Hospice 101

"Working to protect, preserve and promote the health and safety of the people of Michigan by listening, communicating and educating our providers, in order to effectively resolve issues and enable providers to find solutions within our industry. We are committed to establishing customer trust and value by providing a quality experience the first time, every time."

-Provider Relations

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- Introduction to Hospice
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Introduction to Hospice

and How it Works

Michigan Medicaid Provider Manual >> Hospice Chapter

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Introduction to Hospice

- Hospice is a health care program designed to meet the needs of terminally ill individuals when the individual decides that the physical and emotional toll of curative treatment is no longer in their best interest.
  - These individuals choose palliative care, which is not a cure, but ensures comfort, dignity, and quality of life.
  - Hospice is intended to address the full range of needs for the individual with a terminal illness while also considering family needs.
  - Care must be consistent with the individual's values regardless of the location where care is provided.
- The primary objective of the Medicaid Hospice Program is to ensure that essential medical and health services are available to those who would not otherwise have the financial resources to purchase them.
  - Hospice providers must verify eligibility before providing services.
  - Hospice beneficiaries are identified in CHAMPS 270/271 eligibility response with the Benefit Plan ID of Hospice.

How it Works

Concurrent Hospice and Curative Care of Children under 21

- Medicaid will reimburse for the curative care separately from the hospice services. Medicaid will not reimburse for these types of treatments when they are used palliatively.
- Palliative care is always a part of hospice and included in the hospice per diem reimbursement; therefore, cannot be billed separately or reimbursed by Medicaid.
    - Palliative care is defined as an active patient and family–centered approach to pain and symptom management of the terminal illness.
    - Where as, curative care is defined as medically necessary care that serves to eliminate the symptoms of a disease with the goal of long-term disease-free state.
- For further instructions on concurrent hospice and curative care for children under 21 reference the Hospice Chapter, Section 6.8 of the Michigan Medicaid Provider Manual.

How it Works

- Medicaid follows Medicare's hospice guidelines as outlined in the Medicare Conditions of Participation (42 CFR § 418).

Medicare Conditions of Participation for Hospice

- The duration of hospice coverage is measured in election periods, also known as benefit periods. A beneficiary may elect to receive hospice care during one or more of the following election periods:
  - An initial 90-day period;
  - A subsequent 90-day period; or
  - An unlimited number of subsequent 60-day periods
- A hospice must obtain written certification of the terminal illness for each election period before a claim for services is submitted.
  - If the hospice is unable to obtain a written certification within three days of initiation of hospice care, a verbal certification must be obtained, documented, and signed by the person receiving the certification.

How it Works

- The hospice must provide all or substantially all of the core services applicable for the terminal illness in the beneficiary's home.

Core Hospice Services

- Home may include the beneficiary's private dwelling , apartment, boarding home, assisted living facility, Adult Foster Care (AFC) facility, Home For the Aged (HFA), Nursing Facility (NF) or hospice-owned NF and hospital inpatient care.
- Reference Section 6.2 (Other Hospice Covered Services) of the Michigan Medicaid Provider Manual for other services that may be necessary and be available but are not considered core services.

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How it Works

Transportation Service

- Home Setting
  - Non-emergency and emergency transportation related to the terminal illness is the responsibility of the hospice provider.
  - Non-emergency transportation not related to the terminal illness is available through the local MDHHS office.
- Nursing Facility Setting
  - Non-emergency and emergency transportation related to the terminal illness is the responsibility of the hospice provider.
  - Non-emergency transportation not related to the terminal illness must be provided by the nursing facility as part of their per diem.

How it Works

Categories of Care

Routine Home Care	Continuous Home Care	Inpatient Respite Care	General Inpatient Care
Home care that is not continuous.	In home care where at least half of the hours are nursing care (minimum of 8 hours).	Short term care to relieve the primary caregiver.	Care provided to treat symptoms that can no longer be adequately treated under the routine hospice care benefit.

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How it Works

Coordination of Care

- Plan of Care (POC):
  - It is the responsibility of the hospice to develop the POC for hospice services.
  - If another active program is identified, the hospice provider must contact the other program(s) and develop a joint POC to coordinate services.
- Some examples of places and programs that could potentially be providing duplicative services are but not limited to:
  - Adult Foster Care/Home For the Aged
  - Assisted Living Facility
  - Nursing Facility
  - MI Choice Waiver
  - Private Duty Nursing

Provider Requirements

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Provider Requirements

- Hospice providers are bound to federal and state rules, regulations, and policies.
  - The Michigan Medicaid Provider Manual, Hospice Chapter provides state specific guidance for providers.
  - Michigan Medicaid requires hospice agencies to be licensed by the Department of Licensing and Regulatory Affairs (LARA), which requires certification by Medicare, and enrollment in Medicaid.
  - Medicaid-enrolled hospice providers must also comply with the Medicare Conditions of Participation (42 CFR § 418).

Beneficiary Admission and Discharge

and the CHAMPS Process

Michigan Medicaid Provider Manual

Hospice Chapter

Section 3 - Beneficiary Admission

Section 4 - Beneficiary Discharge

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Beneficiary Admission and Discharge: CHAMPS

- Hospice Providers are responsible for admitting and discharging beneficiaries for hospice services in the Admissions section in CHAMPS.
- Timely completion of the beneficiary's admission or discharge will result in real time changes to the beneficiaries Program Enrollment Type (PET) and Benefit Plan assignment.
  - The PET and Benefit Plan assignment are required for correct payment.

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Beneficiary Admission

- A terminally ill Medicaid beneficiary who lives in a hospice service area and whose life expectancy is six months or less (if the illness runs its normal course), as determined by a licensed physician and the Hospice Medical Director, may receive hospice services.
- Medicaid does not cover Hospice services if the following conditions exist:
  - The individual is not eligible for the Medicaid benefit.
  - The beneficiary does not meet the hospice admissions criteria.
- Hospice providers are responsible for admitting beneficiaries for hospice services.
  - The admission process must be electronically completed in CHAMPS.
  - For further details reference Modernizing Continuum of Care (MCC) webpage.
- When completing a hospice admission in CHAMPS, hospice providers must select the beneficiary's place of service for where the services are to be provided.
  - Beneficiary's Home
  - Nursing Facility
  - Hospice Residence

Beneficiary Admission

Duration of Coverage

- There is no minimum period of hospice admission.
- A change in the beneficiary's prognosis could eliminate the need for hospice care.
- A beneficiary may cancel their admission in hospice at any time and without cause.

Beneficiary Discharge

A beneficiary may be discharged from hospice as noted below:

- Beneficiary elects voluntary discharge
- Beneficiary revokes their election due to hospitalization
- Beneficiary no longer meets criteria
- Beneficiary becomes ineligible for Medicaid
- Beneficiary moves outside the service area
- Hospice is revoked due to violation (i.e., fraud, abuse, misconduct)
- Death

- The provider must complete the Discharge screen in CHAMPS.
  - Ensure an accurate roster
  - Ensure beneficiary has the correct PET and Benefit Plan assigned
  - Ensure correct payment

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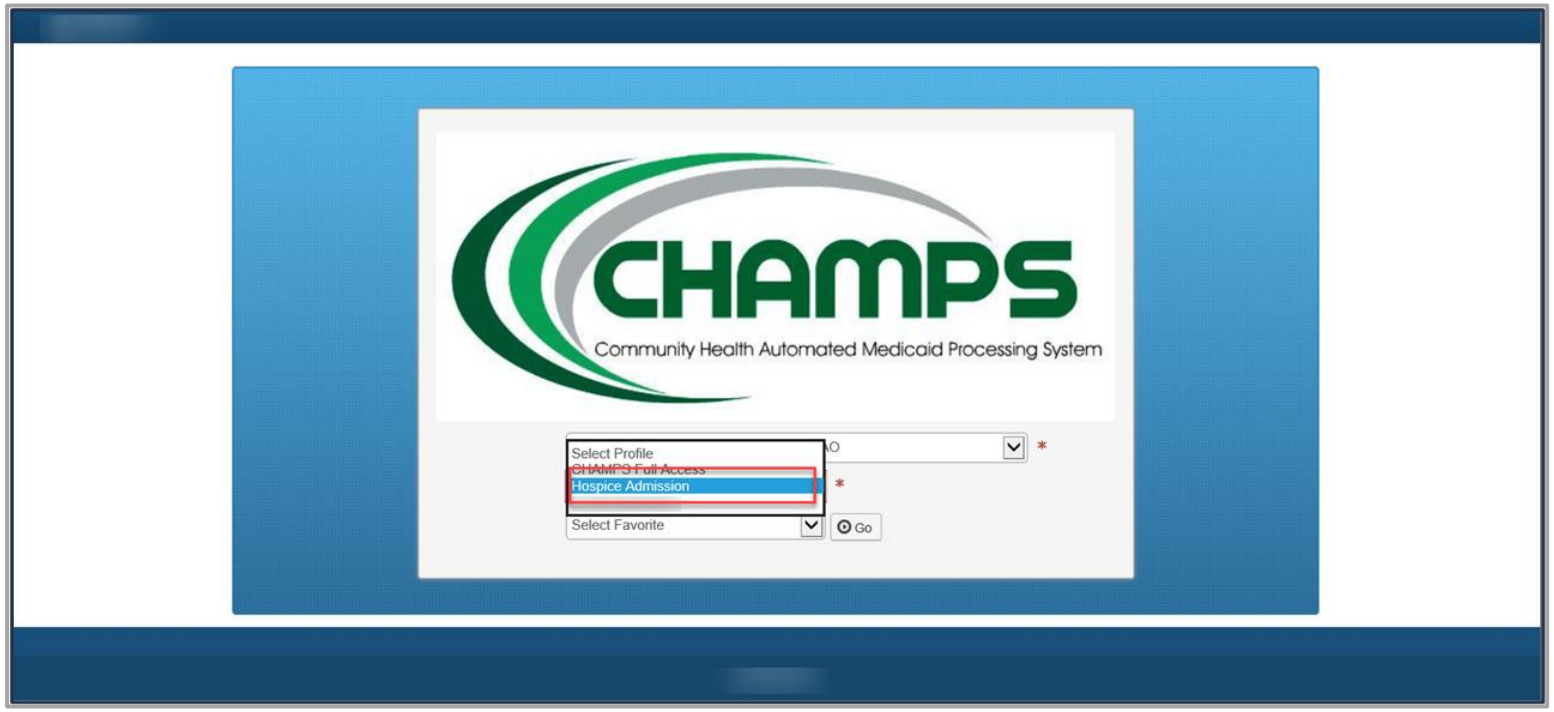
Beneficiary Admission and Discharge

- CHAMPS Process Resources
  - Quick Reference Access
  - Webinar
  - Presentation
- To start the process,
  - Access MILogin - https://milogintp.michigan.gov



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Billing and Reimbursement:

Claim Completion

Michigan Medicaid Provider Manual

Billing and Reimbursement for Institutional Providers Chapter

Hospice – Section 11

The following contains information that should be used in conjunction with National Uniform Billing Committee (NUBC) manual when preparing Hospice claims.

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Billing and Reimbursement: Claim Completion

- Common billed Revenue codes
  - 0651 – Routine Home Care
  - 0658 – Other Hospice (Room and Board)
  - 0551 – Skilled Nurse Visit
    - With HCPCS G0299 – Registered Nurse
  - 0561 – Social Worker
    - With HCPCS G0155 – Social Worker
- For a complete list of payable hospice revenue codes reference, Revenue Code Table.
- For more information when completing a claim reference, Billing & Reimbursement for Institutional Providers Chapter, Section 11.1 – Billing Instructions for Hospice Claim Completion.

Billing and Reimbursement: Claim Completion

- Billing for 0651 – Routine Home Care
  - Reimbursed in two–tier rate:
    - Higher rate for the first 60 days
    - Decreased rate for days 61 and beyond
    - Providers should bill in sequential order to receive correct tier reimbursement
  - Hospice day is counted when any level of hospice care is provided. If a beneficiary is discharged from hospice (not due to death) and returns to hospice within 60 days, the count will resume from the point the beneficiary left hospice. If beneficiary is discharged (not due to death) and returns after more than 60 days have elapsed, the count will reset to day one . The hospice days do not reset if beneficiary transfers to a different hospice provider.

Billing and Reimbursement: Claim Completion

- Billing for 0658 – Other Hospice (Room and Board)
  - Hospice providers are paid 95% of the Nursing Facility per diem.
  - Room and board is reimbursable on the day of discharge
    - If the discharge is due to resident death
    - If the resident is discharged from hospice but remains in the NF

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Billing and Reimbursement: Claim Completion

- Billing for 0551 – Skilled Nurse Visit or 0561 – Social Worker
  - In order to be considered for the Service Intensity Add-On (SIA) rate the following billing requirements must be met:
    - Minimum of 15 minutes but not more than four hours daily during the last 7 days of beneficiary's life when the beneficiary is receiving routine home care.
    - Occurrence Code 55 with the date of death
    - Discharge status of 20 death
    - Allowable codes:
      - Registered Nurse 0551 / G0299
      - Social Worker 0561 / G0155

Top Claim Denials

- CARC – 16 / RARC -N322
  - Hospice certification date missing
- CARC - B9
  - Certification date not in sequential order
- CARC – 16 / RARC - N65
  - Unable to determine rate when billing 0651
- CARC – 16 / RARC - N65
  - Unable to determine rate when billing 0658
- CARC – 16 / RARC - N330
  - Service intensity missing or incomplete

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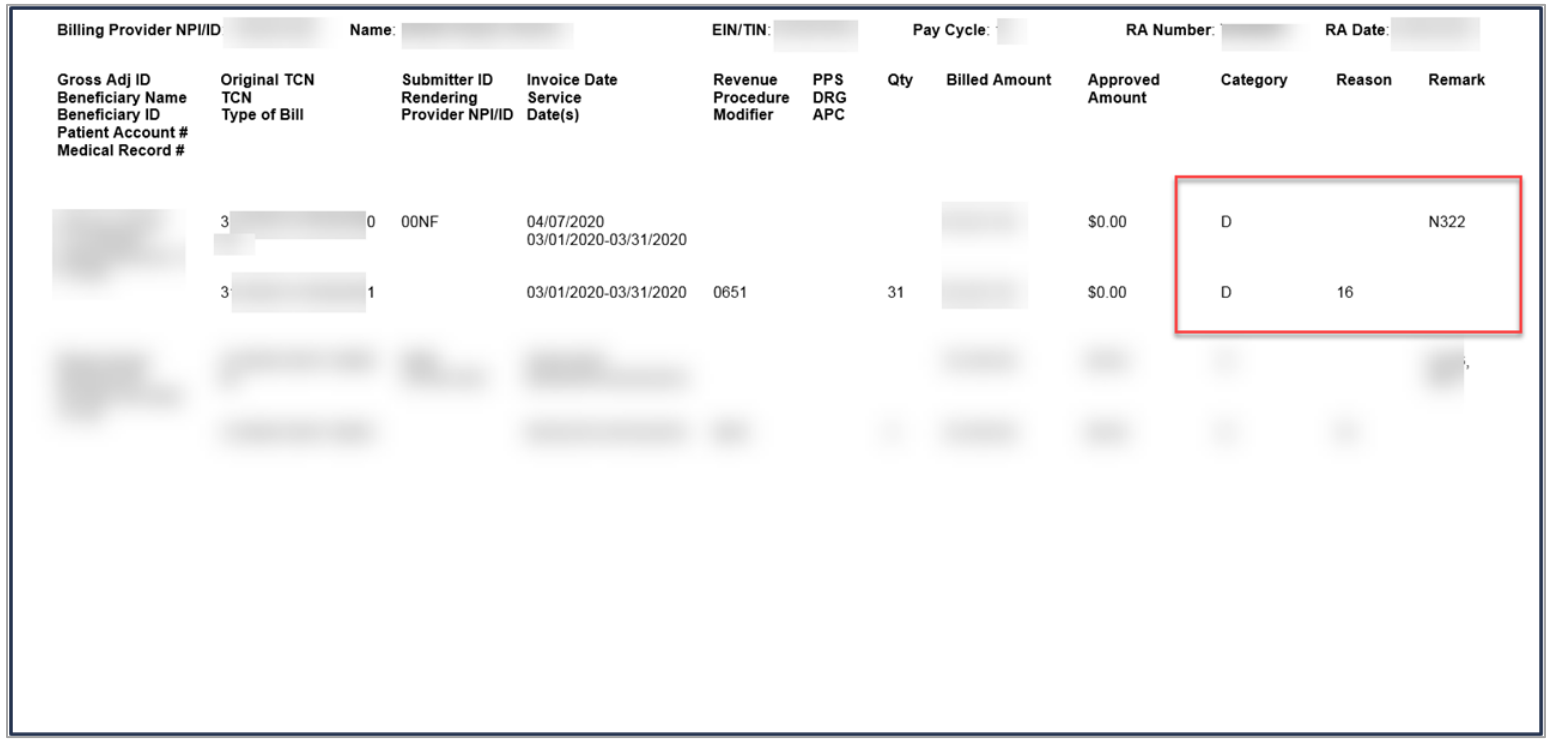
Top Claim Denials: 16/N322

- Claim Service lacks information/Missing Incomplete Invalid Last certification date
- Hospice Certification date missing or invalid
- **Admission Date:** The Certification (start) date must be reported on every hospice claim with Occurrence Code 27 and the applicable date.

- Additional Resources:
  - Retrieving Medicaid Paper RA and RA Explanation - My Inbox webpage



Billing Provider NPI/ID: [redacted] Name: [redacted] EIN/TIN: [redacted] Pay Cycle: [redacted] RA Number: [redacted] RA Date: [redacted]

Gross Adj ID / Beneficiary Name / Beneficiary ID / Patient Account # / Medical Record #	Original TCN / TCN / Type of Bill	Submitter ID / Rendering Provider NPI/ID	Invoice Date / Service Date(s)	Revenue / Procedure / Modifier	PPS / DRG / APC	Qty	Billed Amount	Approved Amount	Category	Reason	Remark
[redacted]	3[redacted]0	00NF	04/07/2020 03/01/2020-03/31/2020				[redacted]	$0.00	D		N322
	3[redacted]1		03/01/2020-03/31/2020	0651		31	[redacted]	$0.00	D	16	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

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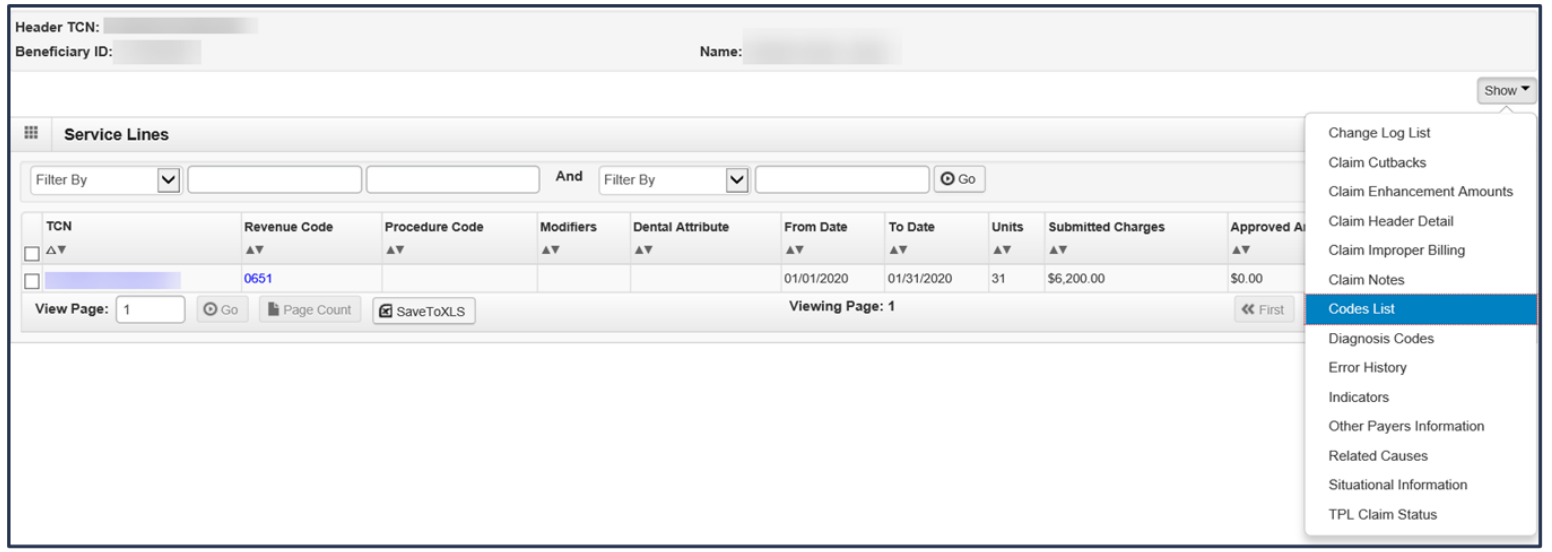
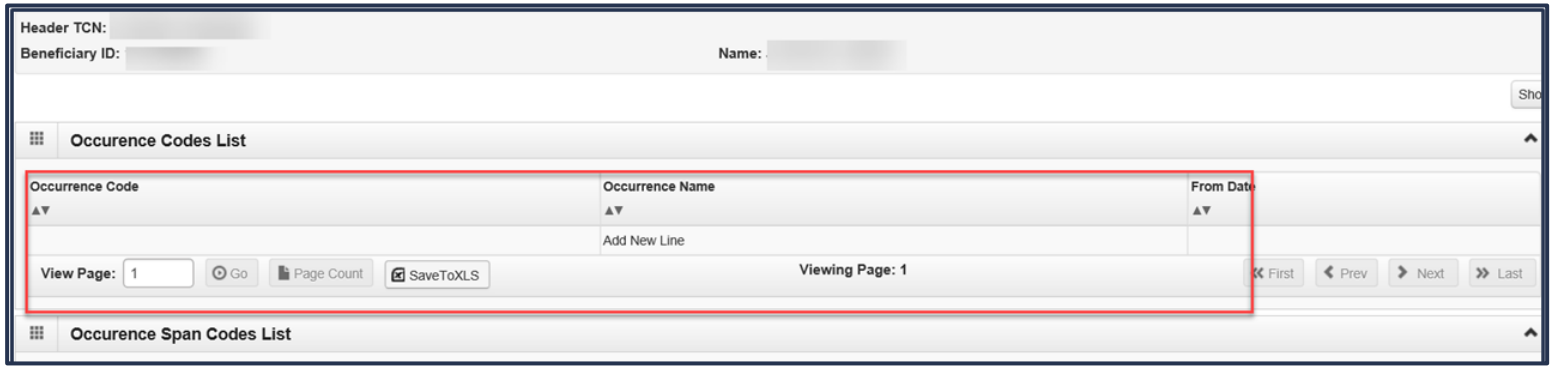
Top Claim Denials

- Pull up the TCN in CHAMPS under Claim Inquiry
- Go into the claim service line
- Click the show drop-down
- Select Codes List
- Occurrence code 27 is missing and is required with an applicable date.

- Additional Resources
  - Claim Inquiry - [CHAMPS Claims and Encounter webpage]





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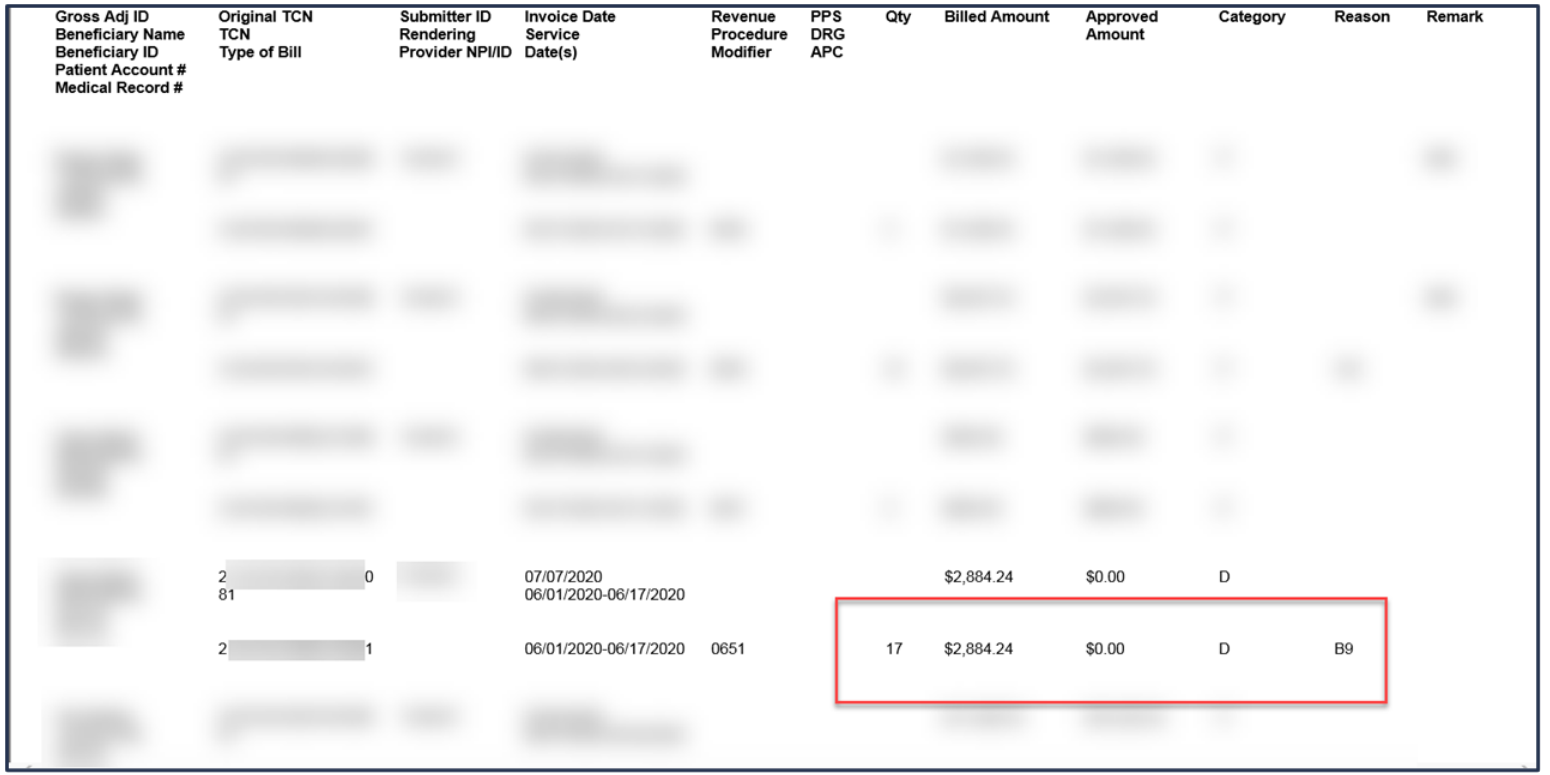
Top Claim Denials: B9

- Patient is Enrolled in a Hospice
- Hospice Cert date prior to initial cert date
- **Admission Date:** The Certification (start) date must be reported on every hospice claim with Occurrence Code 27 and the applicable date.

- Additional Resources:
  - Retrieving Medicaid Paper RA and RA Explanation - My Inbox webpage



Gross Adj ID Beneficiary Name Beneficiary ID Patient Account # Medical Record #	Original TCN TCN Type of Bill	Submitter ID Rendering Provider NPI/ID	Invoice Date Service Date(s)	Revenue Procedure Modifier	PPS DRG APC	Qty	Billed Amount	Approved Amount	Category	Reason	Remark
[redacted]											
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[redacted]	2 [redacted] 0 81	[redacted]	07/07/2020 06/01/2020-06/17/2020				$2,884.24	$0.00	D		
	2 [redacted] 1		06/01/2020-06/17/2020	0651		17	$2,884.24	$0.00	D	B9	
[redacted]											

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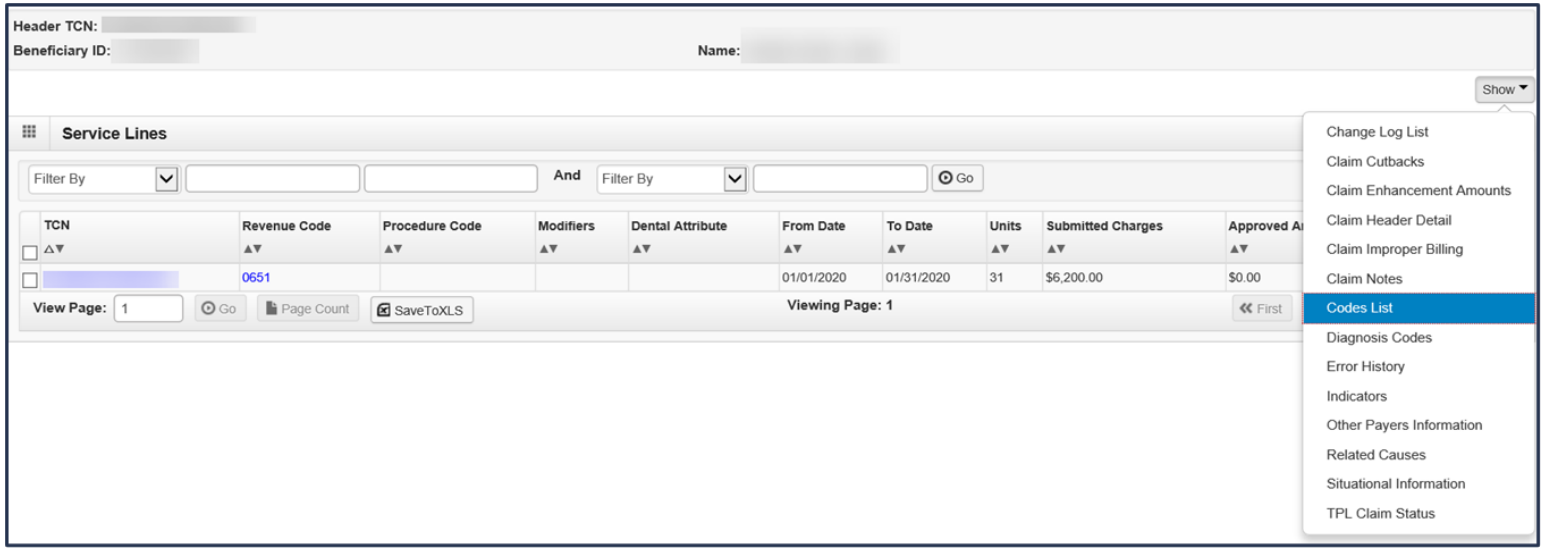
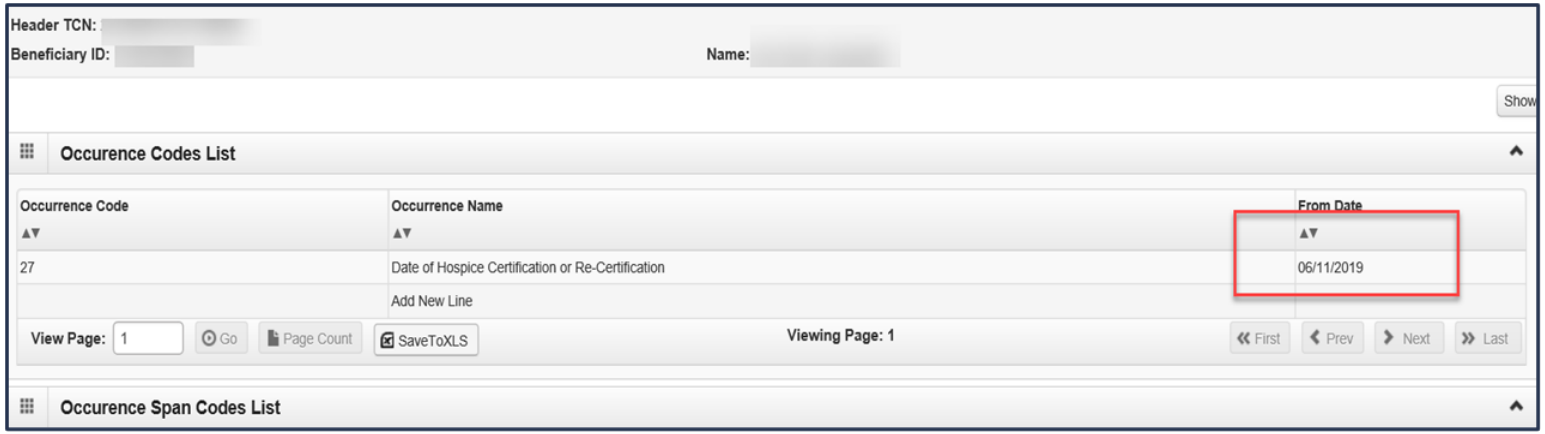
Top Claim Denials

- Pull up the TCN in CHAMPS under Claim Inquiry
- Go into the claim service line
- Click the show drop-down
- Select Codes List
- This is where the certification date is reported.
- Its important to make sure the hospice claims are billed in sequential order to avoid this denial.

- Additional Resources
  - Claim Inquiry - CHAMPS Claims and Encounter webpage





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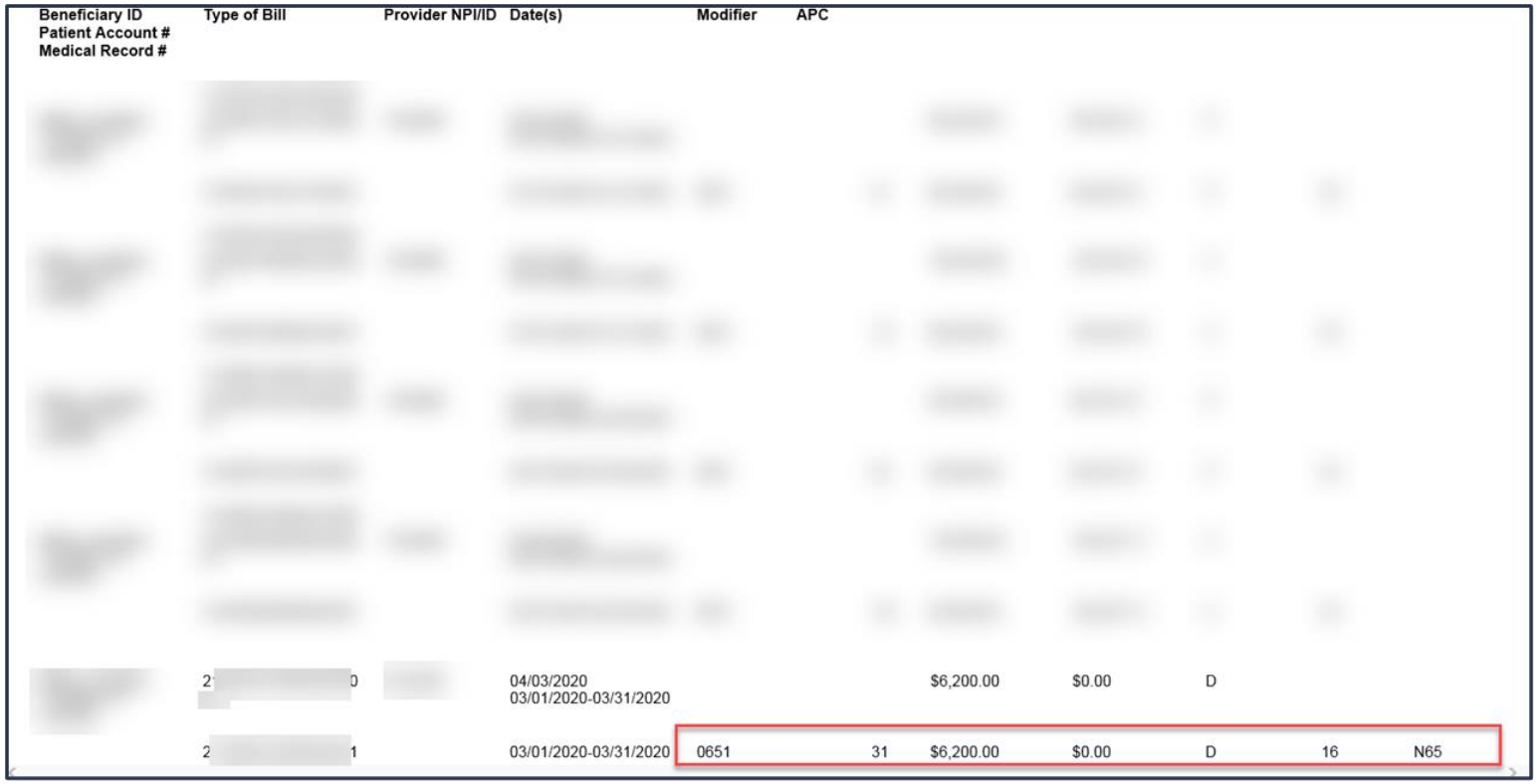
Top Claim Denials: 16/N65

- Claim/service lacks information/Procedure rate count cannot be determined
- Unable to determine rate when billing 0651
- Value code 61 with applicable CBSA code is required on every hospice claim

- Additional Resources:
  - Retrieving Medicaid Paper RA and RA Explanation - My Inbox webpage



Beneficiary ID / Patient Account # / Medical Record #	Type of Bill	Provider NPI/ID	Date(s)	Modifier	APC					
[redacted]										
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[redacted]	2[redacted]0	[redacted]	04/03/2020 03/01/2020-03/31/2020			$6,200.00	$0.00	D		
	2[redacted]1		03/01/2020-03/31/2020	0651	31	$6,200.00	$0.00	D	16	N65

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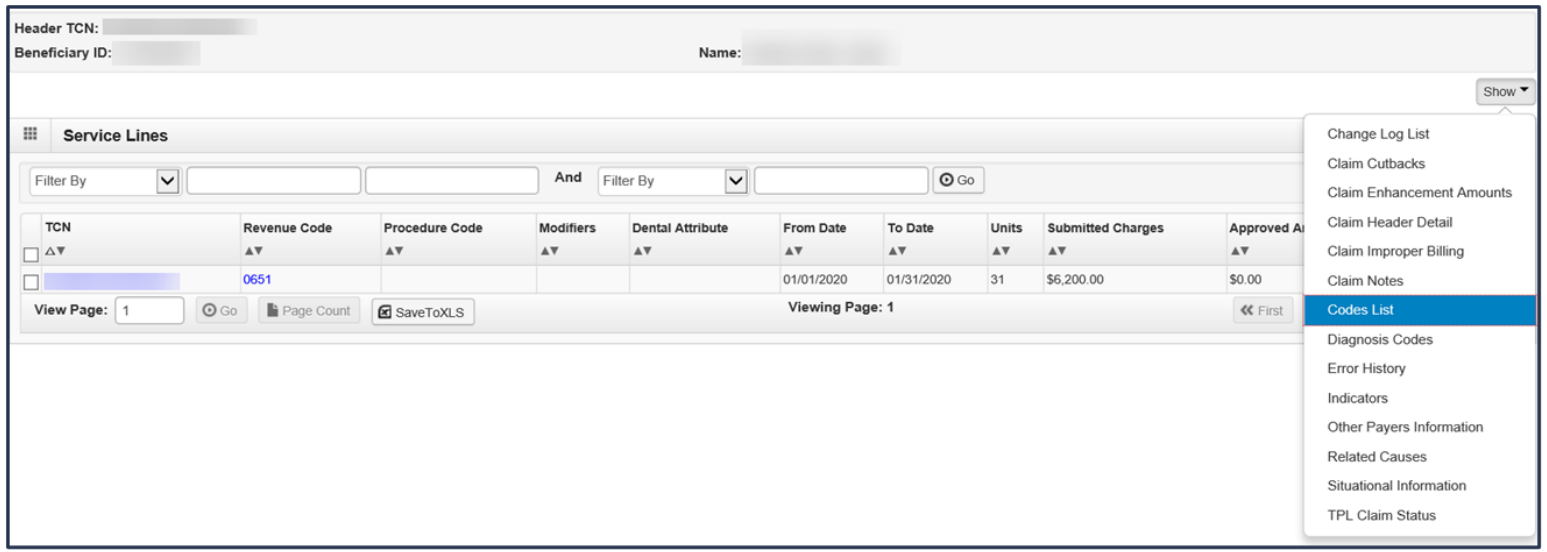
Top Claim Denials

- Pull up the TCN in CHAMPS under Claim Inquiry
- Go into the claim service line
- Click the show drop-down
- Select Codes List

- Additional Resources
  - Claim Inquiry - [CHAMPS Claims and Encounter webpage]



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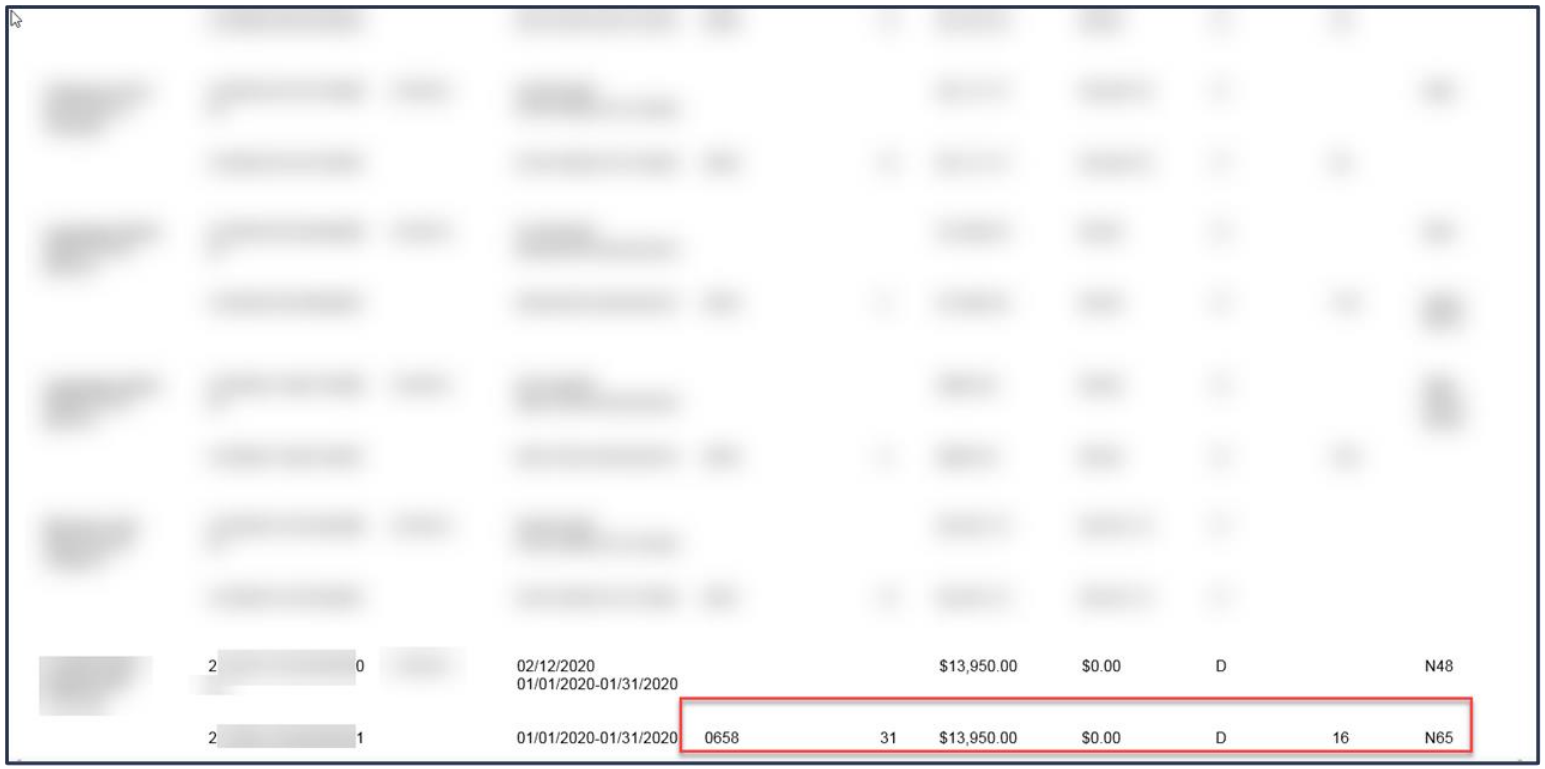
Top Claim Denials: 16/N65

- Claim/service lacks information/Procedure rate count cannot be determined
- Unable to determine rate when billing 0658
- **Room and Board (0658):** Hospice services are payable for room and board in a Nursing Facility.

- Additional Resources:
  - Retrieving Medicaid Paper RA and RA Explanation - My Inbox webpage



2	0	02/12/2020 01/01/2020-01/31/2020			$13,950.00	$0.00	D	N48
2	1	01/01/2020-01/31/2020	0658	31	$13,950.00	$0.00	D	16	N65

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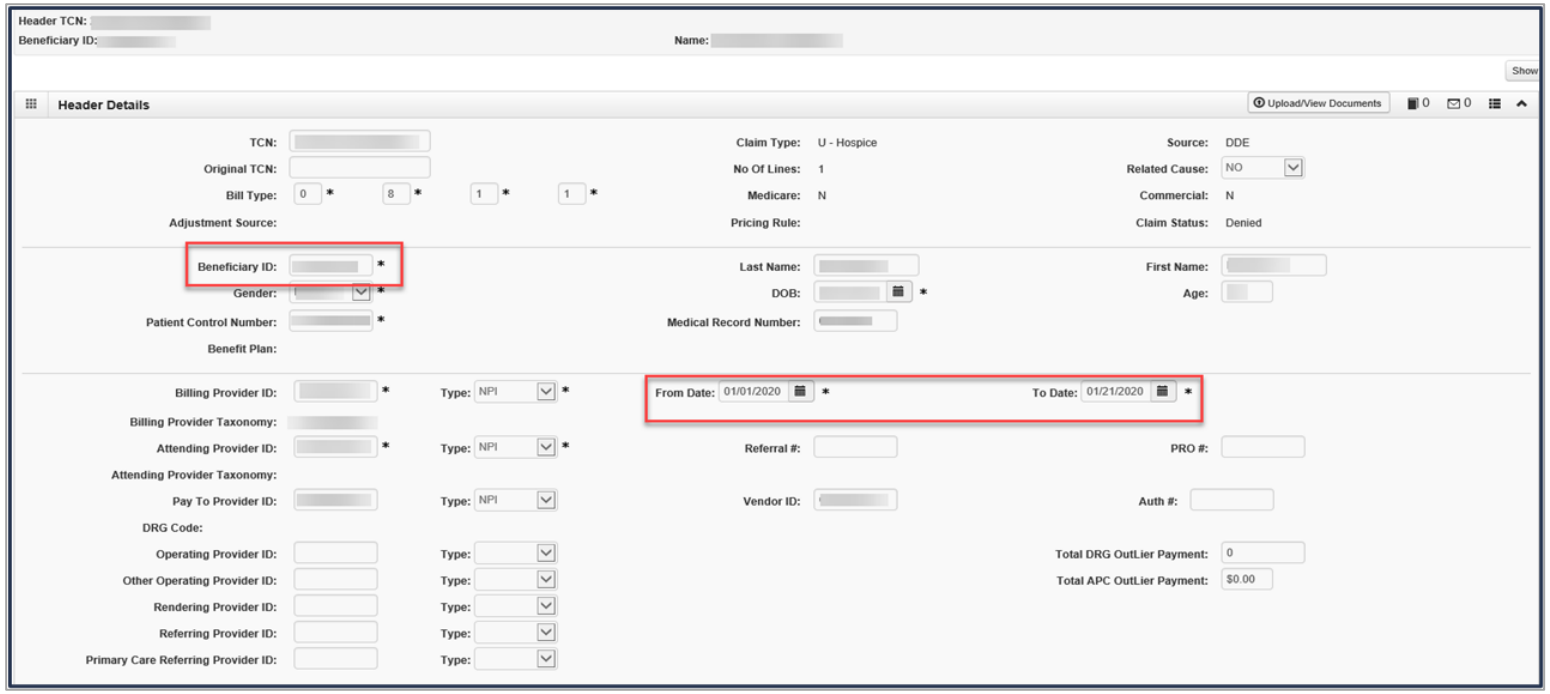
Top Claim Denials

- Pull up the TCN in CHAMPS under Claim Inquiry
- Verify the beneficiary ID and claim From and To date



- Additional Resources
  - Claim Inquiry - [CHAMPS Claims and Encounter webpage]

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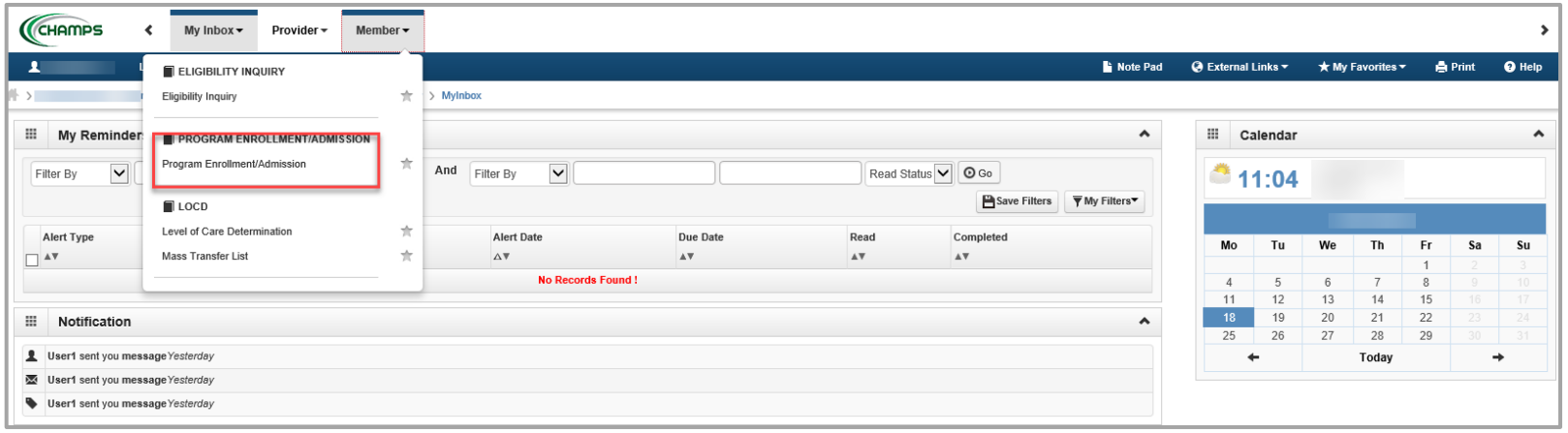
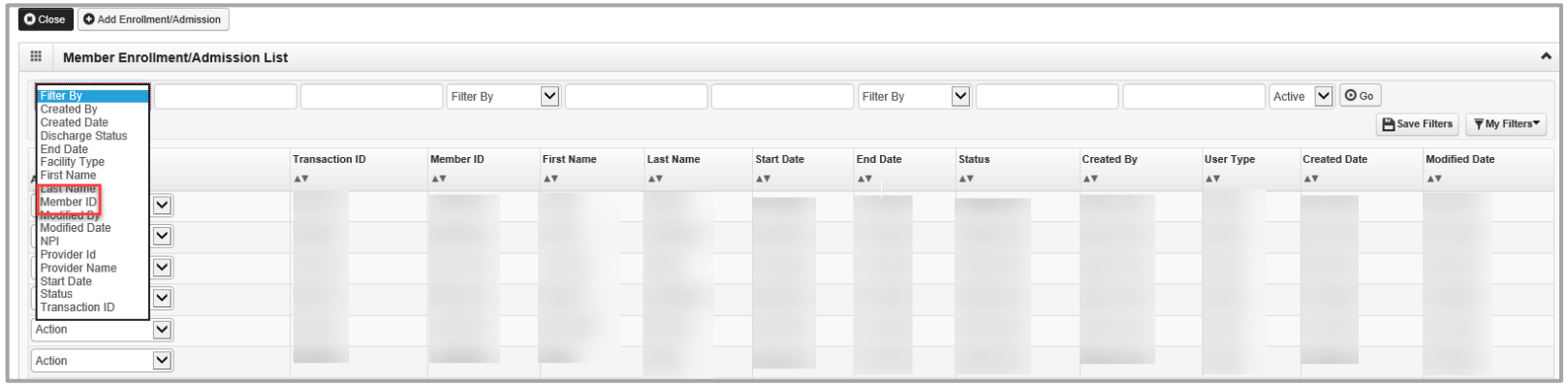
Top Claim Denials

- Take the Bene ID and verify their admission/enrollment under the member tab. To do this:
  - Exit out of claim
  - Select Member Tab to look up Admission Record by selecting Program Enrollment/Admission
  - The Member Enrollment/Admission List will display
  - Select Member ID
  - Enter beneficiary ID number
  - Find the applicable Admission record





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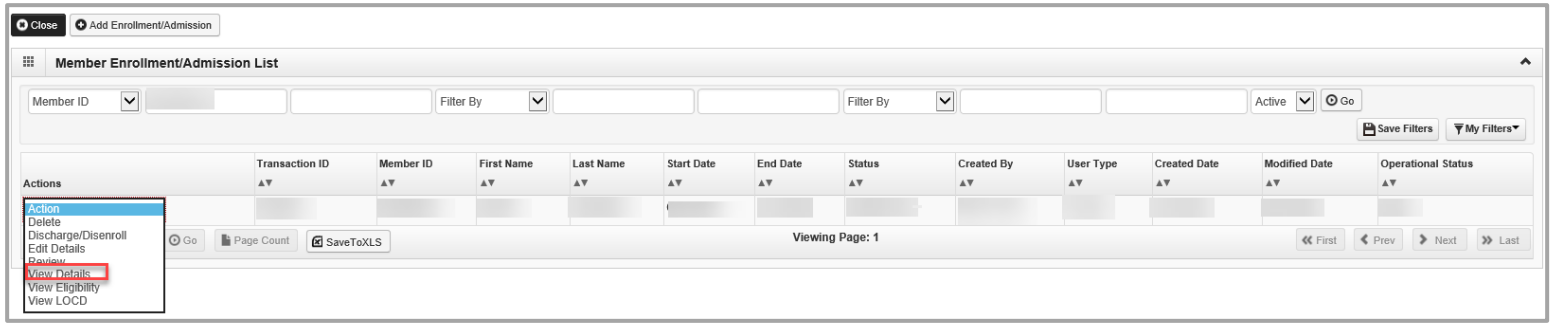
Top Claim Denials

- Once the Admission record is located, select the View Details from the Action drop-down.



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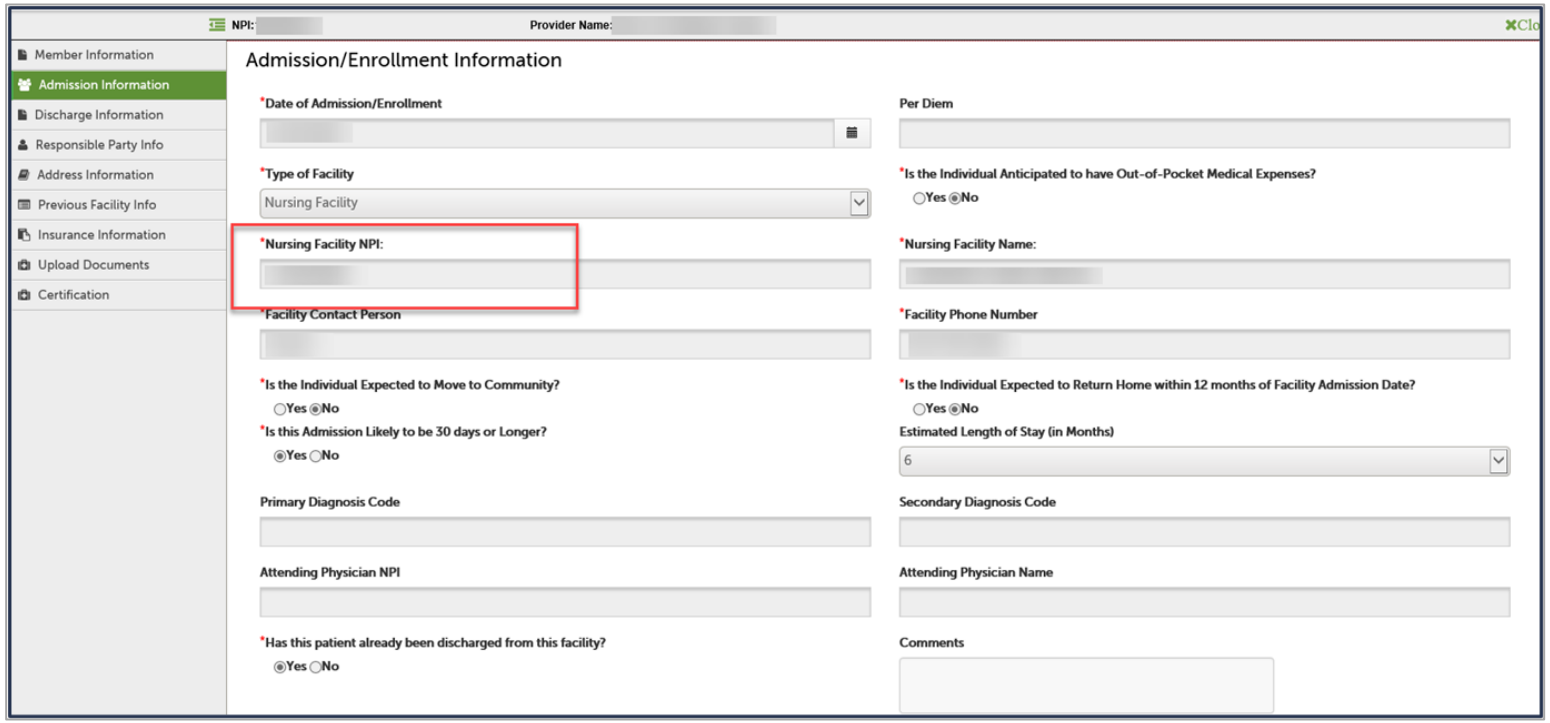
Top Claim Denials

- The Admission/Enrollment Information page will display with the nursing facility NPI reported
- Validate the nursing facility NPI



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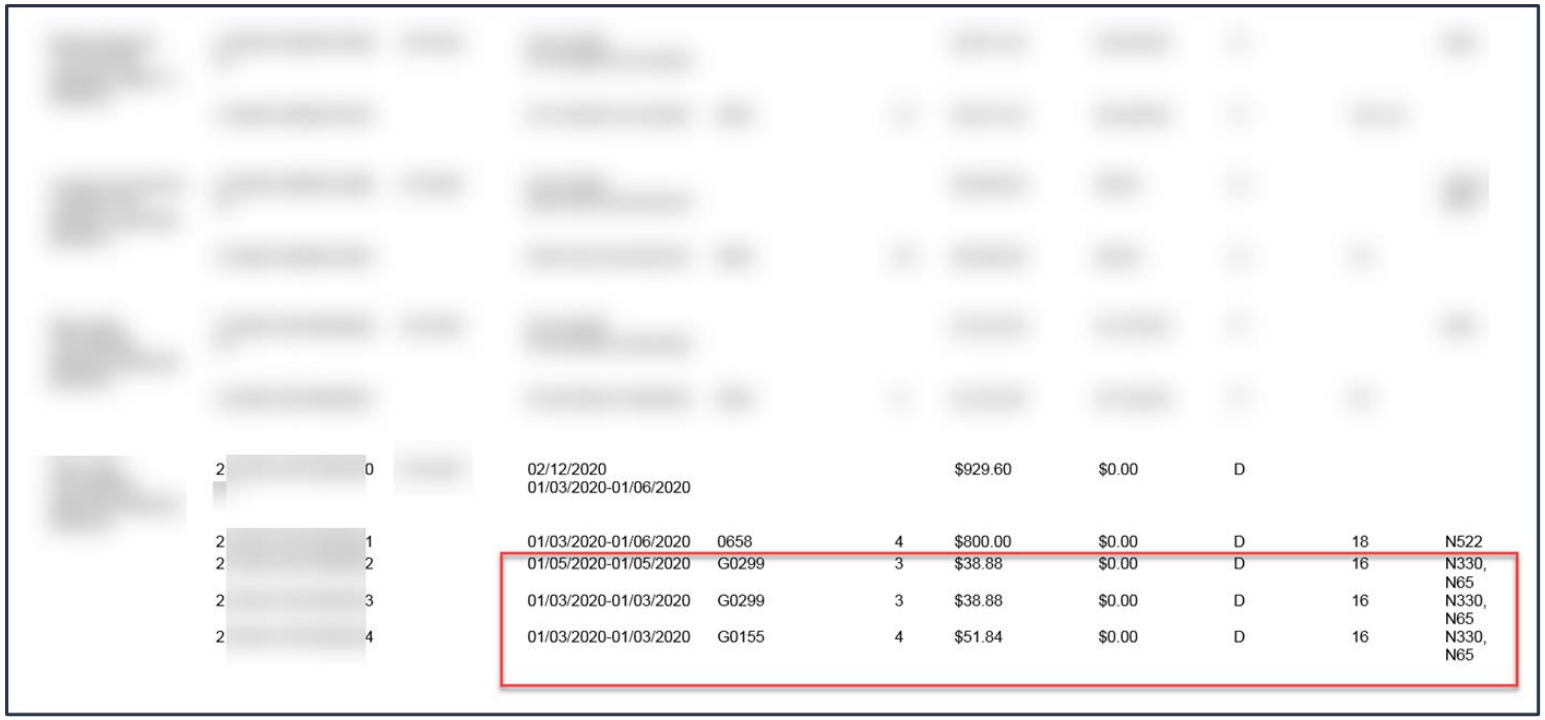
Top Claim Denials

- 16/N330 Claim lacks information /Missing incomplete/invalid patient death date
- Hospice Add on Payment Denied for missing/mismatch information
- **Service Intensity Add On:** Payable during the beneficiary's last seven days of life.

- Additional Resources:
  - Retrieving Medicaid Paper RA and RA Explanation - My Inbox webpage



2	[redacted]	0		02/12/2020 01/03/2020-01/06/2020			$929.60	$0.00	D	
2	[redacted]	1		01/03/2020-01/06/2020	0658	4	$800.00	$0.00	D	18	N522
2	[redacted]	2		01/05/2020-01/05/2020	G0299	3	$38.88	$0.00	D	16	N330, N65
2	[redacted]	3		01/03/2020-01/03/2020	G0299	3	$38.88	$0.00	D	16	N330, N65
2	[redacted]	4		01/03/2020-01/03/2020	G0155	4	$51.84	$0.00	D	16	N330, N65

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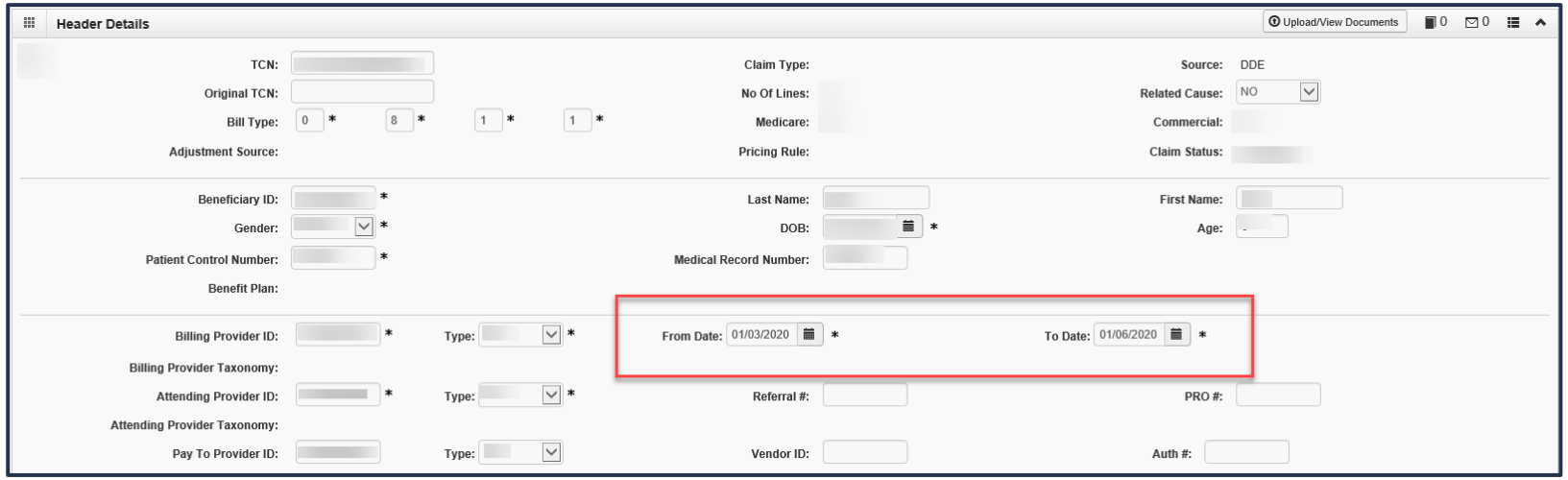
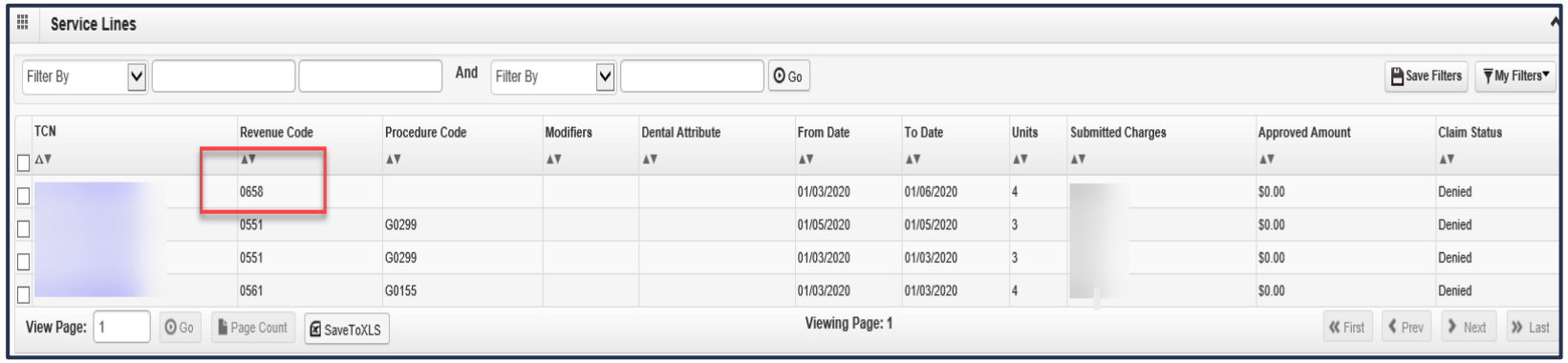
Top Claim Denials

- Pull up the TCN in CHAMPS under Claim Inquiry
- Go into the claim service line
- Verify that 0651 - routine home care was billed in conjunction with the 0551 – Skilled Nurse Visit or 0561 – Social Worker

- Additional Resources
  - Claim Inquiry - CHAMPS Claims and Encounter webpage





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Summary

- General Overview
  - Hospice is a health care program designed to meet the needs of terminally ill individuals. Michigan's Medicaid Program goal is to ensure these essential medical and health services are available to individuals who would not otherwise have the financial resources to receive them.
- State and Federal Regulations
  - Hospice providers must follow regulatory guidelines and policies as set forth by Medicare, Medicaid, and LARA.
- Beneficiary Admissions and Discharges
  - Admissions and Discharges must be completed in a timely manor to allow for real time PET and Benefit Plan assignment to support claim payment.

Summary

- Billing and Reimbursement
  - Revenue codes are required for claim submission.
  - For a complete list of revenue codes visit Revenue Code Table.
- Top Claim Denials
  - 16/N322 Hospice certification date missing or invalid
  - B9 Certification date prior to initial certification date
  - 16/N65 Unable to determine rate
  - 16/N330 Hospice Add on payment denied for missing information

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Provider Resources

MDHHS website:
www.michigan.gov/medicaidproviders

We continue to update our Provider Resources:

- CHAMPS Resources
- Listserv Instructions
- Medicaid Provider Training Sessions
- Provider Alerts
- Provider Enrollment Website

Provider Support:

ProviderSupport@Michigan.gov

1-800-292-2550

Thank you for participating in the Michigan Medicaid Program