A hospice physician or hospice nurse practitioner must conduct a face-to-face recertification visit for each hospice member whose total stay across all hospices is anticipated to reach 180 days. The visit must occur no more than 30 calendar days prior to the 180-day recertification. The physician/nurse practitioner must continue to visit that member no more than 30 calendar days prior to every recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care. (In accordance with [42 CFR §418.22](#)).

The written narrative associated with the 180-day recertification and every subsequent recertification must include:

- Date of the member's face-to-face visit with the hospice physician or hospice nurse practitioner;
- Clinical findings to determine whether the member continues to have a life expectancy of 6 months or less.
- The hospice nurse practitioner must document all clinical findings and submit to the certifying hospice physician, signed and dated on a separate and distinct section of, or an addendum to, the recertification form.
- Signature and date of signature by the hospice physician(s) and the benefit period dates to which the certification or recertification applies.

Authorization is required for all hospice certifications and re-certifications. Appropriate documentation must be submitted to the Utilization Management Contractor (UMC) within 8 calendar days of the member's election of hospice. It is understood that due to the nature of hospice services, services may

CHAPTER 509 HOSPICE SERVICES

need to begin before the initial authorization is finalized and, in these instances, retrospective authorization will be granted for members who meet the requirements of the program.

If the hospice is not able to complete the face-to-face visit according to the above specifications, the hospice must discharge the member and Medicaid will no longer reimburse the hospice for the member's hospice services. Medicaid is not responsible for reimbursement of hospice services during the period of discharge.

When the face-to-face evaluation is completed by the hospice physician or hospice nurse practitioner, the hospice provider will be able to bill the Medicaid program for services.

509.3.3 Enrolling the Member in Hospice Care

The hospice is responsible for enrolling the member who is certified as eligible for hospice care and who gives consent to enter the program.

The provider must develop a Plan of Care designed to meet the member's individual needs. Members must be informed that by electing West Virginia hospice services they must waive Medicaid coverage of the following services if they are related to the member's terminal condition:

- Hospice care provided by a hospice other than the hospice designated by the member, unless provided under arrangements made by the designated hospice.
- Any Medicaid services that are related to treatment of the terminal condition for which hospice care was elected or of a related condition; or that are equivalent to hospice care except for services:
 - a) Provided (either directly or under arrangement) by the designated hospice;
 - b) Provided as room and board by a nursing facility or ICF/IID if the individual is a resident;
 - c) Provided by the member's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

When an election period ends, the hospice discharges a member according to reasons for discharge under [42 CFR §418.26 \(a thru d\)](#), or the member's waiver of other Medicaid benefits expires. Also, regular Medicaid coverage is reinstated if the member revokes hospice care for the subsequent election period. (In accordance with [42 CFR §418.24](#) & [§418.28](#)).

Hospice care does not include, but is not limited to the following:

- Services furnished before or after a hospice election period;
- Services of the member's attending physician, if the attending physician is not an employee of or working under an arrangement with the hospice; or
- Medicaid services received for the treatment of an illness or injury not related to the member's terminal condition. (See [42 CFR §418.402](#)).

Once a member elects to receive West Virginia hospice services, Medicaid will not reimburse for other Medicaid services that treat the terminal condition. However, Medicaid may reimburse for services that are required to treat conditions that are unrelated to the terminal illness.

CHAPTER 509 HOSPICE SERVICES

An exception to this rule is that hospice services may be provided to children under age 21 concurrently with curative treatment. (In accordance with the [Affordable Care Act 2302 Concurrent Care for Children](#)).

509.3.4 Informed Consent of the Member

The hospice 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 hospice provider must complete the [Hospice Election Form HEF-01](#) and have the member or the member's legal representative sign and date it.

509.4 NOTIFICATION OF ENROLLMENT

The completed, signed and dated physician certification, the signed and dated [HEF-01](#), and the signed and dated plan of care must be received by the UMC within 8 calendar days of the initiation of hospice care.

Authorization by the UMC is required for the initial and subsequent certifications. Authorization will not be approved for hospice services without appropriate enrollment documentation.

509.5 TERMINATION OF HOSPICE SERVICES

In accordance with [42 CFR §418.26](#), [§418.28](#), [§418.30](#), hospice services may be terminated for any of the following reasons:

- The member chooses to revoke hospice care;
- The hospice chooses to terminate its provision of services;
- The member no longer meets enrollment criteria;
- The member moves out of the hospice's service area;
- The member transfers to another hospice provider;
- The member's environment becomes unsafe for hospice staff; or
- 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 [HEF-01](#), with original member signature and the date of the termination of services written in the box marked Revoked, to the UMC. This must be received by the UM Contractor within 8 calendar days of revocation to allow the member to resume Medicaid benefits waived upon election of hospice care. When a member is being discharged and will be in need of medication and/or medical supplies upon discharge, then the Hospice Provider must expedite the discharge election form to the UMC.

Also, the hospice provider must send a copy of the [HEF-01](#) to the UMC following the death of the member with the date of death noted in the appropriate box.

CHAPTER 509 HOSPICE SERVICES

509.5.1 Transfer of Member to another Hospice Provider

A member or legal representative may change the hospice provider from which hospice care is received only once in each election period. A transfer does not constitute a revocation of the election period during which the change is made. Transfers must be conducted in accordance with [42 CFR §418.30](#).

509.6 BILLING AND REIMBURSEMENT

Reimbursement by the West Virginia BMS for covered hospice services will be at rates set by the Centers for Medicare and Medicaid Services (CMS) for the following 4 categories of care:

- Routine Home Care
- Continuous Home Care
- Inpatient Respite Care
- General Inpatient Care

509.6.1 Routine Home Care

Revenue Code: 0651

Service Unit: Unit = 1 Day

Service Limit: 1 unit per day

Definition of Service: This level of care consists of providing hospice services as described under Section 509.1.4, Hospice Service Requirements, except for those referring to Inpatient Care, or services provided when the member's needs are so intensive as to require continuous care as described below.

The hospice is paid the Routine Home Care rate for each day the member is under the care of the hospice and not receiving one of the other three more specialized categories of hospice care (Continuous Home Care, Inpatient Respite Care, and General Inpatient 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 member is receiving hospital care for a condition unrelated to the terminal condition.

509.6.2 Continuous Home Care

Revenue Code: 0652

Service Unit: Unit = 1 hour

Service Limit: Minimum of 8 hours, up to a maximum of 24 hours a day

Definition of Service: This code is billable for a minimum of 8 hours on a given day, and up to 24 hours a day. Reimbursement is based on the number of hours provided for the service in a day. Continuous home care is provided to the member during brief periods of crisis.

Continuous home care may be provided for up to 24 hours, but these services must be predominantly nursing services. Home health aide or homemaker services may be provided in addition to nursing care.

CHAPTER 509 HOSPICE SERVICES

509.6.3 Inpatient Respite Care

Revenue Code: 0655

Service Unit: Unit = 1 Day

Service Limit: Up to 5 consecutive days

Definition of Service: An inpatient respite care day is a day on which the individual who has elected hospice receives care in an approved facility (freestanding hospice, hospital, or nursing facility) on a short-term basis to provide respite to family or other persons who are involved in daily care of the member.

Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. (In accordance with [42 CFR §418.204](#)).

509.6.4 General Inpatient Care

Revenue Code: 0656

Service Unit: Unit = 1 Day

Service Limit: 1 unit per day

Definition of Service: General inpatient care may be provided in an approved freestanding hospice, hospital, or nursing facility. This care is usually for pain control or for acute or chronic symptom management which cannot be successfully treated in another setting.

509.7 REIMBURSEMENT PROCEDURES

Hospice services are billed using the UB-04 paper form or electronic form 837i. 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 revenue 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 as an inpatient, then the date of death will be reimbursed at the inpatient rate if the inpatient care was related to the terminal illness. Reimbursement will be based upon the county the hospice service is rendered.

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 member care, and for disaster preparedness:

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

CHAPTER 509 HOSPICE SERVICES

509.9 NURSING FACILITY RESIDENTS

West Virginia Medicaid maintains a separate program of hospice services for members who are residents of nursing facilities.

West Virginia requires a Pre Admission Screening (PAS) be completed on every individual who enters a Medicaid certified nursing facility (Refer to [Chapter 514, Nursing Facility Services](#)). 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 members and for members 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, assistance with care planning, and 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. (In accordance with [42 CFR §418.112](#). See [Chapter 514, Nursing Facility Services](#)).

A hospice physician or hospice nurse practitioner must visit each hospice member face-to-face whose total stay across all hospices is anticipated to reach 180 days, no more than 30 calendar days prior to the 180-day recertification, and must continue to visit that member no more than 30 calendar days prior to every recertification thereafter. (In accordance with [Affordable Care Act, section 3131\(b\)](#)).

If the hospice is not able to complete the face-to-face visit prior to the above specifications, the hospice must discharge the individual and Medicaid will no longer reimburse the hospice for the individual's treatment or room and board. The nursing facility will need to resume billing Medicaid for the care of the individual; and once the face-to-face evaluation is completed by the hospice physician or hospice nurse practitioner, the hospice provider may bill the Medicaid program for services, including the pass-through payment to the nursing facility for room and board.

In accordance with [42 CFR §418.22](#), the written narrative associated with the 180-day recertification and every subsequent recertification must meet the same requirements that are in place for hospice enrollees who are not a resident in a nursing facility.

The nursing facility cannot charge Medicaid a bed hold if the resident/member is under the hospice benefit. The bed hold must be contracted between the nursing facility and the approved hospice provider.

CHAPTER 509 HOSPICE SERVICES

509.9.1 Documentation Requirements for Nursing Facility Authorization

For each individual who applies for hospice coverage in a nursing facility, election of services and physician certification documentation is required. (Refer to [Chapter 514, Nursing Facility Services](#)). The hospice provider must submit the following information to the UM Contractor for review:

- An agreement between the specific nursing facility and the hospice provider specifying the appropriate services each will provide to qualified members;
- Documentation to support the individual's medical necessity for each covered service;
- 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 illness and related conditions. For health needs not related to the terminal diagnosis, additional West Virginia Medicaid policies and procedures are to be followed.

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

509.9.2 Billing and Reimbursement for Nursing Facility Hospice

Revenue Code: 0658

Service Unit: Unit = 1 Day

Service Limit: 1 unit per day

Definition of Service: The West Virginia 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 the member had he or she not elected hospice coverage.

The hospice will in turn 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 member.

Services must be billed on a UB-04 paper form. A printout of the computerized report identifying the specific case mix class of the individual must be attached. The hospice must provide all of the claim information to the BMS Fiscal Agent.

509.10 CARE PLAN OVERSIGHT

Care plan oversight (CPO) consists of physician supervision of members receiving hospice care when the member requires complex or multidisciplinary care modalities with ongoing physician involvement.

The West Virginia Bureau for Medical Services provides payment for 1 CPO service per calendar month, per member, per provider.

CPO services are also not payable to physicians having a 5% or greater ownership interest in or a relationship with a hospice provider that is directly providing services to Medicaid members.

CHAPTER 509 HOSPICE SERVICES

The physician who bills for CPO services must be the same physician who signed the hospice plan of care.

509.11 HOW TO OBTAIN INFORMATION

Please refer to the [Hospice Program](#) website.

Hospice Services Manual:

<http://www.dhhr.wv.gov/bms/Programs/Hospice/Pages/Policy-and-Forms.aspx>

Hospice Approved Forms:

<http://www.dhhr.wv.gov/bms/Programs/Hospice/Pages/Policy-and-Forms.aspx>

Program Contact Information:

<http://www.dhhr.wv.gov/bms/Programs/Hospice/Pages/Program-Contact-Information.aspx>

GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Attending physician: In accordance with [42 CFR §418.3\(1\)\(i\)](#), 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 (ii) **Nurse Practitioner (NP)** – A nurse who meets the training, education and experience requirements as described in [§410.75\(b\)](#). (2) Is identified by the member, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the member's medical care.

Bereavement Counseling: Emotional, psychosocial, and spiritual support and services provided before and after the death of the member to assist with issues related to grief, loss, and adjustment. (See [42 CFR §418.3](#)).

Certificate of Need (CON): West Virginia issues a Certificate of Need (CON) to indicate a health service's compliance with [W.Va. Code §16-2D-1 et seq.](#), and to fulfill a need in the community with no duplication of services. In West Virginia, all healthcare providers, unless exempt, must obtain a CON.

Employee: (including contractors and volunteers) - A person who: (1) works for the hospice and for whom the hospice is required to issue a W-2 form on his or her behalf; (2) 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 (3) is a volunteer under the jurisdiction of the hospice. (In accordance with [42 CFR §418.3](#)).

Evaluation: An initial and ongoing process to determine service requirements and the effectiveness of plans of care.

Home Health Aide: A person specially trained to assist sick, disabled, infirm, or frail persons at home when no family member is fully able to assume this responsibility. Aides are supervised by health

CHAPTER 509 HOSPICE SERVICES

professionals, and provided as part of a continuing medical care plan in accordance with the West Virginia State Plan on Hospice Services.

Homemaker Aide: A person specially trained to provide direct care and support services that are necessary in order to enable a member to remain at home rather than enter a nursing facility, or to enable an individual to return home from a nursing facility. Homemaker services include assistance with personal hygiene, nutritional support, and environment maintenance. These aides are supervised by health professionals and provided as part of a continuing medical care plan in accordance with the West Virginia State Plan on Hospice Services.

Hospice: A public agency or private organization or subdivision of either of these that is primarily engaged in providing hospice care. (See [42 CFR §418.3](#)).

Hospice Care: A comprehensive set of services described in [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 patient plan of care. (See [42 CFR §418.3](#)).

Hospice Discharge: A hospice provider determines that the patient is no longer terminally ill, expires, moves out of the hospice's service area, transfers to another hospice, or the patient (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. (In accordance with [42 CFR §418.26](#)).

Hospice Informed Consent: A written agreement to receive hospice care made by the member or representative that specifies in writing the type of care and services to be provided. The informed consent form shall be signed by the member or the member's legal representative prior to service.

Hospice Interdisciplinary Team: An interdisciplinary team (IDT) of professionals comprised at minimum, of a physician, a social worker, and nurse who plan and direct the care of each hospice member, along with home health aides and counseling/clergy persons who provide additional services. (In accordance with [42 CFR §418.56](#)).

Interdisciplinary Team Plan of Care: A group of interdisciplinary professionals (physician, nurse, social worker, counselor/clergy) that collaborates continuously with the member's attending physician (if the member has an attending physician) to develop and maintain a member-directed, individualized plan of care. The plan is based on the interdisciplinary team assessments which recognize the member and family's physiological, social, religious, and cultural variables and values. (In accordance with [42 CFR §418.56](#)).

Legal 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 member who is mentally or physically incapacitated. This may include a legal guardian. (In accordance with [42 CFR §418.3](#) Definitions).

Palliative Care: Member and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing

CHAPTER 509 HOSPICE SERVICES

physical, intellectual, emotional, social, and spiritual needs and to facilitate member autonomy, access to information, and choice. (See [42 CFR §418.3](#)).

Physician: An individual who meets the qualification and conditions as defined in section [1861\(r\) of the Social Security Act](#) and implemented at [42 CFR §410.20](#) of this chapter. (See [42 CFR §418.3](#)).

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. (See [42 CFR §418.3](#)).

Pre-Existing Conditions: The health status existing prior to the diagnosis of the terminal illness arising in organs that are not typically affected by the terminal illness.

Related Condition: A medical condition that arises as a direct logical consequence of the terminal illness.

Revocation: To cancel or withdraw the election of hospice care. (In accordance with [42 CFR §418.28](#)).

Terminally ill - A medical prognosis that the patient's life expectancy is 6 months or less if the illness runs its normal course. (See [42 CFR §418.3](#)).

Transfer: Changing the hospice provider from which a member is receiving services to another hospice provider.

REFERENCES

The West Virginia state plan references Hospice Services in sections [3.1-A\(18\)](#), [3.1-B\(18\)](#), [supplement 2 \(18\)](#) to 3.1-A and 3.1-B

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter	Hospice Services		June 1, 2015