HOSPICE SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

All hospice providers must be enrolled with Medicare and meet applicable Medicare conditions of participation for patient care and organizational environments in 42 CFR 418.52 to 418.116. Hospice providers must be licensed/certified as either an inpatient hospice and/or residential hospice provider to become enrolled. Each servicing location must be specifically enrolled and while not required, it is recommended that providers consider using a unique NPI for each location.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal.

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to copays, coinsurance, and deductibles on Medicare A and B covered services.

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

Level of Care Requirements
A recipient may live in a home in the community or in a long-term care facility while receiving hospice care. A recipient receiving hospice services in a skilled nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF-IID), swing bed, assisted living center, community support provider, or inpatient hospice must meet the level of care requirements in ARSD Ch. 67:45:01.

Physician Certification

A written certification statement of terminal illness signed by the medical doctor of the hospice or a physician member of the hospice interdisciplinary group and the recipient's attending physician or licensed nurse practitioner should be obtained within two calendar days after hospice care is initiated. An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is 6 months or less if the illness runs its normal course.

If the hospice does not obtain written certification within two calendar days after hospice care is initiated, a verbal certification must be obtained within the two calendar days and a written certification must then be obtained no later than eight days after care is initiated. If the certification requirements are not met, no payment can be made for hospice care provided prior to the date of any subsequent certification. The certification statement must include a statement indicating the recipient's medical prognosis is a life expectancy of six months or less.

Certification of terminal illness for hospice benefits must be based on the clinical judgment of the hospice medical director or physician member of the interdisciplinary team and the individual's attending physician, if he/she has one, regarding the normal course of the individual's illness.

In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:

- Diagnosis of the terminal condition of the recipient;
- Other health conditions, whether related or unrelated to the terminal condition; and
- Current clinically relevant information supporting all diagnoses.

The written certification must include:

- A statement that the recipient's medical prognosis is that their life expectancy is 6 months or less if the terminal illness runs its normal course;
- Specific clinical findings and other documentation supporting a life expectancy of 6 months or less;
- The physician's brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms; and

The signature(s) of the physician(s), the date signed, and the benefit period dates that the certification or recertification covers. The signature may be electronic.

Physician Recertification

The hospice must obtain written recertification of terminal illness for each benefit period, even if a single election continues in effect. The first two benefit periods are for 90 days. After the initial two benefit periods, all subsequent benefit periods are 60 days. Recertifications may be completed up to 15 calendar days before the start of the next benefit period and no later than 2 calendar days after the beginning of the period. For the re-certification (for subsequent hospice benefit periods), only the hospice medical director or the physician member of the interdisciplinary group is required to sign and

date the certification. The recipient's attending physician is not required to sign and date the recertification. The certification must include the statement that the recipient's life expectancy is 6 months or less if the terminal illness runs its normal course. The hospice must retain the certification statements.

A hospice physician or licensed nurse practitioner employed by the hospice or working under a contract with the hospice must have a face-to-face encounter with a hospice recipient prior to, but not limited to more than 30 days prior to the third benefit period recertification and each recertification thereafter to determine continued eligibility. The face-to-face encounter may occur via telemedicine. The hospice physician or licensed nurse practitioner who performs the face-to-face encounter with the recipient must attest in writing that they had a face-to-face encounter including the date and the clinical findings of the face-to-face visit that support the continued need for hospice services.

Election of Hospice Care Statement

A recipient who is eligible for hospice care or legal representative and who wishes to elect hospice care must sign an election statement. A recipient or legal representative may designate an effective date for the election period that begins with the first day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made. The election statement must include:

- The name of the hospice provider;
- An acknowledgment that the recipient or legal representative understands that hospice provides palliative, not curative care for the terminal illness;
- An acknowledgment that the recipient or legal representative waives all rights to Medicaid payments for the duration of the election of hospice care for the following services:
    - Hospice care provided by a hospice other than the designated hospice, unless the care is provided under arrangement made by the designated hospice; and
    - Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected, a related condition, or the equivalent to hospice care, except services:
        - Provided directly or under arrangements by the designated hospice;
        - Provided by the recipient's attending physician if the physician is not an employee of or receiving compensation from the designated hospice;
        - Provided as room and board by a nursing facility or ICF-IID if the recipient is a resident of the facility;
- The effective date of the election; and
- The signature of the recipient or legal representative.

A legal representative of the recipient may act on behalf of the recipient in all matters pertaining to hospice care.

An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual:

- Remains in the care of a hospice;
- Does not revoke the election; and
- Is not discharged from the hospice.

Change of Designation of Hospice Care

A recipient, or legal representative, may change, once in each election period, the designation of the hospice from which he or she elects to receive hospice care. The change of the designated hospice is not considered a revocation of the election. To change the designation of hospice programs, the recipient or legal representative must file, with the hospice from which he or she has received care and with the newly designated hospice, a signed statement that includes the following information:

- Name of the current hospice;
- Name of the new hospice from which the recipient plans to receive care;
- Date the change is effective.

A change of ownership of a hospice is not considered a change in the recipient's designation of a hospice and requires no action on the recipient's part.

Revocation of Election of Hospice Care

A recipient may revoke the election of hospice care at any time by signing and dating a revocation statement that indicates the effective date of the revocation of the hospice care. The effective date of the revocation must be on or after the date the form is signed. After revoking the election, a recipient may receive any of the Medicaid benefits they waived by choosing hospice care. A recipient may elect hospice again at any time if they are eligible for hospice care benefits.

If a recipient is eligible for Medicare as well as Medicaid, the hospice benefit must be elected and revoked simultaneously under both programs.

Hospice Discharge

Once a hospice chooses to admit a Medicaid recipient, it may not automatically or routinely discharge the beneficiary at its discretion, even if the care will be costly or inconvenient. The election of the hospice benefit is the recipient's choice rather than the hospice's choice, and the hospice cannot revoke the recipient's election. Neither should the hospice request or demand that the recipient revoke his/her election.

Discharge from a hospice can occur as a result of one of the following:

- The recipient decides to revoke the hospice benefit;
- The recipient transfers to another hospice;
- The recipient dies;
- The recipient moves out of the geographic area that the hospice defines in its policies as its service area.
- The recipient's condition improves and he/she is no longer considered terminally ill.

The hospice must notify the Division of Economic Assistance of the discharge within 5 working days of the end of hospice services.

Discharge for cause: There may be extraordinary circumstances in which a hospice would be unable to continue to provide hospice care to a recipient. These situations would include issues where patient safety or hospice staff safety is compromised. When a hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause, that the recipient's (or other persons in the recipient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the recipient or the ability of the hospice to operate effectively is seriously impaired, the hospice can consider discharge for cause. The hospice must do the following before it seeks to discharge a recipient for cause:

- Advise the recipient that a discharge for cause is being considered;
- Make a serious effort to resolve the problem(s) presented by the recipient's behavior or situation;
- Ascertain that the recipient's proposed discharge is not due to the recipient's use of necessary hospice services; and
- Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into the recipient's medical records.

The hospice may also need to make referrals to other relevant state/community agencies (i.e., Adult Protective Services) as appropriate.

Discharge Order

Prior to discharging a recipient for any reason other than a recipient revocation, transfer, or death, the hospice must obtain a written physician's discharge order from the hospice medical director. If a recipient has an attending physician or other licensed practitioner involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.

Effect of Discharge

An individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice:

- Is no longer covered under hospice care;
- Resumes Medicaid coverage of the benefits waived; and
- May at any time elect to receive hospice care if he or she is again eligible to receive the benefit.

Discharge Planning

The hospice must have in place a discharge planning process that takes into account the prospect that a recipient's condition might stabilize or otherwise change such that the recipient cannot continue to be certified as terminally ill. The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the recipient is discharged because he or she is no longer terminally ill. Once a recipient is no longer considered terminally ill with a life expectancy of 6 months or less if the disease runs its normal course, coverage and payment for hospice care should cease. Medicaid does not expect that a discharge would be the result of a single moment that does not allow time for some post-discharge planning. Rather, it would be expected that the hospice's interdisciplinary group is following the recipient, and if there are indications of

improvement in the recipient's condition such that hospice may soon no longer be appropriate, then planning should begin. If the recipient seems to be stabilizing, and the disease progression has halted, then it could be the time to begin preparing the recipient for alternative care. Discharge planning should be a process, and planning should begin before the date of discharge.

COVERED SERVICES AND LIMITS

General Coverage Principles

Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

Notification to the Department

A statement of election, revocation, death or discharge must be sent to the Department of Social Services, Division of Economic Assistance within five working days after the hospice provider obtains the signed statement from the recipient. Payment for hospice services will not be made until the appropriate documentation has been received by the Department.

A statement of election, revocation, death or discharge form is available on South Dakota Medicaid's website. A hospice provider may design and print a statement of certification, election, and revocation of election form to use instead of the form provided by South Dakota Medicaid. If a hospice provider chooses to create a form, it must contain the same information as the form provided by South Dakota Medicaid. For recipients dually eligible for Medicare and Medicaid, the statements used for Medicare may be used if appropriate references to Medicaid are included. For example, an election form should include a statement acknowledging the recipient waives Medicaid as well as Medicare benefits.

General Hospice Coverage Requirements

Hospice provided to dually eligible recipients must be provided first in accordance with Medicare policies, rules, regulations, and guidelines and second by the policies set forth the State Medicaid Manual and the coverage criteria in this manual.

To be covered hospice services must meet the following requirements:

- The services must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions;
- The recipient must elect hospice care in accordance with the requirements in this manual;
- A plan of care must be established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary team of the hospice program;
- The plan of care must be established before hospice care is provided;
- The services provided must be consistent with the plan of care;

A certification that the recipient is terminally ill must be completed in accordance with the requirements of this manual.

Plan of Care

An interdisciplinary team, which may consists of a include a nurse, physician, medical social worker or counselor with one of these individuals being a nurse or physician or other licensed practitioner, must assess a recipient's needs and develop a written plan of care before hospice services are provided. The other members of the interdisciplinary team must review and provide input to the plan of care within two working days following the day of assessment. For the assessment day to be a covered day of hospice service, the plan of care must be established on the same day as the assessment. Services provided by the hospice must be consistent with the plan of care and must be reasonable and necessary for palliation or management of the terminal illness and related conditions.

HCBS Waiver Services

Recipients may receive both HCBS waiver services and hospice services if the HCBS waiver services were in place prior to the hospice services being elected and are unrelated to the terminal illness that resulted in the election of hospice care. It may be appropriate for HCBS waiver services to be approved after a recipient has elected hospice services if the HCBS services are unrelated to the terminal illness that resulted in the election of hospice care. HCBS waiver services may not be utilized as a means by hospice providers to forgo providing core and supplemental services that they are required to provide.

Covered Core Services

The hospice must provide core services to the recipient based upon the recipient's individual needs. Core services, with the exception of physician services, must be provided directly by hospice employees on a routine basis. These services must be provided in a manner consistent with acceptable standards of practice. All services must be performed by appropriately qualified personnel. The following are considered hospice core services:

- Physician services;
- Nursing services;
- Medical social services and
- Counseling.

Physician Services (Core Service)

A physician must perform physicians' services (as defined in 42 CFR 410.20(b)(1)(1)), except that the services of the hospice medical director or the physician member of the interdisciplinary team must be performed by a doctor of medicine or osteopathy. Nurse practitioners may not serve as a medical director or as the physician member of the interdisciplinary group. The hospice face-to-face encounter is an administrative requirement related to certifying the terminal illness. By itself, it is not billable, as it is considered administrative. However, if a hospice physician, or a hospice nurse practitioner who is also the recipient's attending physician, provides reasonable and necessary non-administrative recipient care during the face-to-face visit, that portion of the visit would be billable.

Attending Physician and Nurse Practitioner Services (Core Services)

The attending physician is a doctor of medicine or osteopathy, a nurse practitioner, or a physician assistant and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the recipient's medical care.

The election statement must include the recipient's choice of attending physician. The information identifying the attending physician should be recorded on the election statement in enough detail so that it is clear which physician, NP, or PA was designated as the attending physician. This information should include, but is not limited to, the attending physician's full name, office address, NPI number, or any other detailed information to clearly identify the attending physician. Hospices have the flexibility to include this information on their election statement in whatever format works best for them, provided the content requirements in 42 CFR 418.24(b) are met. The language on the election form should include an acknowledgement by the recipient (or legal representative) that the designated attending physician was the recipient's (or legal representative's) choice.

If a recipient (or legal representative) wants to change his or her designated attending physician, he or she must follow a procedure similar to that which currently exists for changing the designated hospice. Specifically, the recipient (or legal representative) must file a signed statement with the hospice that identifies the new attending physician in enough detail so that it is clear which physician, NP, or PA was designated as the new attending physician. This information should include, but is not limited to, the attending physician's full name, office address, NPI number, or any other detailed information to clearly identify the attending physician. The statement must include the date the change is to be effective, the date that the statement is signed, and the recipient's (or legal representative's) signature, along with an acknowledgement that this change in the attending physician is the recipient's (or legal representative's) choice. The effective date of the change in attending physician cannot be earlier than the date the statement is signed.

Physician services can be provided by nurse practitioners or physician assistant's only if the:

- Nurse practitioner or physician assistant is the recipient's designated attending physician; and
- Services are medically reasonable and necessary; and
- Services are performed by a physician in the absence of the nurse practitioner or physician assistant; and
- Services are not related to the certification of terminal illness.

Services that are duplicative of what the hospice nurse would provide are not separately billable for a nurse practitioner or physicians assistant. Physician assistants cannot perform the face-to-face encounter.

Nursing Services (Core Service)

Nursing services provided by or under the supervision of a registered nurse. Services must require the skills of a registered nurse or licensed practical nurse and must be reasonable and necessary for the palliation and management of the patient's terminal illness and related conditions. Services provided by a nurse practitioner who is not the patient's attending physician, are included under nursing care. In this scenario, since the services are nursing, payment is encompassed in the hospice per diem rate and

may not be billed separately regardless of whether the services are provided by a nurse practitioner or a registered nurse.

Medical Social Services (Core Service)
Social services provided by a social worker under the direction of a physician or other licensed practitioner. Social workers must meet the qualification requirements in 42 CFR 418.114(b)(3). Services of these professionals which may be covered include, but are not limited to:

- Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care;
- Assessment of the relationship of the recipient's medical and nursing requirements to the recipient's home situation, financial resources and availability of community resources;
- Appropriate action to obtain available community resources to assist in resolving the recipient's problem;
- Counseling services that are required by the recipient;
- Medical social services furnished to the recipient's family member or caregiver on a short-term basis when the hospice can demonstrate that a brief intervention (that is, two or three visits) by a medical social worker is necessary to remove a clear and direct impediment to the effective palliation and management of the patient's terminal illness and related conditions. To be considered "clear and direct," the behavior or actions of the family member or caregiver must plainly obstruct, contravene, or prevent the recipient's medical treatment. Medical social services to address general problems that do not clearly and directly impede treatment, as well as long-term social services furnished to family members, such as ongoing substance misuse counseling, are not covered.

Counseling Services (Core Service)
Counseling services provided to the recipient and family member or other persons caring for the recipient at the recipient's home. Counseling, including dietary counseling, may be provided to train the recipient's family or caregiver to provide care and help the recipient, family members, and caregivers adjust to the recipient's approaching death.

Bereavement counseling is available to the recipient and his or her immediate family to provide emotional, psychosocial, and spiritual support and services before and after the death of the recipient and to assist with issues related to grief, loss, and adjustment for up to 1 year after the recipient's death. It is not separately reimbursable.

Covered Non-Core Services
In addition to the hospice core services (physician services, nursing services, medical social services, and counseling), the following services must be provided by the hospice, either directly or under arrangements, to meet the needs of the recipient and family and are not separately billable.

The hospice may contract for supplemental services provided during periods of peak patient load or for extraordinary circumstances. All services must be performed by appropriately qualified personnel, skilled nursing facility (SNF) or nursing facility (NF) that additionally meets the special hospice

standards regarding patient and staffing areas. Services provided in an inpatient setting must conform to the written plan of care.

Medical Appliances and Supplies (Supplemental Service)
Medical appliances and supplies may be provided, including drugs and biologicals. Drugs which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. This includes both prescription and over-the-counter drugs.

Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the recipient's home while the recipient is under hospice care. Medical supplies include those that are part of the written plan of care and that are for palliation and management of the terminal illness or related conditions.

Home Health Aide and Homemaker Services (Supplemental Service)
Home health aide (hospice aide) services and homemaker services which include personal care services and household services, such as changing a bed, light cleaning and laundering, necessary to maintain a safe and sanitary environment in areas of the home used by the recipient. Aide services must be provided under the supervision of a registered nurse. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide. The hospice aide must meet the Medicare conditions of participation requirements in 42 CFR 418.76.

Therapy Services (Supplemental Service)
Physical therapy, occupational therapy, and speech and language pathology services may be provided for symptom control or to enable the recipient to maintain activities of daily living and basic functional skills.

A hospice may use chemotherapy, radiation therapy, and other modalities for palliative purposes if it determines that these services are needed. This determination is based on the patient's condition and the individual hospice's care-giving philosophy. Services are considered reimbursed through the standard Medicaid hospice reimbursement.

Treatment of Terminal Condition
When hospice is elected by a recipient age 21 or older, the recipient is no longer eligible for any Medicaid services related to the treatment of the terminal condition for which hospice care was elected, a related condition or the equivalent to hospice care. The recipient is still eligible for treatment of conditions unrelated to the terminal condition.

Individuals age 20 or younger may receive hospice services and continue to receive other Medicaid covered services that are not duplicative of hospice care for the terminal condition, a related condition, or unrelated condition.

Levels of Hospice Care

South Dakota Medicaid covers four levels of hospice care. Services must be provided by a provider that meets the criteria in the Eligible Providers section of this manual. The level of hospice care that is covered each day depends on the type and intensity of the services furnished to the recipient on the date of service. Coverage and reimbursement is limited to one of the levels of hospice care described below per day.

Routine Home Care Day (Revenue Code 651)

A routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous care. In addition to a traditional place of residence, for purposes of routine home care a recipient's home may be a skilled nursing facility, ICF-IID, swing bed, assisted living center, residential hospice, community support provider, or inpatient hospice. On any day on which the recipient is not an inpatient, the hospice provider is reimbursed the routine home care rate, unless the recipient receives continuous care for a period of at least 8 hours.

Service Intensity Add-On - End of Life (Revenue Code 551 and 561)

Routine home care days that occur in the last 7 days of a recipient's life are eligible for a service intensity add-on when direct patient care is provided by one of the following:

- Registered nurse (Revenue Code 551, HCPCS G0299);
- Licensed practical nurse (Revenue Code 551, HCPCS G0300);
- Social worker (Revenue Code 561, HCPCS G0155).

Services must be billed in 15-minute increments and are limited to 16 combined units per day. The service intensity add-on rate is the same as the continuous home care rate.

Continuous Home Care Day (Revenue Code 652)

A continuous home care day is a day in which the recipient receives nursing services, which may include hospice aide or homemaker services, on a continuous basis during a period of crisis, for at least eight hours and as many as 24 hours per day, as necessary to maintain the recipient at home. More than half the care during the crisis must be nursing care provided by a registered nurse or licensed practical nurse. Continuous home care is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill recipient at home. A period of crisis is a period in which the individual requires continuous care to achieve palliation and management of acute medical symptoms.

In addition to a traditional place of residence, for purposes of continuous home care a recipient's home may be a skilled nursing facility, ICF-IID, swing bed, assisted living center, residential hospice, community support provider, or inpatient hospice.

The 24-hour day begins and ends at midnight. This care need not be continuous, i.e., 4 hours could be provided in the morning and another 4 hours provided in the evening of that day. The hospice provider is reimbursed on an hourly basis for every hour of continuous home care furnished up to a maximum of 24 hours a day.

While in the majority of situations, one individual would provide continuous care during any given hour, there may be circumstances where the recipient's needs require direct interventions by more than one covered discipline resulting in an overlapping of hours between the nurse and hospice aide. In these circumstances, the overlapping hours would be counted separately. The total hours paid cannot exceed 24 hours per day. Documentation of care, modification of the plan of care, and supervision of aides or homemakers would not qualify as direct care nor would these activities qualify as necessitating the services of more than one care provider. In addition, while the services provided by other disciplines such as medical social workers, pastoral counselors, marriage and family therapists or mental health counselors are an integral part of the care provided to a hospice recipient, these services are not included in the definition of continuous care and are not counted towards total hours of continuous care. However, the services of social workers, pastoral counselors, marriage and family therapists or mental health counselors would be expected during these periods of crisis, if warranted as part of hospice care, and are included in the provisions of routine hospice care.

When a hospice determines that a recipient meets the requirements for continuous home care, appropriate documentation must be available to support the requirement that the services provided were reasonable and necessary and were in compliance with an established plan of care in order to meet a particular crisis situation. This would include the appropriate documentation of the situation and the need for continuous care services consistent with the plan of care.

Inpatient Respite Care (Revenue Code 655)

An inpatient respite care day is a day on which the individual who has elected hospice care receives care in an approved facility on a short-term basis for respite. Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual. In addition to a traditional place of residence, inpatient respite care is covered for recipients residing in assisted living centers, residential hospices, or community support providers. Inpatient respite care may be provided in a hospital, nursing facility, or inpatient hospice that meets the conditions of participation in 42 CFR 418.108.

Several examples of appropriate respite care for a recipient who does not reside in a facility include providing a few days for the caregiver to rest at home, to visit family, attend a wedding, or attend a graduation for a needed break, or providing a few days immediately following a GIP stay if the usual caregiver has fallen ill.

Coverage for inpatient respite care is limited to 5 consecutive days beginning with the day of admission but excluding the day of discharge. Any inpatient respite care days in excess of 5 consecutive days must be billed as routine home care.

Revenue code 655 includes room and board. Revenue code 659 may not be billed in addition to it.

General Inpatient Care Day (Revenue Code 656)

A general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings. This level of hospice care may only be provided in a skilled

nursing facility, ICF-IID, swing bed, inpatient hospice, or hospital. Inpatient care is provided for a limited period of time as determined by the physician and interdisciplinary team.

General inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicaid hospital benefit. For example, a brief period of general inpatient care may be needed in some cases when a patient elects the hospice benefit at the end of a covered hospital stay. If a patient in this circumstance continues to need pain control or symptom management, which cannot be feasibly provided in other settings while the patient prepares to receive hospice home care, general inpatient care is appropriate.

Other examples of appropriate general inpatient care include a patient in need of medication adjustment, observation, or other stabilizing treatment, such as psycho-social monitoring. It is not appropriate to bill Medicaid for general inpatient care days for situations where the individual has lost caregiver support unless the coverage requirements for the general inpatient level of care are otherwise met. For a hospice to provide and bill for the general inpatient level of care, the patient must require an intensity of care directed towards pain control and symptom management that cannot be managed in any other setting.

42 CFR 418.110 specifies the conditions of participation for general inpatient hospice care and should be reviewed in its entirety. All condition-of-participation requirements must be met whether a hospice provides general inpatient care in its own inpatient unit or by arrangement with another entity. Unless the nursing facility is a skilled nursing facility in a hospital setting, most nursing facilities do not meet the skilled nursing requirement for this level of care. Specifically, the nursing facility must provide 24-hour registered nurse coverage and the registered nurse at the nursing facility must be capable of providing the pain management required for this level of hospice care. The presence of a registered nurse on staff at the nursing facility for 24 hours per day is not sufficient to meet the requirements.

The day of admission to the facility is general inpatient care and the day of discharge is not general inpatient care, unless the recipient is discharged deceased. Reimbursement for general inpatient care may not be made to a long-term care facility when that facility is considered the recipient's home; however, payment for general inpatient care can be made to another long-term care facility rendering this level of hospice care.

Revenue code 656 includes room and board. Revenue code 659 may not be billed in addition to it.

Room and Board (Revenue Code 659)
Once a nursing facility resident elects hospice, the recipient is considered a hospice patient and no longer a nursing facility patient for billing purposes.

For dually enrolled Medicare and Medicaid eligible recipients receiving one of the categories of hospice care, coverage and reimbursement is limited to the recipient's room and board. Medicare will pay for the hospice care at the applicable routine home care rate. Medicaid will reimburse the hospice the routine home care rate, plus the established room and board rate for patients who are not dually

eligible. Medicaid payment for the room and board is to the hospice provider and the hospice provider must reimburse the nursing facility for room and board.

Room and board reimbursement does not include the day of discharge or death from hospice. The hospice will be reimbursed for hospice clinical services provided on the date of death and discharge, but not for room and board.

Revenue code 659 may not be billed in addition to revenue code 655 or 656 as room and board are already included in the reimbursement for those revenue codes.

Non-Covered Services

General Non-Covered Services
Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

Non-Covered Hospice Services
Volunteer Physician Services
Physician services provided on a volunteer basis are not covered. In determining which services are furnished on a volunteer basis and which are not, a physician must treat Medicaid recipients on the same basis as other patients in the hospice. For example, a physician may not designate all physician services rendered to non-Medicaid patients as volunteered and at the same time seek payment from the hospice for all physician services rendered to Medicaid patients.

A physician who is designated by a recipient as the attending physician and who also volunteers services to the hospice is considered an employee of the hospice pursuant to 42 CFR 418.3. Physician services unrelated to the recipient's terminal illness are reimbursable for providers that meet this criteria.

Documentation Requirements

General Requirements
Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

Reimbursement and Claim Instructions

Timely Filing
South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability

Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Reimbursement

Hospice services are reimbursed at the lesser of billed charges or the applicable rate on the Hospice fee schedule. Reimbursement is based on the level of hospice care and intensity of services provided each day to the recipient. The maximum reimbursement rate for routine home care is based on the length of time the recipient is in hospice care on a cumulative basis without a 60-day break in stay. If readmission occurs after 60 days, the cumulative day calculation starts over.

- Day 0 to 60 = Routine high rate on fee schedule
- Days 61+ = Routine low rate on fee schedule

If a recipient is a live discharge from hospice and is then readmitted to hospice within 60 days of being discharged, that recipient's days from his or her initial admission will count towards their total day count. For example, if a recipient is discharged on day 55 and readmitted 5 days later, upon readmission their first day will be considered day 56. If a recipient is a live discharge from hospice and is not readmitted until more than 60 days after discharge the count of days will start over at 1 upon readmission.

Services Included in the Fee Schedule Rate

The applicable fee schedule rate is considered reimbursement for the cost of all covered services related to the treatment of the recipient's terminal illness, including palliation and management of symptoms of the terminal illness, payment for the administrative and general supervisory activities performed by the medical director or a physician member of the interdisciplinary team. These activities include participation in establishment of care plans, supervision of care and services, periodic review and updating of care plans, and establishment of governing policies. These items are not separately reimbursable.

Physician Services Unrelated to the Terminal Illness for Recipients Age 21 and Older

A hospice may be reimbursed for physician services unrelated to the recipient's terminal illness, such as direct patient care services furnished to individual patients by a physician employed by the hospice and for physician services furnished under arrangements made by the hospice. The only services that may be billed by an attending physician are the physician's face-to-face professional services. The reimbursement for physician services is in addition to the daily rates. Costs for services such as lab or x-rays done in relation to the terminal illness may not be included on the attending physician's claim. Covered physician services are paid at the current Medicaid rate for physician or other licensed practitioners. Volunteer physician services are not covered. Please refer to the Non-Covered Services section for more information.

Services of an independent attending physician are not part of the hospice care and not reimbursable to a hospice. An independent physician must bill South Dakota Medicaid directly when providing physician services unrelated to the recipient's terminal illness.

Inpatient Care Days Limits

Payments for inpatient care days will be limited according to the number of inpatient care days furnished to medical assistance recipients by the hospice in a year. The maximum number of payable inpatient respite and general inpatient days may not exceed 20 percent of the total number of hospice care days provided to all Medicaid recipients by the hospice. If the maximum number of days exceeds twenty percent of total days, an adjustment will be made to pay the excess days at the routine home care rate and the difference will be recovered from the hospice provider. The limitation on inpatient care days does not apply to recipients diagnosed with acquired immunodeficiency syndrome (AIDS).

Room and Board

If a recipient is receiving routine home care or continuous home care in a skilled nursing facility, ICF-IID, or swing bed, a room and board payment equal to 95 percent of the Medicaid rate will be made to the hospice provider. The facility is paid by the hospice provider pursuant to their written agreement as required by 42 CFR 418.112.

The hospice may not negotiate a room and board rate with the long-term care facility with the exception of payment for private room accommodations. No additional payment will be made to the hospice for negotiated private room rates. No retroactive adjustments are available for charges in the Medicaid rate made subsequent to the payment of room and board. Adjustments may be made to correct errors in billing.

Post-Eligibility Treatment of Income

If a recipient has a recipient liability, the amount will be shown on a remittance advice. The hospice is responsible for collection of this amount from the recipient. The hospice may make arrangements with the long-term care facility to collect the recipient liability. The department will not reimburse the hospice for any uncollected recipient liability. Refer to the Billing a Recipient Manual for additional information.

Claim Instructions

Hospice Services

Claims for Hospice services must be submitted on the UB-04 claim form or via an 837I electronic transaction. Detailed claim instructions are available on our website.

Physician Services Unrelated to the Terminal Illness

Physician services unrelated to the terminal illness must be submitted on a CMS 1500 form or 837P at their usual and customary charge. Detailed claim instructions are available on our website. Hospice employed physician services are included in the hospice services and are not separately billable.

DEFINITIONS

1. “Assisted living center,” a facility as defined in SDCL 34-12-1.1(2);

2. “Continuous home care day,” a level of care as defined in 42 CFR 418.302 (as amended to January 1, 2010);

3. "Community support provider," a nonprofit facility as defined in SDCL 27B-1-17(4);

4. "General inpatient care day," a level of care as defined in 42 CFR 418.302 (as amended to January 1, 2010).

5. "Hospice facility," an agency or organization engaged in providing care to terminally ill individuals;

6. "Inpatient respite care day," a level of care as defined in 42 CFR 418.302 (as amended to January 1, 2010);

7. "Inpatient hospice," a facility as defined in SDCL 34-12-1.1(10);

8. "ICF-IID," a facility as defined in ARSD 67:54:03:01;

9. "Nursing facility," a facility as defined in SDCL 34-12-1.1(7);

10. "Residential hospice," a facility as defined in SDCL 34-12-1.1(11);

11. "Routine home care day," a level of care as defined in 42 CFR 418.302 (as amended to January 1, 2010);

12. "Swing bed," a licensed hospital bed approved by the Department of Health to provide short-term nursing facility care pending the availability of a nursing facility bed; and

13. "Terminally ill," a medical prognosis that an individual's life expectancy is six months or less if the illness runs its normal course.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **Does a hospice provider need to submit a new notification of election of hospice services to the Division of Economic Assistance if the recipient was previously receiving hospice services and revoked their election or was discharged?**

   Yes, providers are required to notify the Division of Economic Assistance that the recipient had been discharged or revoked their election of hospice services. If the recipient is electing hospice

services again, the provider must notify the Division of Economic Assistance of the new election using the form available on our website.

2. **If a recipient revokes their election of hospice or is discharged and subsequently elects hospice services again, is a new physician certification of terminal illness required?**

   Yes, if there is a break in hospice services due to revocation of election or discharge a new physician certification of terminal illness must be obtained.

3. **Does a hospice provider have to notify the Division of Economic Assistance when a physician recertifies that the recipient has a terminal illness?**

   No, the Division of Economic assistance only needs to be notified at the time of election of hospice care and again at the time of revocation, death or discharge. The recertification must be documented in the recipient's medical record.

4. **Does a PASRR apply to hospice recipients?**

   Yes, a PASRR screening must be completed for any individual admitting to a Medicaid certified nursing facility including individuals receiving hospice services in the nursing facility a PASRR must be completed. Please refer to the Pre-Admission Screening and Resident Review provider manual for more information.