Table of Contents

1. Home Health and Hospice Services

This section covers Medicaid services rendered by home health and hospice service providers as deemed appropriate by the Department of Health and Welfare.

Sections of the Idaho Medicaid Provider Handbook applicable in specific situations are listed throughout the handbook for provider convenience. Handbook sections that always apply to these provider types include the following:

- *General Billing Instructions*;
- *General Information and Requirements for Providers*; and
- *Glossary*.

1.1. Advanced Care Planning (ACP)

Home health and Hospice service providers must explain to each participant their right to make decisions regarding their medical care. This includes the right to accept or refuse treatment. Providers must also inform the participant of their right to formulate advance directives, such as a Living Will or Durable Power of Attorney. A written copy of the provider's policies on implementing these rights must be provided to the participant before services are initiated for the first time. The participant's medical record must document whether or not they have an advance directive. Treatment decisions cannot be based on the participants election or refusal of an advance directive. It is recommended the Idaho Physician Orders for Scope of Treatment (POST) Form be completed and placed at the care location so the participant's end-of-life wishes are honored. The POST Form and other resources are available from the Idaho Secretary of State's Office's health care directive registry webpage.

See the Physician and Non-Physician Practitioner, Idaho Medicaid Provider Handbook for more information about advanced care planning.

1.2. Home Health Services

Home health services are physician-ordered services under a written plan of care provided where the participant's normal life activities take place. All services must be provided in compliance with IDAPA 16.03.07, "Rules for Home Health Agencies" to be eligible for reimbursement.

1.2.1. Provider Qualifications

Home Health Agencies must be licensed in Idaho and certified to participate in the Medicare Program. Agencies must enroll as an Idaho Medicaid provider prior to submitting claims for services. As of July 1, 2021, Home Health Agencies must implement an Electronic Visit Verification (EVV) system compatible with the state's EVV aggregator, Sandata, for all home health services that require an in-home visit. Providers must follow the provider handbook and all applicable state, and federal, rules and regulations.

See *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

See the Electronic Visit Verification (EVV) section in the General Billing Instructions, Idaho Medicaid Provider Handbook for more information about EVV requirements.

1.2.1.1. References: Provider Qualifications

21st Century Cures Act. Section 12006(a). "Electronic Visit Verification System Required for Personal Care Services and Home Health Care Services Under Medicaid". https://www.congress.gov/bill/114th-congress/house-bill/34/text.

Home Health Services, 42 C.F.R. Sec. 440.70(d) (2016). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec440-70.pdf.

"Home Health Services: Provider Qualifications and Duties." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 724. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Medicaid Electronic Visit Verification (EVV) Guidance, Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/home-community-based-services/guidance/electronic-visit-verification-evv/index.html.

State of Idaho, Electronic Visit Verification (EVV) Website. https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/electronic-visit-verification-evv.

1.2.2. Eligible Participants

To be eligible for home health services, it must be medically necessary for the participant to receive services in their place of residence. Participants are still eligible if they don't need institutional care or aren't homebound.

1.2.2.1. References: Eligible Participants

Comparability of Services for Groups, 42 CFR 440.240(b) (1981). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2017-title42-vol4/pdf/CFR-2017-title42-vol4-sec440-240.pdf.

Detsel v. Sullivan, 895 F.2d 58 (2d Cir.1990).

Home Health Services, 42 CFR 441.15(c) (1978). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2017-title42-vol4/pdf/CFR-2017-title42-vol4-sec441-15.pdf.

Home Health Services, 42 C.F.R. Sec. 440.70 (2016). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec440-70.pdf.

Skubel v. Fuoroli, 113 F.3d 330 (2d. Cir. 1997).

State Medicaid Director Letter Olmstead Update No: 3 (2000). The Health Care Finance Administration, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd072500b.pdf.

"State Plans for Medical Assistance" Social Security Act, Sec. 1902(a)(10)(B) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

"State Plans for Medical Assistance" Social Security Act, Sec. 1902(a)(10)(D) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

Sufficiency of Amount, Duration, and Scope, 42 CFR 440.230 (1981). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2017-title42-vol4/pdf/CFR-2017-title42-vol4-sec440-230.pdf.

1.2.3. Covered Services and Limitations: Home Health Services

All home health services must be medically necessary and ordered by a physician as part of a home health plan of care. Service eligible for home health include skilled nursing, home health aide services, audiology, durable medical equipment and supplies, drugs, physical therapy, occupational therapy, and speech-language pathology. Services are typically provided in the participant's place of residence, but may be provided anywhere normal life activities take place. Services are prohibited from being provided in a hospital, nursing facility, ICF/IID (unless the ICF/IID is not required to provide the service), or any other place with inpatient services that include room and board. Medicaid requires all Medicare conditions of participation including, but not limited to, the Outcome and Assessment Information Set (OASIS) documentation and the requirement of a face-to-face visit by the ordering physician.

Home health services are limited to a total of 100 medically necessary visits per participant, per calendar year. A visit is considered all services that occur on a date of service. Additional

visits require a prior authorization from the Medical Care Unit. See the Prior Authorization (PA) section for more information.

1.2.3.1. Evaluation Visit

Payment for the initial nursing evaluation visit depends upon the participant's need for home health services. The provider should bill according to the following requirements:

- If the participant needs further home health services, bill the evaluation visit as a skilled nursing visit; or
- If the participant does not require home health services, the visit must be charged to the agency administration cost center.

1.2.3.2. Durable Medical Equipment and Supplies

Home health agencies are responsible for providing durable medical equipment and supplies (DME and DMS) to participants under a home health plan of care. DME and DMS must be medically necessary and suitable for use in the home, but may be provided for use anywhere normal life activities take place. A physician must provide an order for DME and DMS and reevaluate their necessity in the plan of care annually. Home Health Agencies must adhere to the Suppliers, Idaho Medicaid Provider Handbook for any dispensed DME or supplies.

The Department of Health and Welfare may arrange purchase agreements with providers to purchase medical equipment when the rental charges total more than the purchase price of the equipment. All such purchases will be handled separately from the home health program as medical vendor transactions.

Claims for DME and DMS must be billed with the correct revenue code and CPT®/HCPCS, one combination per claim line.

a. Routine Supplies

Routine supplies are included in the cost of the home health visit and are not separately reimbursable. A routine supply is generally used in small supplies during most home health visits, and aren't included in the plan of care. The items are part of the staff's supplies and aren't designated for an individual participant. Routine supplies usually include, but are not limited to:

- Swabs, alcohol preps, and skin prep pads;
- Tape removal pads;
- Cotton balls;
- Adhesive and paper tape;
- Nonsterile applicators;
- 4 x 4 gauze dressings;
- Nonsterile gloves;
- Aprons;
- Masks;
- Gowns;
- Specimen containers;
- Thermometers; and
- Tongue depressors.

1.2.3.3. Influenza Vaccinations

All routine injections are included in the reimbursement for home health agency scheduled nursing visits. The exception to this rule is the administration of the influenza vaccine. The Department will reimburse the agency "injection administration" costs if no other home health

visit is billed on the same day as the vaccination. A description in the remarks section must indicate that influenza vaccine was administered.

1.2.3.4. References: Covered Services and Limitations: Home Health Services

Basic Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho, http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/BasicBenchmark.pdf.

Detsel v. Sullivan, 895 F.2d 58 (2d Cir.1990).

Home Health Services, 42 C.F.R. Sec. 440.70(b) (2016). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec440-70.pdf.

"Home Health Services: Coverage and Limitations." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 722. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Home Health Services: Definitions." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 720.02—720.03 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

Skubel v. Fuoroli, 113 F.3d 330 (2d. Cir. 1997).

State Medicaid Director Letter Olmstead Update No: 3 (2000). The Health Care Finance Administration, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd072500b.pdf.

1.2.4. Documentation Requirements

Documentation requirements applicable in specific situations are listed throughout the handbook for provider convenience. General documentation requirements are also required and found in the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook.

1.2.4.1. Face-to-Face Visit

A face-to-face visit with the participant's physician, or a non-physician practitioner, is required to initiate home health services. If the visit is conducted by a non-physician practitioner, they must coordinate and provide clinical records to the ordering physician. The visit must be primarily for the condition requiring home health services in order to meet this requirement. The visit may be conducted via telehealth so long as it meets all requirements for telehealth services found in the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook. The ordering physician must document when the visit occurred, and the name and credentials of the professional that conducted the encounter.

The face-to-face visit must occur either ninety days before, or no more than thirty days after, home health services begin. Durable medical equipment or supplies, however, must have their visit occur within the six months preceding their delivery.

a. References: Face-to-Face Visit

Home Health Services, 42 C.F.R. Sec. 440.70(f) (2016). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec440-70.pdf.

Home Health Services, 42 C.F.R. Sec. 440.70(g) (2016). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec440-70.pdf.

"Home Health Services: Procedural Requirements." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 723.02—723.03 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Face to Face Encounter with Patient Required Before Physicians May Certify Eligibility for Home Health Services or Durable Medical Equipment Under Medicare." H.R. 3590, "The Patient Protection and Affordable Care Act," Sec. 6407 (2010). Government Printing Office, https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf.

1.2.4.2. Plan of Care

All home health services must have an individualized home health plan of care before beginning treatment. The participant's plan of care must be reviewed, signed and dated by the attending physician every 60 days for services and annually for durable medical equipment and supplies. The home health agency must maintain a copy in their records, and provide a copy to the participant. The plan must include at a minimum:

- All pertinent diagnoses;
- The participant's mental status;
- The services, equipment and supplies required;
- The frequency of visits;
- Functional limitations;
- Ability to perform activities of daily living;
- Activities permitted;
- Nutritional requirements;
- Medication and treatment orders;
- Any safety measures implemented to prevent injury;
- Any environmental factors that may impact the home health agency's ability to provide safe and effective care;
- The participant's support system's ability to provide care;
- The participant and support system's teaching needs;
- A plan for discharge; and
- Any other appropriate items.

a. References: Plan of Care

"Home Health Services: Home Health Plan of Care." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 720.01 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Home Health Services: Home Health Plan of Care." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 723.04 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Plan of Care." *IDAPA 16.03.07, "Rules for Home Health Agencies,"* Sec. 030 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160307.pdf.

1.2.4.3. Physician Orders

Home health services must be ordered by a physician at least every sixty days, and durable medical equipment and supplies must be ordered annually.

Orders must include at a minimum the physician's national provider identifier, the services or items to be provided, the frequency, and when applicable the expected duration of time services will be needed.

a. References: Physician Orders

Home Health Services, 42 C.F.R. Sec. 440.70(a)(2) (2016). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec440-70.pdf.

"Home Health Services: Definitions." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 720(01) & (02)(a). Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Home Health Services: Physician Orders." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 723.01 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

1.2.5. Prior Authorization (PA)

If the participant requires visits over the 100-visit limit, the agency must fax documentation to the Medical Care Unit for prior authorization. Approval will be determined on a case-by-case basis. The following documentation is required to determine the need for additional visits:

- Completed Home Health Prior Authorization Request Form;
- Current physician's order;
- Current signed Home Health Certification and Plan of Care;
- Last 30 days' visit notes;
- Current history and physical;
- Hospital discharge/admission orders and paperwork;
- MSRP or invoice for manually priced CPT or HCPCS codes; and
- Any other documentation that will support medical necessity.

Please include the frequency and type of visit being requested, along with a start and stop date. Please fax or mail PA requests to the address below.

Medical Care Unit
PO Box 83720
Boise, ID 83720-0009
Fax: 1 (877) 314-8779

1.2.6. Reimbursement

Medicaid reimburses home health services on a per visit basis, which includes the cost of mileage bundled in. Usual and customary fees for services are paid up to the reasonable cost as determined by the Medicaid or Medicare percentile cap. Durable medical equipment and supplies (DME and DMS) are paid up to the Medicaid allowed amount per the Suppliers, Idaho Medicaid Provider Handbook. Participants with Medicare eligibility will have all services paid for by Medicare. The Department will cover any remaining coinsurance and deductible.

All home health services, including DME and DMS must be billed by the home health provider on the UB-04 claim form using the appropriate revenue and type of bill codes. See the Home Health Billing Appendix for more information on allowed revenue codes and bill types. It's important to bill all services on the same date of service in a single claim when possible. If providers submit multiple claims for the same date of service, the claims processing system counts each one separately against the 100 visit limitation.

See the General Billing Instructions, Idaho Medicaid Provider Handbook regarding Medicaid policy on billing all other third party resources before submitting claims to Medicaid. Participants cannot be billed for any non-reimbursed amount. Providers may only bill non-covered services to the participant if the provider meets the requirements in the Participant Financial Responsibility section of the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook.

1.2.6.1. Interim Payment

Interim payment is based on the lesser of the Medicaid cost caps established by DHW on a state fiscal year basis or billed amount. Interim payments are made for:

- Skilled nurse visit;
- Home health aide;
- Physical therapy;
- Occupational therapy; and
- Speech-language pathology services

Final payments are the lower of reasonable costs as determined by the Medicare finalized cost report or the Medicaid cost caps.

1.2.6.2. References: Reimbursement

"Home Health Services: Provider Reimbursement." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 725. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

1.2.7. References: Home Health Services

Home Health Services, 42 C.F.R. Sec. 440.70 (2016). Government Printing Office, https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/pdf/CFR-2018-title42-vol4-sec440-70.pdf.

"Home Health Services." *IDAPA 16.03.09, "Medicaid Basic Plan Benefits,"* Sec. 720 – 729. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160309.pdf.

"Rules for Home Health Agencies." *IDAPA 16.03.07, "Rules for Home Health Agencies."* Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160307.pdf.

"Definitions." Social Security Act, Sec. 1905(a)(7) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

1.3. Hospice Services

Hospice is a public agency or private organization primarily engaged in providing care to terminally ill participants. Hospice agencies provide a holistic care concept designed to keep the participant comfortable, free of pain, and in the least restrictive environment possible by

providing services that are reasonable and necessary for the palliation and management of a terminal illness, while honoring the individual's end-of-life care decisions.

Inherent in the Hospice Program is that the participant or his/her representative understands the nature of hospice care and philosophy. It is expected that the hospice interdisciplinary team coordinates and manages all care received by the participant. The expectation is that the participant and caregiver communicate with hospice personnel regarding needs or wishes related to emergent care for hospice or non-hospice diagnoses, so that there is a coordination of care and updating of the overall plan of care as needed. For example, teaching interventions to deal with changes of status and crisis management to prevent unnecessary emergent transportation and/or medical services which are not a part of the participant's end-of-life choices.

1.3.1. Provider Qualifications

Hospice Agencies must be licensed in Idaho and certified to participate in the Medicare Program. Agencies must enroll as an Idaho Medicaid provider prior to submitting claims for services. Providers must follow the provider handbook and all applicable state, and federal, rules and regulations.

See *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

1.3.1.1. References: Provider Qualifications

"Hospice: Definitions." *IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits,"* Sec. 451.09 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160310.pdf.

1.3.2. Eligible Participants

Only participants with Medicaid Enhanced Plans are eligible to receive hospice services. The participant must elect to receive hospice services and a physician must certify that the participant's life expectancy is six months or less. Providers must check participant eligibility prior to delivery of the service by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

1.3.2.1. Participants on Waiver Services

Participants on the Aged & Disabled (A&D) Waiver or Developmentally Disabled (DD) Waiver are eligible for hospice services. The level of service within these Medicaid programs may be adjusted if the participant elects hospice. Rehabilitative services, such as community-based rehabilitation, are not covered once hospice is elected. However, participants under twenty-one (21) retain their eligibility for curative services.

1.3.2.2. Certified Family Homes (CFH)

Participants residing in a certified family home (CFH) are eligible for hospice services. A written agreement should be developed between the hospice agency and the CFH to delineate management responsibilities for the participant's care.

1.3.2.3. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

Participants in intermediate care facilities for individuals with intellectual disabilities (ICF/IID) are eligible for hospice services. A written agreement should be developed between the hospice agency and the ICF/IID that explains the hospice provider's professional management responsibilities for the individual's hospice care and the facility's agreement to provide room and board to the individual. The facility's responsibilities under room and board includes all assistance in the activities of daily living, social activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies.

1.3.2.4. Residential Assisted Living Facility (RALF)

Participants in a residential assisted living facility (RALF) are eligible for hospice services. A written agreement should be developed between the hospice agency and the RALF to delineate management responsibilities for the participant's care. The hospice agency is not responsible to reimburse the RALF for room and board payment.

1.3.2.5. Skilled Nursing Facilities

Participants in a skilled nursing facility are eligible for hospice services. A written agreement should be developed by the hospice agency that explains the hospice provider's professional management responsibilities for the individual's hospice care and the facility's agreement to provide room and board to the individual. The facility's responsibilities under room and board includes all assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies.

Medicaid will reimburse hospice agencies 95 percent of the per diem interim nursing home daily or special rate for the nursing facility providing room and board to the hospice participant. The hospice agency is then responsible to reimburse the facility for the room and board payment.

1.3.2.6. References: Eligible Participants

"Hospice: Cap on Overall Reimbursement." *IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits,"* Sec. 459.08. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160310.pdf.

"Hospice: Definitions." *IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits,"* Sec. 451.13. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160310.pdf.

"Hospice: Eligibility." *IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits,"* Sec. 452. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160310.pdf.

1.3.3. Covered Services and Limitations: Hospice Services

Hospice services reasonable and necessary for the palliation and management of the terminal illness and related conditions are a covered benefit. The participant must meet medical necessity criteria according to the CMS Local Coverage Determination. A participant may elect or revoke hospice services at any time during the benefit period. The hospice provider may not coerce or prevent a participant's termination of election.

The hospice provider is required to notify the Medical Care Unit (MCU) of all hospice elections or recertification for Medicaid participants regardless of other insurance coverage including Medicare. The MCU determines if the medical necessity criteria for hospice care is met based upon submitted documentation. If the participant is approved for the Hospice Medicaid Benefit, Election and recertification dates are entered into the Medicaid system as a Hospice Alert. The MCU faxes an approval to the hospice agency.

The hospice agency is responsible for the overall management and coordination of the hospice plan of care. It is the hospice's responsibility to inform other providers the participant is eligible for hospice. The hospice plan of care supersedes any other Medicaid provider plan of care. Rehabilitative services are not contained within the hospice philosophy of care, and therefore a service such as community-based rehabilitation service is not covered once hospice is elected. However, participants under age twenty-one (21) are eligible for concurrent curative treatments and hospice. This means that children are not limited to palliative treatment only.

Hospice participants may receive care where they live, including their own home, a certified home, a hospice house, or an assisted living or skilled nursing facility. The following services are included in the hospice reimbursement rate regardless of the service location:

- Nursing care;
- Medical social services;
- Counseling services;
- Home health aide and homemaker services;
- Physical therapy, occupational therapy, and speech-language pathology services; and
- Medical Equipment and Supplies per *IDAPA 16.03.10.453.06* includes:
    - Durable medical equipment and supplies related to the palliation or management of the patient's terminal illness; and
    - Self-help and personal comfort items related to the palliation or management of the patient's terminal illness; and
- Drugs and biologicals as defined in Subsection 1861(t) of the Social Security Act and which are used primarily for the relief of pain and symptom control related to the patient's terminal illness. Medications related to the participant's hospice diagnosis are also the responsibility of the hospice.

Claims for services rendered to participants receiving hospice services are pended for review by the Department to determine whether the hospice agency or Medicaid is responsible for payment. It is the hospice agency's responsibility to communicate and coordinate all services included in the patient's plan of care, including billing processes.

See the Election and Recertification Notifications section for information on requesting an authorization for hospice services.

1.3.3.1. Routine Home Care

Effective for dates of service on or after January 1, 2016, Idaho Medicaid hospice rates for routine home care, revenue code 0651 are revised in accordance with federal requirements. Medicaid Information Release (MA15-08) delineates this change.

Authorizations related to Revenue Code 0651 will be issued by the Medical Care Unit and manually priced for those with Medicaid primary or other third party insurance and Medicaid.

Authorizations will be created and priced:

- For the Day 1-60 higher payment rate.
- For the Day 61-240 reduced rate.
- For subsequent reduced rate periods when applicable.
- For the Service Intensity Add-on (SIA) in the last seven days of life. The provider will need to submit the dates and total increments for which the SIA applies.

The Hospice Notification Form should be faxed to the Medical Care Unit to request authorizations as described above. Participants with Medicare primary will not require authorizations related to Revenue Code 0651; Medicare will pay those claims according to Payment Reform.

1.3.3.2. Personal Care Services

Medicaid may authorize personal care services (PCS) for some participants to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance quality of life, to encourage individual choice, and to maintain community integration. The hospice must coordinate its hospice aide and homemaker services with the PCS agency and the regional Medicaid Nurse Reviewer. Medicaid PCS services may not be substituted for the primary care required to be provided by the hospice provider.

1.3.3.3. Physician Services

Physicians who render hospice services who are not employees, contractors, or volunteers of the hospice agency, must bill Medicaid directly. The claim form should indicate that they have no affiliation with the hospice agency. Hospice-based physician employee services are billed by the hospice provider on the UB-04 claim form using revenue code **0657** and the appropriate CPT procedure codes. Physicians not employed by the hospice must bill independently for their services. Notify the Medical Care Unit of any changes in physicians who are employees, contractors, or volunteers of the hospice agency.

1.3.3.4. Skilled Nursing Facility Room and Board

It is a federal requirement that room and board "pass through" the hospice agency when a hospice participant resides in a skilled nursing facility, if Medicaid's Long-Term Care Unit has authorized nursing facility payment. If a hospice participant resides in a skilled nursing facility or intermediate care facility, an authorization number is required so that the hospice provider can be paid by Medicaid for room and board (revenue code 658).

Complete the Room and Board section of the Hospice Notification Form, noting the name of the facility and the date that hospice room and board payment responsibility begins. An eight-month period of time is the usual approved time. It is very important to notify Medicaid if the hospice participant has been discharged from hospice, or revoked hospice care, and the end date of the authorization will be modified.

1.3.3.5. Timeliness of Requests

Factors outside the control of the hospice provider may create an occasional need for a retrospective review. These will be considered on a case-by-case basis (e.g., if the participant's Medicaid eligibility has been pending). Hospice care will be approved retrospectively based upon eligibility date.

1.3.4. Election and Recertification

The hospice provider is required to notify the Medical Care Unit (MCU) of all hospice elections or recertification for Medicaid participants regardless of other insurance coverage. The

provider is required to notify the MCU of the election or recertification within 15 working days by faxing the required information on the Hospice Notification Form. Forms are available on MCU's Hospice Services webpage. Forms are faxed to:

Medical Care Unit – Hospice
Fax: 1 (877) 314-8779

The initial election period is an eight-month period beginning at the start-of-care date. Recertification periods then extend authorization for eight-month increments. Providers should be aware that other payors, such as Medicare, have different election and recertification periods. The hospice provider is responsible to track when the recertification is due. See *IDAPA 16.03.10.451.06 Hospice Definitions; Election Period* at https://adminrules.idaho.gov/rules/current/16/160310.pdf.

1.3.4.1. Election Document Requirements

Hospice elections must be submitted with the required documentation:

- The completed Idaho Medicaid Hospice Notification Form;
- The hospice election form signed by the participant or legal representative;
- The attending physician's recent history and physical. This requirement may also be met with a comprehensive physical assessment signed by the hospice Medical Director;
- The hospice agency's completed Interdisciplinary Plan of Care (POC), signed by the Hospice Medical Director; and
- A certification which states that the individual's medical prognosis for life expectancy is six months or less and is signed by the Hospice Medical Director and the attending physician, if the participant has one.

1.3.4.2. Recertification Document Requirements

Hospice recertifications must be submitted with the required documentation:

- The completed Idaho Medicaid Hospice Notification Form;
- The hospice agency's updated Interdisciplinary Plan of Care (POC), signed by the Hospice Medical Director;
- A certification which states that the individual's medical prognosis for life expectancy is six months or less and is signed by the Hospice Medical Director; and
- Documentation of compliance with CMS eligibility standards for the participant's specific hospice diagnosis (e.g., Local Coverage Determination (LCD) or Criteria Worksheet).

1.3.5. Revocation, Discharge, Transfer, or Notice of Death

When a participant's hospice status changes, the hospice provider will notify the Medical Care Unit as soon as possible, not later than 15 working days, by faxing the completed Hospice Notification Form. Complete the Termination of Care section of the form and mark the appropriate box.

Fax the Medicaid Hospice Notification Form to the following number:

Medical Care Unit – Hospice
1 (877) 314-8779

1.3.6. Documentation Requirements

Documentation requirements applicable in specific situations are listed throughout the handbook for provider convenience. General documentation requirements are also required

and found in the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook.

1.3.6.1. Physician Certification

The hospice must obtain a physician certification statement, reflecting a prognosis of life expectancy of six months or less, no later than two calendar days after the participant chooses hospice care.

In addition to the requirements for electronic signatures in the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook, facsimiles of original written or electronic signatures are acceptable if they are for certifications of terminal illness for hospice. Facsimile and hard copies of a physician's electronic signature must be in the patient's medical record.

1.3.7. Reimbursement

All hospice providers are paid through the use of prospective rates determined by the Department. All services related to the terminal illness are included in the prospective rates paid. The hospice provider is responsible for all services bundled in the prospective rate regardless of whether they are supplied directly by the hospice provider or by a non-hospice provider. Refer to the Hospice fee schedule under Current Provider Reimbursement Rates on the Medicaid Fee Schedule webpage for rates. Those participants that have special rate pricing must bill revenue code **0658** and the appropriate CPT procedure codes.

See the Hospice Billing Appendix for more information on allowed revenue codes and bill types.

See the General Billing Instructions, Idaho Medicaid Provider Handbook regarding Medicaid policy on billing all other third party resources before submitting claims to Medicaid. Participants cannot be billed for any non-reimbursed amount except as allowed by the Department such as the Participant Liability in the section below. Providers may only bill non-covered services to the participant if the provider meets the requirements in the Participant Financial Responsibility section of the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook.

1.3.7.1. Participant Liability

Medicaid participants residing in a nursing facility or ICF/IID must contribute toward the cost of room and board, when applicable. The amount of each participant's monthly liability (the contribution toward the cost of care) will be determined under the same rules that are currently applied to all other Medicaid nursing facility residents. Medicaid hospice participants will be notified when they must pay a contribution. The hospice should request from the nursing facility the Authorization for Nursing Facility Payment form, which shows the participant's liability amount.

1.3.7.2. References: Reimbursement

"Hospice." *IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits,"* Sec. 450. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160310.pdf.

1.3.8. References: Hospice Services

"Hospice." *IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits,"* Sec. 450 – 459. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160310.pdf.

Appendix A. Home Health Billing

a. Revenue Codes

Covered Revenue Codes		
Revenue Codes	**Description**	**Notes**
0270	Home Health Supplies	Requires a CPT®/HCPCS. Nutritional products are included. All items must be in the plan of care.
0291	Rental Durable Medical Equipment	Requires a CPT®/HCPCS. All items must be included in the plan of care.
0421	Physical Therapy Visit	Must be included in the plan of care.
0431	Occupational Therapy Visit	Must be included in the plan of care.
0441	Speech- Language Pathology Visit	Must be included in the plan of care.
0470	Audiology - General	Must be included in the plan of care.
0471	Audiology - Diagnostic	Must be included in the plan of care.
0472	Audiology - Treatment	Must be included in the plan of care.
0551	Skilled Nurse Visit	Requires the skills of a Registered Nurse or Licensed Practical Nurse. Must be included in the plan of care.
0571	Aide Visit	Services performed by trained nurse aides, licensed personnel or a home health aide. Must be included in the plan of care.
0771	Drugs Requiring Special Coding	Requires a CPT®/HCPCS. Used for the administration of drugs. Refer to the Physician and Non-Physician Practitioner, Idaho Medicaid Provider Handbook.

b. Bill Types

Covered Home Health Bill Types	
Code	**Description**
0321	Home Health (Admit - Through - Discharge Claim) (Including Medicare Part A)
0322	Home Health (Interim - First Claim) (Including Medicare Part A)
0323	Home Health (Interim - Continuing Claim) (Including Medicare Part A)
0324	Home Health (Interim - Last Claim) (Including Medicare Part A)
0327	Home Health (Replacement of Prior Claim) (Including Medicare Part A)
0328	Home Health (Void or Cancellation of Prior Claim)

c. Patient Status Codes

Accepted Patient Status Codes (Field 17)	
Code	**Description**
01	Discharge to Home or self care
02	Transfer to Hospital
03	Transfer to Nursing Home

Accepted Patient Status Codes (Field 17)	
Code	**Description**
04	Transfer to Intermediate Care Facility
05	Discharged to Another Type of health care institution not defined elsewhere in this list
06	Discharge/Transfer to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care (Indicate in appropriate field the status or location of patient and time they left the facility)
07	Left Against Medical Advice
08	Discharged/Transferred to Home Under Care of a Home IV Provider
20	Death
30	Not Discharged, Still A Patient
40	Expired at Home
41	Expired in an Institution
42	Expired, Place Unknown
43	Discharged/transferred to a Federal Health Care Facility

d. Occurrence Codes

Accepted Occurrence Codes (Fields 31-34)	
Code	**Description**
01	Auto Accident
02	Auto Accident/No Fault
03	Accident/Tort
04	Accident/Employment Related
05	Other Accident
06	Crime Victim
24	Date Insurance Denied
25	Date Benefits Terminated by Primary Carrier
42	Date of Discharge
X0	Plan of Care on file

Appendix B. Hospice Billing

a. Revenue Codes

Hospice – Covered Revenue Codes		
Revenue Code	**Description**	**Notes**
0651	Routine Care	Daily care provided for general hospice care.
0652	Continuous Care	Care rendered during crisis conditions. Requires a minimum of eight hours. Hours are counted from midnight to midnight. This procedure must be billed using units of time in 15 minute increments. Partial blocks may be billed in 15 minute increments. Services must be provided by a registered or licensed practical nurse.
0655	Inpatient Respite Care	Respite care is limited to five days per election period (calendar month) for each participant in an approved inpatient facility. Respite care may only be rendered in a licensed freestanding hospice or a qualified nursing facility.
0656	General Inpatient Care (Non-Respite)	Participant care must be rendered in an approved inpatient hospital or freestanding hospice bed.
0657	Physician Care	Hospice-employed physician services must be billed with the appropriate CPT® procedure codes on each line for each service. When the physician billing for services is an employee of the hospice, the UB-04 claim form must be used with Revenue Code **0657**.
0658	Room and Board Care	Room and Board reimbursement for a hospice participant only occurs when the participant has been approved for a level of care in a long-term care facility. Medicaid is always the primary payer of the hospice room and board charge. Per diems are paid for Medicaid or dually eligible hospice participants residing in a Medicare certified nursing facility. The reimbursement rate will be 95 percent of the nursing facility rate on file in which the hospice participant is a resident. The 9-digit Medicaid Nursing Home provider number must be submitted on the claim in field 80 of the UB-04 claim form or in the appropriate field of the electronic claim form. Any participant liability will be withheld from the total hospice payments. Prior Authorization is required.

b. Bill Types

Hospice – Covered Bill Types	
Code	**Description**
0811	Hospice - Non-Hospital Based (Admit - Through - Discharge Claim)
0812	Hospice - Non-Hospital Based (Interim - First Claim)
0813	Hospice - Non-Hospital Based (Interim - Continuing Claim)
0814	Hospice - Non-Hospital Based (Interim - Last Claim)
0817	Hospice - Non-Hospital Based (Replacement of Prior Claim)
0818	Hospice - Non-Hospital Based (Void or Cancellation of Prior Claim)
0821	Hospice - Hospital Based (Admit - Through - Discharge Claim)
0822	Hospice - Hospital Based (Interim - First Claim)
0823	Hospice - Hospital Based (Interim - Continuing Claim)
0824	Hospice - Hospital Based (Interim - Last Claim)
0827	Hospice - Hospital Based (Replacement of Prior Claim)
0828	Hospice - Hospital Based (Void or Cancellation of Prior Claim)

c. Patient Status Codes

Accepted Patient Status Codes (Field 17)	
Code	**Description**
01	Discharge to Home or self care
20	Death
30	Not Discharged, Still A Patient

d. Occurrence Codes

Accepted Occurrence Codes (Fields 31-34)	
Code	**Description**
24	Date Insurance Denied
25	Date Benefits Terminated by Primary Carrier
42	Date of Discharge

Appendix C. Home Health and Hospice Services, Provider Handbook Modifications

Version	Section	Modification Description	Publish Date	SME
15.0	All	Published version	03/05/2021	TQD
14.2	1.2.1.1 References: Provider Qualifications	Added reference for EVV	03/2/2021	E Wainaina E Garibovic
14.1	1.2.1.Provider Qualifications	Added EVV requirements	03/2/2021	E Wainaina E Garibovic
14.0	All	Published version	12/31/2020	TQD
13.1	All	Removed DXC references, rebranded to Gainwell Technologies	12/31/2020	TQD
13.0	All	Published version	01/01/2020	TQD
12.66	Appendix C. Section Modifications	Renamed Home Health and Hospice Services, Provider Handbook Modifications. Removed changes older than three years.	12/30/2019	W Deseron K Duke
12.65	d. Occurrence Codes	New Section. Incorporated tables from UB-04 Instructions.	12/30/2019	W Deseron K Duke
12.64	c. Patient Status Codes	New Section. Incorporated tables from UB-04 Instructions.	12/30/2019	W Deseron K Duke
12.63	b. Bill Types	New Section. Incorporated tables from UB-04 Instructions.	12/30/2019	W Deseron K Duke
12.62	a. Revenue Codes	New Section. Incorporated tables from UB-04 Instructions.	12/30/2019	W Deseron K Duke
12.61	Appendix B. Hospice Billing	New Section.	12/30/2019	W Deseron K Duke
12.60	d. Occurrence Codes	New Section. Incorporated tables from UB-04 Instructions.	12/30/2019	W Deseron K Duke
12.59	c. Patient Status Codes	New Section. Incorporated tables from UB-04 Instructions.	12/30/2019	W Deseron K Duke
12.58	b. Bill Types	New Section. Incorporated tables from UB-04 Instructions.	12/30/2019	W Deseron K Duke
12.57	a. Revenue Codes	New Section. Incorporated tables from UB-04 Instructions.	12/30/2019	W Deseron K Duke
12.56	Appendix A. Home Health Billing	New Section.	12/30/2019	W Deseron K Duke
12.55	2.3.5 Medicare Crossover	Section deleted. Redundancy.	12/30/2019	W Deseron K Duke
12.54	2.3.4 Medicare or Third-Party Insurance	Section deleted. Redundancy.	12/30/2019	W Deseron K Duke

Version	Section	Modification Description	Publish Date	SME
12.53	2.3.3.4. Restrictions	Section deleted. Text incorporated into Covered Services and Limitations: Hospice Services and Personal Care Services.	12/30/2019	W Deseron K Duke
12.52	2.3.3.3. Covered Services	Section deleted. Text incorporated into Covered Services and Limitations: Hospice Services	12/30/2019	W Deseron K Duke
12.51	2.3.3.1. Customary Fees	Header deleted. Text incorporated into Reimbursement.	12/30/2019	W Deseron K Duke
12.50	2.3.2.3. Agreements with Residential Assisted Living Facilities (RALF) or	Section deleted. Text incorporated into Residential Assisted Living Facility (RALF) and Certified Family Homes (CFH)	12/30/2019	W Deseron K Duke
12.49	2.3.2.2. Agreements between Hospice Agencies and Nursing Facilities or I	Section deleted. Text incorporated into Skilled Nursing Facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	12/30/2019	W Deseron K Duke
12.48	1.3.7.1. Participant Liability	Section moved under Reimbursement.	12/30/2019	W Deseron K Duke
12.47	1.3.7. Payment	Renamed Reimbursement. Incorporated Customary Fees.	12/30/2019	W Deseron K Duke
12.46	2.3 Hospice Participants Residing in Nursing Homes/Intermediate Care	Section deleted.	12/30/2019	W Deseron K Duke
12.45	2.3.1. Advance Directives/Physician Orders for Scope of Treatment	Section deleted. Text incorporated into Advanced Care Planning (ACP).	12/30/2019	W Deseron K Duke
12.44	2.3.1.8. Reporting Requirements	Section deleted.	12/30/2019	W Deseron K Duke
12.43	1.3.6.1. Physician Certification	Section moved under Documentation Requirements.	12/30/2019	W Deseron K Duke
12.42	1.3.6. Documentation Requirements	New section.	12/30/2019	W Deseron K Duke
12.41	1.3.5. Revocation, Discharge, Transfer, or Notice of Death	Section moved under Election and Recertification.	12/30/2019	W Deseron K Duke
12.40	1.3.4.2. Recertification Document Requirements	New section. Includes list from Hospice Election and Recertification Notifications.	12/30/2019	W Deseron K Duke
12.39	1.3.4.1. Election Document Requirements	New section. Includes list from Hospice Election and Recertification Notifications.	12/30/2019	W Deseron K Duke
12.38	1.3.4. Hospice Election and Recertification Notifications	Renamed Election and Recertification. Incorporated Election Period and Recertification Periods.	12/30/2019	W Deseron K Duke

Version	Section	Modification Description	Publish Date	SME
12.37	1.3.3.5. Timeliness of Requests	Section moved under Covered Services and Limitations: Hospice Services.	12/30/2019	W Deseron K Duke
12.36	1.3.3.4. Prior Authorization (PA) for Skilled Nursing Facility Room and Board	Renamed Skilled Nursing Facility Room and Board. Section moved under Covered Services and Limitations: Hospice Services.	12/30/2019	W Deseron K Duke
12.35	1.3.3.3. Physician Services	Section moved under Covered Services and Limitations: Hospice Services. Added information about billing.	12/30/2019	W Deseron K Duke
12.34	1.3.3.2. Personal Care Services	New section. Text incorporated from Restrictions.	12/30/2019	W Deseron K Duke
12.33	1.3.3.1. Routine Home Care	Section moved under Covered Services and Limitations: Hospice Services.	12/30/2019	W Deseron K Duke
12.32	1.3.3. Covered Services and Limitations: Hospice Services	New section. Text incorporated from Covered Services, Hospice Election and Recertification Notifications	12/30/2019	W Deseron K Duke
12.31	1.3.2.5. Skilled Nursing Facilities	New section. Text incorporated from Agreements between Hospice Agencies and Nursing.	12/30/2019	W Deseron K Duke
12.30	1.3.2.4. Residential Assisted Living Facility (RALF)	New section. Text incorporated from Agreements with Residential Assisted Living Facilities.	12/30/2019	W Deseron K Duke
12.29	1.3.Intermediate Care Facilities for Individuals with Intellectual Disab	New section. Text incorporated from Agreements between Hospice Agencies and Nursing.	12/30/2019	W Deseron K Duke
12.28	1.3.2.2. Certified Family Homes (CFH)	New section. Text incorporated from Agreements with Residential Assisted Living Facilities.	12/30/2019	W Deseron K Duke
12.27	1.3.2.1. Participants on Waiver Services	New section with information from Hospice Service Policy.	12/30/2019	W Deseron K Duke
12.26	1.3.2. Participant Hospice Eligibility	Renamed Eligible Participants.	12/30/2019	W Deseron K Duke
12.25	1.3.1. Provider Qualifications	New section.	12/30/2019	W Deseron K Duke
12.24	2.3.1 General Policy	Section deleted. Redundancy.	12/30/2019	W Deseron K Duke
12.23	1.3. Hospice Services Policy	Renamed Hospice Services.	12/30/2019	W Deseron K Duke
12.22	2.2.7.3 Crossover Claims	Header deleted. Text incorporated into Reimbursement.	12/30/2019	W Deseron K Duke
12.21	2.2.7.1 Customary Fees	Header deleted. Text incorporated into Reimbursement.	12/30/2019	W Deseron K Duke
12.20	1.2.6. Payment	Renamed Reimbursement.	12/30/2019	W Deseron

Version	Section	Modification Description	Publish Date	SME
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12.19	1.2.4.3 Physician Orders	New section.	12/30/2019	W Deseron K Duke
12.18	1.2.4.2. Plan of Care	Section moved under Documentation Requirements. Clarified required components.	12/30/2019	W Deseron K Duke
12.17	1.2.4.1. Face-to-Face Visit	New section.	12/30/2019	W Deseron K Duke
12.16	1.2.4. Documentation Requirements	New section.	12/30/2019	W Deseron K Duke
12.15	1.2.3.3. Influenza Vaccinations	Subsection moved under Covered Services and Limitations: Home Health Services.	12/30/2019	W Deseron K Duke
12.14	2.2.6.1 Rental Costs	Header deleted. Text incorporated into Durable Medical Equipment and Supplies.	12/30/2019	W Deseron K Duke
12.13	1.2.3.2 Medical Equipment and Supplies	Renamed Durable Medical Equipment and Supplies. Subsection moved under Covered Services and Limitations: Home Health Services.	12/30/2019	W Deseron K Duke
12.12	2.2.4 Limits	Section deleted. Text incorporated into Covered Services and Limitations: Home Health Services.	12/30/2019	W Deseron K Duke
12.11	1.2.3.1 Evaluation Visit	Subsection moved under Covered Services and Limitations: Home Health Services.	12/30/2019	W Deseron K Duke
12.10	2.2.3 Advanced Directives	Section deleted. Text incorporated into Advanced Care Planning (ACP).	12/30/2019	W Deseron K Duke
12.9	2.2.2 Program Abuse	Section deleted. Redundancy.	12/30/2019	W Deseron K Duke
12.8	1.2.3. Covered Services and Limitations: Home Health Services	New section. Incorporated previous section Limits. Added text from Participant Eligibility.	12/30/2019	W Deseron K Duke
12.7	1.2.2 Participant Eligibility	Renamed Eligible Participants. Clarified homebound not required. Some text moved to Covered Services and Limitations: Home Health Services.	12/30/2019	W Deseron K Duke
12.6	1.2.1 Provider Qualifications	New section.	12/30/2019	W Deseron K Duke
12.5	1.2. Home Health Service Policy	Renamed Home Health Services.	12/30/2019	W Deseron K Duke
12.4	1.1 Advanced Care Planning (ACP)	New section incorporating previous Advanced Directives and Advance	12/30/2019	W Deseron K Duke

Version	Section	Modification Description	Publish Date	SME
		Directives/Physician Orders for Scope of Treatment (POST).		
12.3	2.1 Introduction	Header deleted.	12/30/2019	W Deseron K Duke
12.2	1. Home Health and Hospice Services	Added reference to other applicable handbooks.	12/30/2019	W Deseron K Duke
12.1	All	Handbook renamed from Agency – Institutional to Home Health and Hospice	12/30/2019	W Deseron K Duke
12.0	All	Published version	11/1/2018	TQD
11.1	All	Removed Molina references	11/1/2018	D Baker E Garibovic
11.0	All	Published version	6/21/2018	TQD
10.2	2.2.4.1 Prior Authorization	Updated PA requirements	6/21/2018	D Baker E Garibovic W Deseron
10.1	2.2.2 Participant Eligibility	Deleted outdated line	6/21/2018	D Baker E Garibovic W Deseron
10.0	All	Published version	4/20/2017	TQD
9.1	2.2.4.2 Healthy Connections (HC) Referral	Removed section	4/20/2017	C Brock D Baker E Garibovic