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200.000 HOSPICE GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Hospice Providers

201.100 Enrollment Criteria

1-1-19

Hospice Services providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

- A. The hospice provider must be certified as a Title XVIII (Medicare) hospice provider. The provider must submit a copy of the Medicare certification to Provider Enrollment when submitting the Hospice Program application and contract.
- B. The hospice provider must be licensed by the Division of Health Facility Services, Arkansas Department of Health. The provider must submit a copy of their current license.
- C. All Medicaid-enrolled hospice providers that employ or contract physicians to provide direct patient care to Medicaid-eligible hospice patients must be enrolled as hospice physician billing intermediaries in order to bill Medicaid for hospice physician. See Section 240.200 for additional information regarding this requirement.
- D. The following individuals employed or contracted with a hospice provider must comply with criminal background checks as required by law currently codified at Arkansas Code Annotated 20-33-213 and 20-38-101 et seq.:
 1. Owners;
 2. Principals;
 3. Operators;
 4. Employees; and
 5. Applicants (prior to the extension of a job offer).

201.110 Hospice Inpatient Facilities 11-1-06

- A. Providers of short-term inpatient care for hospice patients must be certified by the Division of Health Facility Services, Arkansas Division of Health, as hospice inpatient facilities.
 - 1. The patient's designated hospice provider pays the provider of short-term inpatient services and bills Medicaid for reimbursement.
 - 2. Hospices that have arrangements with certified hospice inpatient facilities must maintain documentation of each such facility's current certification status.
- B. Acute care hospitals enrolled in the Arkansas Medicaid Program may provide short-term inpatient care under arrangements with hospice providers. Medicaid requires no additional licensing or certification.
- C. Hospices may make arrangements for inpatient respite care with skilled nursing facilities that meet the standards at 42 CFR, 418.100, (a) and (e). Hospices making such arrangements must maintain documented assurances that the facilities meet the referenced standards.

201.200 Routine Services Providers 9-1-14

Only hospice providers licensed in the State of Arkansas may enroll as routine services providers.

- A. Routine services providers may enroll in the program as regular providers of routine services.
- B. Reimbursement may be available for hospice services covered in the Arkansas Medicaid Program.
- C. Claims must be filed according to the specifications in this manual. This includes using the HCPCS procedure codes Arkansas Medicaid has assigned to the Hospice Program, and using ICD diagnosis codes in accordance with the guidelines and regulations in this manual and in the ICD manual.

201.300 Hospice Providers in Other States 3-1-11

Providers in other states who are not licensed in Arkansas may be enrolled in the Arkansas Medicaid Hospice Program as limited services providers, and the services they provide must be prior authorized.

To enroll, providers must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application and contract to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and Medicaid contract. [View or print the provider enrollment and contract package \(Application Packet\).](#) [View or print Provider Enrollment Unit Contact information.](#)

Out-of-state providers must also submit a written request for prior authorization accompanied by copies of the provider's license and Medicare certification, the beneficiary's identifying information, and the beneficiary's service plan to the Utilization Review Section. [View or print the Arkansas Division of Medical Services Utilization Review Section contact information.](#)

Limited services provider claims will be manually reviewed prior to processing to ensure that only prior authorized services are approved for payment. Claims should be mailed to the Division of Medical Services, Program Communications Unit. [View or print Program Communications Unit Contact Information.](#)

201.400 Physician Services in the Hospice Program

10-13-03

In accordance with Public Law (PL) 105-33 hospices may employ or contract physicians. Physicians may donate services to hospice patients as well. For the purpose of compliance with Hospice Program staffing requirements, a staff member function may be performed by a paid individual or by a volunteer. The physician services discussed in this section may be performed by paid physicians or by volunteer physicians. See Section 203.500 for more information regarding hospice volunteers.

- A. Federal regulations require a hospice to provide the physician services required by a hospice patient's plan of care for the palliation and management of the patient's terminal illness and to compensate its physicians for any of those services not donated by a physician volunteer.
- B. Federal regulations require a hospice to ensure that its physicians meet the "general medical needs" of the hospice's patients (to the extent those needs are not met by a patient's attending physician) and to compensate its physicians for any of those services not donated by a physician volunteer.
- C. In order for a hospice to bill Medicaid for reimbursement for physician services:
 1. The hospice's physicians must be enrolled with Arkansas Medicaid, as detailed in Section 140.00.
 2. The hospice must apply for and obtain a physician billing intermediary provider number, also known as a physician "group" provider number.
- D. Medicaid-enrolled physicians employed or contracted by the hospice must appoint the hospice physician group as their billing intermediary for hospice physician services. Appointing a billing intermediary is accomplished by completing and forwarding Section IV of form DMS-652 Provider Group Affiliations. [View or print form DMS-652.](#)
- E. **Hospice physician services, performed by physicians contracted or employed by a hospice, may be billed only by the hospice, through a hospice physician group billing intermediary provider number.** Such services billed by individual physicians or physician groups are subject to post-payment denial and recovery of payment unless the attending physicians concerned have no affiliation with the hospices their terminally ill patients have chosen.
- F. The physician billing intermediary provider number assigned to a hospice includes an identifier that enables Medicaid to monitor service utilization and program costs.
- G. Providers may obtain a manual and enrollment materials by downloading the Arkansas Medicaid Physician/Independent Laboratory/CRNA/Radiation Therapy Center Provider Manual from the Arkansas Medicaid website: <https://medicaid.mmis.arkansas.gov/>.
- H. All Medicaid-enrolled hospice providers that employ or contract physicians to provide direct patient care to Medicaid-eligible hospice patients must be enrolled as hospice physician billing intermediaries in order to bill Medicaid for hospice physician. See Section 240.200 for additional information regarding this requirement.

202.000 Reserved**203.000 Hospice Staffing Requirements**

10-13-03

- A. Federal regulations require that core hospice functions and services be performed only by employees of the hospice or by volunteers under the supervision of hospice employees.

- B. Supplemental services may be provided by individuals who are either employed or contracted by the hospice, or who are volunteers.
- C. Hospice staffing involves employing, contracting and otherwise obtaining the services of the individuals who provide core services, supplemental services and physician services.

203.100 Interdisciplinary Group (IDG)

10-13-03

- A. Each hospice must have an Interdisciplinary Group (IDG, composed of individuals who provide or supervise the care and services offered by the hospice). Each IDG must include at least the following individuals:
 - 1. A doctor of medicine or osteopathy,
 - 2. A registered nurse,
 - 3. A social worker and
 - 4. A pastoral or other counselor.
- B. The registered nurse, the social worker and the (pastoral or other) counselor must be employees of the hospice, or volunteers under the supervision of designated employees of the hospice.
- C. In accordance with PL 105-33, the physician member of the IDG may be a volunteer or a hospice employee, or the hospice may contract with the physician.
 - 1. Only one physician may perform the physician's function in any given patient's IDG.
 - 2. Each patient's IDG must contain the same physician member from the beginning of the patient's first election period until the patient leaves hospice care.
 - 3. Refer to Section 203.400 for additional information, including the role of "on-call" physicians in the IDG.
- D. The membership of a patient's IDG may not rotate or fluctuate by design. It is acknowledged that staff turnover and personal matters (e.g., vacation, illness, etc.) require occasional replacement of or substitution for individual IDG members; however:
 - 1. There must be a continuous and identifiable relationship between each patient and her or his IDG, and
 - 2. Replacements and substitutions within each IDG must be described and explained in the IDG's minutes and in the clinical record of each patient assigned to that IDG.

203.200 Core Services Staffing

10-13-03

Medicaid mandates the provision of certain core services to every hospice patient. Core services must be provided by or supervised by an employee of the hospice. In the Hospice Program, "employee" also refers to a volunteer under the jurisdiction of the hospice.

- A. **Registered Nurse:** A registered nurse must provide or supervise nursing care and services. The registered nurse must be an employee of the hospice.
- B. **Social Worker:** A qualified social worker, under the direction of a physician, must provide medical social services. The social worker must be an employee of the hospice.
- C. **Counselor (pastoral or other):** A qualified professional counselor must provide or supervise counseling services for the patient and the patient's family in accordance with the plan of care and standards established by the Title XVIII (Medicare) Program. The counselor must be an employee of the hospice.

203.300 Supplemental Services Staffing

10-13-03

- A. Supplemental services may be provided directly by hospice employees or provided under arrangements between the hospice and other entities or individuals.
- B. Direct services as well as services provided under arrangements with other entities or individuals must be offered in a manner consistent with accepted standards of practice.
- C. When a hospice contracts or arranges for any services, the hospice must maintain professional, financial and administrative responsibility for the services and must ensure that all staff members meet the regulatory qualification requirements.

203.400**Physician Services Staffing****10-13-03**

- A. In accordance with Public Law 105-33, hospices may employ or contract with physicians to perform functions and services that may be executed only by physicians. Physicians may donate services to the hospice or to its patients as well. A physician must be a doctor of medicine or osteopathy.
- B. The following functions may be fulfilled by a physician employee, a volunteer physician or a contracted physician:
 - 1. Hospice medical director,
 - 2. Physician services related to the palliation and management of the patient's terminal illness,
 - 3. Care for general medical needs not provided by the patient's attending physician and
 - 4. Physician participation in the IDG.
 - a. A hospice may have two or more Interdisciplinary Groups, but each patient must be assigned to only one IDG, and the physician membership of each patient's IDG may not rotate.
 - b. Hospices may not divide a physician's duties in a single IDG among two or more physicians.
 - c. The hospice or the physician member of the Interdisciplinary Group (IDG) may designate another physician or other physicians to be 'on call' during the hours the physician member is not on duty.
 - i. The on-call physician may assist with urgent, emergency or otherwise unscheduled plan of care revisions.
 - ii. The hospice or the physician member of the IDG may not designate substitute physicians to routinely assist with initial plans of care and scheduled plan of care reviews and revisions.

203.500**Volunteers****10-13-03**

A hospice uses volunteers, in defined roles, under the supervision of designated hospice employees. Volunteers may perform administrative functions as well as direct care services for which they are qualified and which law or regulation allows them to perform. In the Hospice Program, "employee" also refers to a volunteer under the jurisdiction of the hospice.

- A. Volunteer hours of service must equal at least five percent of the hours of direct patient care furnished by paid personnel, employed or contracted.
- B. If a physician volunteers some services and is reimbursed by the hospice for other services, the terms and conditions of such shall be described in a written agreement or contract between the physician and the hospice.
- C. Physicians may not bill Medicaid for services that they perform at no charge for patients not eligible for Medicaid, unless they also perform, at no charge, the same or demonstrably comparable services for patients who are eligible for Medicaid.

1. Examples of equitable ways for a physician to meet this condition are to donate or volunteer:
 - a. A percentage of his or her time or
 - b. A particular service (e.g., treatment of bedsores or psychotherapy) or a particular occurrence of a service (donate one visit per week/month/etc. to each patient in his or her care).
2. Any method of satisfying this condition must ensure equity between Medicaid-eligible and non-Medicaid-eligible patients and parity among payers.

203.600 Electronic Signatures

10-8-10

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

210.000 PROGRAM COVERAGE

210.100 Program Purpose

1-1-13

Hospice is a continuum of care, directed by professionals, designed to optimize the comfort and functionality of terminally ill patients for whom curative medicine has exhausted its possibilities. Hospice emphasizes relief from distress for the patient without actively shortening or prolonging life. Relief from distress includes palliation of physical, psychological and psychosocial symptoms of distress and a regular regime for alleviation of physical pain. All efforts are directed to the enrichment of living during the final days of life and to the provision of ongoing opportunities for the patient to be involved in life.

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

Individuals under the age of 21 may receive treatment for a terminal illness in addition to hospice services.

210.200 Conditions for Provision of Hospice Service

11-1-06

- A. Hospice services require primary care physician (PCP) referral unless the patient is exempt from PCP referral requirements.
- B. The hospice patient must be terminally ill. "Terminally ill" is defined as having a medical prognosis with a life expectancy of six months or less. The hospice must obtain the certification that an individual is terminally ill in accordance with the following requirements:
 1. For the first 90-day election period of hospice coverage, the hospice must obtain, no later than two days after the initiation of hospice care, written certification statements signed by the hospice medical director or the physician member of the hospice interdisciplinary group and the individual's attending physician or PCP.
 - a. If the hospice does not obtain a written certification within two days after the initiation of hospice care, an oral certification may be obtained within these two days, and a written certification obtained no later than eight days after care is initiated.
 - b. If these requirements are not met, the provider is not eligible for reimbursement of hospice services furnished before the date that written certification is obtained.
 2. For any subsequent election period, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement

prepared by the hospice medical director or the physician member of the hospice's interdisciplinary group.

- C. Patients must voluntarily elect to receive hospice services and choose their hospice provider.
- D. Patients who elect to receive hospice services must receive hospice services instead of certain other Medicaid benefits. See Section 214.000, part D, for more details in this regard.
- E. Hospice services must be provided primarily in a patient's place of residence.
 - 1. A patient may elect to receive hospice services in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID) if:
 - a. The Department of Health and Human Services has determined that the patient is eligible for nursing facility or ICF/IID care and
 - b. The hospice and the facility have a written agreement under which:
 - i. The hospice takes full responsibility for the professional management of the patient's hospice care and
 - ii. The facility agrees to provide room and board to the patient.
 - 2. When a patient elects to receive hospice care in a nursing facility or ICF/IID, the hospice pays the nursing facility or ICF/IID for the patient's room and board and bills Medicaid for reimbursement.
- F. Hospice services must be provided in accordance with a written plan of care.

211.000 **Scope of the Program**

10-13-03

- A. Hospice services include routine home care, continuous home care, inpatient respite care and general inpatient care.
- B. Routine home care and continuous home care include core services, supplemental services and some physician services.
- C. Inpatient respite care and general inpatient care are supplemental services.
- D. Physician participation in the IDG is a core service.
- E. Physician supervision of hospice employees (when required by law or regulation) is a core service.

211.100 **Hospice Services**

10-13-03

Medicaid-eligible patients electing hospice care surrender their eligibility (until they revoke hospice or are discharged from hospice care) to receive, independently of their hospice plan of care, the services described and defined in this section. Therefore, when a Medicaid-eligible individual has elected hospice care, Medicaid providers may not bill separately for any core or supplemental hospice service; nor may they bill separately for any component of a core or supplemental service.

211.101 **Personal Care/Hospice Policy Clarification**

1-1-18

Medicaid beneficiaries are allowed to receive Medicaid personal care services, in addition to hospice aide services, if the personal care services are unrelated to the terminal condition or the hospice provider is using the personal care services to supplement the hospice aide and homemaker services.

- A. The hospice provider is responsible for assessing the patient's hospice-related needs and developing the hospice plan of care to meet those needs, implementing all interventions described in the plan of care, and developing and maintaining a system of communication and integration to provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. The hospice provider coordinates the hospice aide with the services furnished under the Medicaid personal care program to ensure that patients receive all the services that they require. Coordination occurs through contact with beneficiaries or in home providers.
- B. The hospice aide services are not meant to be a daily service, nor 24-hour daily services, and are not expected to fulfill the caregiver role for the patient. The hospice provider can use the services furnished by the Medicaid personal care program to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care. The hospice provider is only responsible for the hospice aide and homemaker services necessary for the treatment of the terminal condition.
- C. Medicaid payments for personal care services provided to an individual also receiving hospice services, regardless of the payment source for hospice services, must be supported by documentation in the individual's personal care medical chart or the Independent Choices Cash Expenditure Plan. Documentation must support the policy described above in this section of the Personal Care provider manual.

Prior Authorization for personal care for beneficiaries receiving both hospice services and personal care services will be considered based on the individual beneficiary's physical dependency needs. Requests for personal care services require an Independent Assessment to determine medical necessity and to assure duplication of services will be adjusted accordingly. Please refer to the Independent Assessment Guide for related information.

NOTE: Based on audit findings, it is imperative that required documentation be recorded by the hospice provider and available in the hospice record. Documentation must substantiate all services provided. It is the hospice provider's responsibility to coordinate care and assure there is no duplication of services. While hospice care and personal care services are not mutually exclusive, documentation must support the inclusion of both services and the corresponding amounts on the care plan. To avoid duplication and to support hospice care in the home that provides the amount of services required to meet the needs of the beneficiary, the amount of personal care services needed beyond the care provided by the hospice agency must meet the criteria detailed in this section. Most often, if personal care services are in place prior to hospice services starting, the amount of personal care services will be reduced to avoid any duplication. If those services are not reduced or discontinued, documentation in the hospice and personal care records must explain the need for both and be supported by the policy in this section.

211.110 Core Services

211.111 Interdisciplinary Group (IDG) Purpose and Responsibilities

10-13-03

- A. A hospice must have at least one interdisciplinary group (IDG).
 - 1. If a hospice has more than one IDG, each patient must have only one IDG responsible for his or her care.
 - 2. The hospice must designate only one IDG to be responsible for establishing and maintaining policies governing the day-to-day provision of hospice care and services.
- B. Each interdisciplinary group is responsible for:

1. Developing and establishing a plan of care for each patient whose care the IDG's members provide or supervise,
2. Providing or supervising hospice care and services for each patient whose plan of care the IDG maintains and
3. Periodically reviewing and updating the plan of care for each patient in the IDG's charge.

211.112 Non-Physician Direct-Care Services**10-13-03**

- A. Registered nurse nursing care, or licensed practical nurse nursing care provided under the supervision of a registered nurse, is a core service. A designated registered nurse must coordinate the delivery of services required by each patient's plan of care. The nurse must be employed by the hospice provider.
- B. Medical social services provided by a State licensed social worker or a social worker with a bachelor degree and 2 years experience, who is working under the supervision of a physician, is a core service. The social worker must be employed by the hospice provider.
- C. Counseling services (including bereavement, dietary and spiritual counseling) to the patient, family and/or other care giver(s) is a core service.
 1. The counselor employed by the hospice must provide or arrange and coordinate counseling services.
 2. Counseling may be provided both for the purpose of training the patient's family or other caregiver to provide care and for the purpose of helping the patient and those caring for him or her to adjust to the patient's approaching death.
 3. Bereavement counseling provided to the patient's family or other caregiver is a required service for up to one year after the patient's death but it is not reimbursable.

211.120 Supplemental Services**10-13-03**

Supplemental services must be provided when necessary and specified by the plan of care. Supplemental services are detailed in the sections that follow.

211.121 Medical Supplies and Appliances, Including Drugs and Biologicals**10-13-03**

- A. Drugs and biologicals that are used primarily for the relief of pain and control of symptoms related to the individual's terminal illness are included in the hospice benefit.
 1. Arkansas Medicaid reimbursement for daily hospice care includes reimbursement for those medications.
 2. Hospice patients may not obtain, through the Pharmacy Program, medications for relief of pain and control of symptoms related to their terminal illness. For instance, if the attending physician prescribes morphine for control of pain caused by the terminal illness, the hospice is responsible for supplying the drug and carrying out the prescribed regimen for pain relief.
 3. Hospice patients may use their Medicaid prescription drug benefit for medications prescribed to treat conditions not directly related to their terminal illness. For example, if the attending physician prescribes a steroid for an intractable allergic reaction, such as a rash, the patient may use his or her Medicaid prescription drug benefit to fill the prescription at a pharmacy.
- B. Equipment and medical supplies related to the palliation or management of the patient's terminal illness shall be furnished by the hospice for use in the patient's home while he or she is receiving hospice care.

1. "Equipment" includes 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. "Medical supplies" include disposable items related to the palliation or management of the patient's terminal illness.
2. "Furnished by the hospice" includes provision by a vendor under an arrangement with the hospice, wherein the vendor may not bill Medicaid for the equipment or supplies.
3. Durable medical equipment furnished by the hospice or under an arrangement with the hospice remains the property of the hospice or of the vendor supplying the equipment.
4. Medically necessary and prescribed medical equipment and supplies for conditions unrelated to the patient's terminal illness may be furnished by enrolled vendors who may bill Medicaid for the rental or purchase of the items as appropriate.

211.122 Home Health Aide and Homemaker Services 10-13-03

- A. Home health aide services are covered supplemental services. The aide may be employed or contracted by the hospice provider.
- B. Aide services must be provided under the general supervision of a registered nurse. The registered nurse must visit the patient's residence at least every two weeks.
- C. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient.

211.123 Physical, Occupational and Speech Therapy Services 10-13-03

Occupational and physical therapy and speech pathology services may be provided for purposes of symptom control or to enable the patient to maintain activities of daily living and basic functional skills. Therapists may be employed or contracted by the provider.

211.124 Short Term Inpatient Care 10-13-03

- A. Medicaid covers inpatient respite care and general inpatient care in the Hospice Program.
 1. For these services, a hospice may admit patients to an acute care general hospital with which the hospice has an arrangement or the hospice may admit the patient to a hospice inpatient facility.
 2. Please see Section 201.100 for hospice inpatient facility participation requirements.
 3. A hospice may admit a patient for inpatient respite care to a skilled nursing facility that meets the standards at 42 CFR, 418.100, (a) and (e).
- B. Inpatient respite care is short-term inpatient care provided to the patient only when necessary to relieve the family members or other persons caring for the individual at home.
 1. Inpatient respite care may be provided only twice.
 - a. This is a lifetime limitation.
 - b. The Arkansas Medicaid Program will consider extending this benefit. See Section 213.000 for details.
 2. Inpatient respite care may not be reimbursed for more than five consecutive days per stay. The Arkansas Medicaid Program will not extend this benefit beyond five days.
- C. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot be provided in an outpatient setting.

- D. Services provided in an inpatient setting must conform to the written plan of care.

211.130 Physician Services 10-13-03

Some physician services are included in core and supplemental services. Other physician services are covered separately.

211.131 Required Hospice Physician Services 10-13-03

- A. The following services must be provided by a physician or physicians employed or contracted by the hospice, or who volunteer services to the hospice:
1. General supervisory services of the medical director,
 2. Participation in the establishment of plans of care,
 3. Supervision of care and services,
 4. Periodic review and updating of plans of care and
 5. Establishment of the hospice's governing policies.
- B. The services listed above in part A are constituent services of routine home care, continuous home care and inpatient respite care. They are not covered separately from the applicable daily care.

211.132 Physician Services Hospices Must Ensure 10-13-03

- A. Hospices must ensure that patients receive the following physician services as needed:
1. Direct care related to the palliation and management of the patient's terminal illness and
 2. Care for the hospice patient's general medical needs.
- B. Hospice physicians must provide such services to the extent that the patient's attending physician does not provide them.
1. A patient's attending physician may bill Medicaid on a fee-for-service basis unless the physician is a "hospice physician," defined as providing the care:
 - a. As an employee of the hospice,
 - b. Under an arrangement with the hospice or
 - c. As a volunteer.
 2. Hospice physicians may bill Medicaid on a fee-for-service basis, subject to the following conditions:
 - a. Each hospice whose physicians provide any direct patient care to the hospice's patients on a fee-for-service basis must enroll with Medicaid as a physician billing intermediary. See Section 201.400 of this manual for participation requirements and enrollment materials.
 - b. Each of the hospice's physicians providing patient care for which the hospice or the physician claims Medicaid reimbursement in addition to the hospice daily rate must authorize the hospice to bill for that care as the physician's billing intermediary. See Section 201.400 of this manual for participation requirements and enrollment materials.
 - c. Medicaid does not reimburse hospices for donated physician services.

211.200 Levels of Care 10-13-03

There are four levels of care into which each day of care is classified.

211.210 **Routine Home Care** **12-1-07**

- A. Routine Home Care includes core and supplemental services as detailed in the plan of care.
- B. When a hospice patient is at his or her place of residence or at a nursing facility or ICF/IID in which he or she resides and the patient receives less than eight hours of Hospice care in one calendar day (midnight through 11:59 P.M.), that day is a Routine Home Care day.
 - 1. The discharge day and any days beyond the fifth day of an Inpatient Respite Care stay are covered as home care days (Routine or Continuous as appropriate), unless the patient is discharged deceased, in which case Medicaid covers the discharge day as an Inpatient Respite Care day.
 - 2. The discharge day of a General Inpatient Stay is covered as a home care day (Routine or Continuous as appropriate) unless the patient is discharged deceased, in which case Medicaid covers the discharge day as a General Inpatient Care day.
- C. Routine Home Care is a covered service for Hospice patients who reside in nursing facilities or ICF/IIDs in accordance with the rules described at Section 210.200, part E.
- D. When a Hospice patient expires at home or at a nursing facility or ICF/IID in which he or she has chosen Hospice care, Medicaid covers the patient's date of death as either a Routine Home Care day or a Continuous Home Care day, whichever category of care applies.

211.220 **Continuous Home Care** **12-1-07**

- A. Continuous home care is provided only during a period of crisis in which more than routine care is required to achieve palliation or management of the patient's acute medical symptoms.
- B. For a day of Hospice care to qualify as a Continuous Home Care day, a minimum of eight hours of care must be provided during a twenty-four hour calendar day, which is midnight through 11:59 P.M.
 - 1. Care need not be continuous; for instance, four hours of care may be provided in the morning and an additional four hours or more later in the day.
 - 2. A nurse must be providing care for more than half of the total period of care each day.
 - 3. Homemaker and aide services may be provided to supplement the nursing care.
- C. Continuous Home Care is a covered service for Hospice patients who reside in nursing facilities or ICF/IIDs in accordance with the rules described at Section 210.200, part E.
- D. When a Hospice patient expires at home or at a nursing facility or ICF/IID in which he or she has chosen Hospice care, Medicaid covers the patient's date of death as either a Routine Home Care day or a Continuous Home Care day, whichever category of care applies.

211.230 **Inpatient Respite Care** **12-1-07**

- A. Inpatient Respite Care is short-term inpatient care of the terminally ill beneficiary, in a hospital or other qualified facility, provided to relieve the family members or other caregivers at the beneficiary's home.
 - 1. Inpatient Respite Care is covered only twice (without a benefit extension) and for no more than five consecutive days per stay.

2. The sixth and subsequent days of an Inpatient Respite Care stay are covered as Routine Home Care or Continuous Home Care days, whichever category applies, unless the patient is discharged deceased, in which case the discharge day is covered as an Inpatient Respite Care day.
 3. Additional Inpatient Respite Care stays (but not additional days within a stay) may be available by benefit extension request. See Section 213.000, part C, subparts 2 and 3 for details pertaining to benefit extension requests.
- B. A Hospice patient may have Inpatient Respite Care at an acute care hospital, in a licensed Hospice inpatient facility or in a skilled nursing facility that meets the standards at 42 CFR § 418.100(a) and 418.100(e), and which is associated with or has an arrangement with the Hospice provider to furnish Inpatient Respite Care, and which is equipped to provide appropriate accommodations, equipment, services, supplies etc., all in accordance with the beneficiary's plan of care.
- C. Hospice patients residing in nursing facilities or ICF/IIDs (in accordance with the rules described at Section 210.200, part E) are not eligible for Inpatient Respite Care.

211.240 General Inpatient Care

12-1-07

General Inpatient Care, at a hospital or other qualified facility, may be required for procedures that cannot be provided in a home or other outpatient setting, but which are necessary for pain control or for acute or chronic symptom management.

- A. A Hospice patient may have General Inpatient Care at an acute care hospital, in a licensed Hospice inpatient facility or in a skilled nursing facility that meets the standards at 42 CFR § 418.100(a) and 418.100(e), and which is associated with or has an arrangement with the Hospice provider to furnish General Inpatient Care, and which is equipped to provide appropriate accommodations, equipment, services, supplies etc., all in accordance with the beneficiary's Hospice plan of care.
- B. Medicaid covers the discharge day from General Inpatient Care as a home care day, Routine or Continuous as applicable, unless the patient is discharged deceased, in which case Medicaid covers the day as a General Inpatient Care day.

212.000 Exclusions

10-13-03

The following services are not appropriate for hospice care and are not reimbursable under the Arkansas Medicaid Hospice Program.

- A. Services provided by another hospice except those provided by a hospice under an arrangement with the hospice elected by the patient.
- B. Services that constitute custodial care.
- C. Services not consistent with accepted sound medical practices.
- D. Services not reasonable and not necessary for the palliation or management of the terminal illness or related conditions.
- E. Services not reasonable and not necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- F. Services not in accordance with the plan of care.
- G. Inpatient care services provided in a nursing facility, unless the nursing facility is certified by the State of Arkansas as a hospice inpatient facility or meets the standards at 42 CFR, 418.100, (a) and (e).

- H. Room and board services in conjunction with inpatient respite care or general inpatient care.
- I. Hospice care during any days remaining in an election period after the patient's revocation of hospice care. A patient may drop out of hospice care during any election period, but, by doing so, forfeits hospice care for the remaining days in that election period.
 - 1. Thus, a patient who revokes hospice during an election period may not reenter the Hospice Program during that same election period.
 - 2. Upon revoking the election of Medicaid hospice care for a particular election period, a patient resumes regular Medicaid coverage. A patient may at any time elect to receive hospice coverage for any subsequent hospice election periods.

213.000**Benefit Limits**

12-1-07

- A. Arkansas Medicaid Hospice coverage is based on providers' furnishing medical and other services and on their providing specified categories of care during renewable election periods of mandated duration.
 - 1. Election periods are of ninety-day and sixty-day duration.
 - 2. Each of the first and second election periods is ninety days, followed by an unlimited number of sixty-day election periods.
 - 3. Having once elected Hospice, a patient is not required to elect Hospice again, unless he or she revokes Hospice care or is discharged from Hospice care, in which case the patient may re-elect Hospice care only after the last day of the election period in which the revocation or discharge occurred.
 - 4. The conditions set forth in Section 210.200 are required for initial Hospice election and for Hospice re-election.
- B. Continuous Home Care coverage is limited to periods of crisis.
- C. Inpatient Respite Care is limited to two periods of no more than five consecutive days each.
 - 1. The Arkansas Medicaid Program will not extend the Inpatient Respite Care benefit beyond five days per stay; counting the admission day but not counting the discharge day, which is covered as a Routine Home Care day or a Continuous Home Care day, as applicable.
 - a. A discharge day is covered as an Inpatient Respite Care day only if the patient is discharged deceased on that date.
 - b. When, as infrequently happens, the beneficiary is not discharged by the end of the sixth day, Medicaid covers the sixth and subsequent days (if any) as Routine Home Care days.
 - 2. The Arkansas Medicaid Program will consider extending the Inpatient Respite Care benefit to permit additional stays. Send written benefit extension requests to the Arkansas Division of Medical Services, Utilization Review Section. [View or print the Arkansas Division of Medical Services, Utilization Review Section contact information.](#)
 - 3. The request must justify the need for an additional period of Inpatient Respite Care, specify the number of days of respite (up to five) needed, and include the names, addresses and telephone numbers of the caregivers requesting the additional Inpatient Respite Care.

214.000**Election**

1-1-13

- A. A patient electing hospice care must file an election statement with the designated hospice.
 - 1. The provider must furnish a printed statement that meets all the conditions of this section.
 - 2. The patient must sign and date the election statement.
- B. An election to receive hospice care continues through the initial election period and through any subsequent election periods without a break in care as long as the patient remains in the care of the hospice.
- C. A patient must designate an effective date for the election period.
 - 1. The effective date may be the first day of hospice care or any subsequent day of hospice care.
 - 2. A patient may not designate an effective date that is earlier than the date on which the election is made.
- D. A patient must waive all rights to Medicaid coverage of the following services for the duration of the election of hospice care:
 - 1. Hospice care provided by a hospice other than the hospice designated by the patient, unless provided under arrangements made by the designated hospice
 - 2. Any Medicaid services that are related to treatment of the terminal condition for which hospice care was elected or of a related condition; or that are equivalent to hospice care except for:
 - a. Services provided (either directly or under arrangement) by the designated hospice
 - b. Services provided as room and board by a nursing facility or ICF/IID if the individual is a resident
 - c. Services provided by the patient's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services
 - d. Treatment of the terminal illness for Medicaid eligible individuals under the age of 21
 - 3. Home Health Program services and drugs and biologicals obtained through the Arkansas Medicaid Pharmacy Program for the palliation and management of symptoms related to the patient's terminal illness
- E. Individuals under the age of 21 electing hospice and receiving treatment for a terminal illness must meet all program criteria and guidelines established for both hospice and the treatment of the terminal illness.
- F. When an election period ends, the patient's waiver of other Medicaid benefits expires and regular Medicaid coverage is possible if the patient revokes hospice care for the subsequent election period.
- G. An individual eligible for both Medicare and Medicaid must elect the hospice benefit simultaneously under both programs.
- H. When a hospice discharges a patient because the patient's condition is no longer considered terminal, the patient's waiver of other Medicaid benefits expires immediately and regular Medicaid coverage is possible.

A patient may revoke the election of hospice care at any time.

- A. To revoke the election of hospice care, the patient must file with the hospice a provider-developed document that includes a signed and dated statement that the patient revokes the election for Medicaid coverage of hospice care for the remainder of that election period.
- B. The patient forfeits hospice coverage for any remaining days in the election period.
- C. A patient may not designate an effective date earlier than the date the revocation is made.
- D. An individual eligible for both Medicare and Medicaid must revoke the benefit simultaneously under both programs.

216.000 Changing Hospice Selection**10-13-03**

An individual may change, once in each election period, the designation of the hospice from which he or she elects hospice care.

- A. The change of the designated hospice is not considered a revocation of the election.
 - 1. To change the designation of hospice programs, the patient must file a signed statement with the newly designated hospice and with the hospice from which he or she has received care.
 - 2. The signed statement must include the following information:
 - a. The name of the hospice from which the individual has received care;
 - b. The name of the hospice from which he or she plans to receive care and
 - c. The date the change is to be effective.
- B. A change of ownership of hospice is not considered a change in the patient's designation of a hospice and requires no action on the patient's part.

217.000 Acknowledgment of Informed Consent**10-13-03**

- A. An individual (or his or her representative) electing hospice care must sign a statement, prepared by the hospice, that specifies the type of care and services that may be provided as hospice care during the course of their illness.
- B. The patient or his or her representative acknowledges by his or her signature that he or she is giving informed consent to hospice care.
- C. Individuals permitted to act as representatives of patients are those meeting the requirements of Arkansas law regarding legal representatives of private individuals.

218.000 Plan of Care**7-1-20**

A written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan.

- A. The attending physician, the medical director or physician designee, and the interdisciplinary group must establish the plan of care before hospice care begins.
- B. The attending physician, the medical director or physician designee, and the interdisciplinary group must review and update the plan at intervals specified in the plan. Reviews must be documented.
- C. The plan of care must:
 - 1. Include an assessment of the individual's needs and identification of the services, including:

- a. Management of discomfort; and
 - b. Symptom relief.
2. State in detail the scope and frequency of services needed to meet the patient's and family's needs.
- D. In establishing the initial plan of care, the member of the interdisciplinary group who assesses the patient's needs must meet or confer by telephone with at least one (1) other IDG member before writing the initial plan of care.
1. At least one (1) of the persons developing the initial plan of care must be a nurse or physician.
 2. The plan must be established on the same day as the assessment if the day of the assessment is to be a covered day of hospice care.
 3. The other two (2) members of the IDG must review the initial plan of care and provide their contributions to it within two (2) calendar days following the day of assessment.
- E. Waiver Services
1. Waiver Eligibility

Some Medicaid beneficiaries are eligible under special programs known as waivers. The claims system will indicate waiver eligibility status with "NO" (not a waiver client) or the letter "W" followed by a number currently (one (1) or two (2)).

Waiver clients may receive only services listed in the plan of care designed for them under the guidelines of the waiver program in which they participate.
 2. **ARChoices in Homecare** Waiver Clients
 - a. If the hospice provider intends to initiate care to a W2 waiver client, contact must be made with the DHS County Office in the client's county of residence for the name and location of the DHS RN responsible for the client's **ARChoices** plan of care. Through contact with the DHS RN, the hospice services may be included in the plan of care before rendering the service.
 - b. The **ARChoices** plan of care supersedes any other plan of care previously developed by another Medicaid provider for the beneficiary. The **ARChoices** plan of care must be obtained from the client's family.
 - c. The **ARChoices** plan of care must include all appropriate **ARChoices** services and certain non-waiver services appropriate to the applicant, such as Hospice.
 - d. The hospice provider must report services to an **ARChoices** client to the DHS RN. The services must be included on the **ARChoices** plan of care prior to beginning services. All changes in services or changes in the **ARChoices** client's circumstances must be reported promptly to the DHS RN. Services provided that are not included on the **ARChoices** plan of care may be subject to recoupments by the Arkansas Medicaid Program.

219.000 Service Logs and Notes

10-13-03

Hospices must maintain documentation of all pertinent events and all services provided, whether the services are furnished directly or under arrangements made by the hospice.

- A. The person providing a service must make and sign the pertinent notes as the services are provided.
- B. Notes regarding services and relevant events must be signed and dated.
- C. Each person providing services constituent of continuous home care must also record (signed and dated) the beginning and ending time of day of the services they provide.

220.000 DOCUMENTATION**220.100 Enrollment and Participation Documentation****10-13-03**

The hospice provider must maintain documentation that verifies its enrollment in the Arkansas Medicaid Program as well as documentation confirming its qualification to continue its participation in the Arkansas Medicaid Program. The documentation must be current (up-to-date) as well as contemporaneous with the patient records maintained in accordance with Section 202.000.

- A. Provider participation documentation that must be on file includes the provider's:
 - 1. Certification(s) as a Title XVIII (Medicare) hospice provider.
 - 2. Hospice license.
 - 3. Medicaid contract to participate in the Arkansas Medicaid Program.
 - 4. When applicable, the hospice's contract with Medicaid to act as billing intermediary for the hospice's physicians, and a copy of each physician's signed appointment of the hospice as his or her billing intermediary for hospice physician services.
- B. It is the responsibility of the hospice to ensure the qualifications and the quality of services provided by its staff as well as by the staffs of facilities, agencies and vendors with which the hospice has contracts and agreements.
 - 1. The hospice must maintain licensure, certification and credentials of its:
 - a. Employed Staff,
 - b. Volunteer Staff and
 - c. Contract Staff
 - 2. With regard to agencies, vendors, facilities, professionals and other individuals or entities providing services or direct patient care under arrangements with the hospice, the hospice must maintain documentation of:
 - a. The provisions of agreements and contracts with those entities and
 - b. Verifiable assurances of the qualifications of, and the quality of service to be provided by, those entities.

220.200 Central Clinical Records**11-1-09**

A hospice must establish and maintain a clinical record for every individual receiving care and services. The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval. The Department of Human Services requires retention of all records for five (5) years or until all audits are completed, whichever is later. Each record must contain:

- A. Primary care physician (PCP) referral (written referral from the PCP or oral referral noted in the clinical record) if the patient is not exempt from PCP referral requirements.
- B. Physician statements certifying the patient's terminal illness.
- C. Pertinent medical history.
- D. Plan of care, including:
 - 1. Plan of care revisions,
 - 2. Initial and subsequent assessments and

3. Dates and pertinent notes of IDG meetings regarding the patients' care, including the names and signatures or initials of IDG members present and participating.
- E. Election-of-hospice statement.
- F. Acknowledgment of informed consent.
- G. Revocation of Hospice and Change of Hospice statements when applicable.
- H. Complete documentation of all services and events, including evaluations, treatments, service and progress notes, and service-time logs corresponding to continuous home care days billed to Medicaid.
- I. Other correspondence, including any documented telephone conversations, between the patient (or the patient's authorized representative) and the hospice staff or administration, relevant to the patient's hospice services.
- J. Correspondence, memoranda, notes and observations regarding the performance of, and quality of service delivery by, other entities providing services or direct patient care under contract or other arrangement with the hospice.
- K. See Section 142.300 for additional details regarding conditions related to record keeping.

230.000 PRIOR AUTHORIZATION

10-13-03

Prior authorization is not required for hospice services furnished by providers located and licensed in the State of Arkansas.

240.000 REIMBURSEMENT

240.001 Introduction to Hospice Reimbursement Methodology

12-1-07

- A. Medicaid pays enrolled Hospices for four categories of Hospice care.
- B. Medicaid pays for Medicaid-enrolled physician's services for Hospice patients.
- C. Medicaid reimburses enrolled Hospices for a Hospice patient's room and board in a nursing facility or an intermediate care facility for individuals with intellectual disabilities (ICF/IID) when the patient is eligible for Medicaid long-term care assistance and he or she requests Hospice care in the long-term care facility.

240.100 Hospice Categories of Care Reimbursement Methodology

12-1-07

Reimbursement for Hospice direct care is at one of four adjusted prospective rates, only one of which applies to any given day in which a beneficiary who has elected Hospice is, in accordance with an authorized Hospice plan of care, under the care of a Medicaid-enrolled Hospice.

- A. One prospective reimbursement rate (daily or hourly as applicable) corresponds to each category of Hospice care.
 1. Hospice home and inpatient care reimbursement is by daily prospective rate.
 2. Reimbursement for Continuous Home Care is at an hourly prospective rate.
- B. The Centers for Medicare and Medicaid Services (CMS) annually establishes and publishes in the *Federal Register*, Hospice care reimbursement baseline prospective rates for dates of service from October 1 of the year of their publication through September 30 of the following year (i.e., the federal fiscal year, October 1 through September 30).

1. Payment for the two home-care categories varies by vicinity, reflecting adjustment by indices linked to the patient's home address.
 2. Payment for the two inpatient care categories varies by vicinity, reflecting adjustment by indices linked to the Hospice's location.
- C. CMS has established for every county and parish in the United States, *Hospice Wage Index* factors by which each state's Medicaid Agency adjusts the wage component of the annually established base prospective rate for each Hospice care category.
1. CMS annually determines and publishes in the *Federal Register*, each base prospective rate's corresponding wage component for dates of service on and after October 1 of the year of publication through September 30 of the following year (the federal fiscal year, October 1 through September 30).
 2. Each state's Medicaid Agency calculates reimbursement for one unit of service of a Hospice care category by applying the local wage index multiplier to the wage component of the category's prospective rate and then adding the product to the non-wage portion of the same category's base prospective rate.
 - a. For Routine Home Care and Continuous Home Care reimbursement, the local wage index multiplier is that of the county or parish in which Medicaid's records reflect the Hospice patient's home address.
 - b. For Inpatient Respite Care and General Inpatient Care reimbursement, the local wage index multiplier is that of the county or parish in which the Hospice provider is located.

240.110**Routine Home Care****1-1-16**

- A. The Routine Home Care adjusted prospective rate is a daily rate.
- B. The Medicaid Program reimburses Hospice providers at the applicable Routine Home Care rate for each day of an authorized election period which is not reimbursed at the applicable prospective rate for another Hospice category of care.
- C. Routine Home Care includes core and supplemental services as detailed in the plan of care.
 1. Medicaid pays for Routine Home Care regardless of the amount (if less than eight hours in a calendar day), the frequency or the type of service provided on a given day, but only if on that day the Hospice provider is fulfilling the requirements of the beneficiary's authorized Hospice plan of care.
 2. Medicaid pays for Routine Home Care as described in subpart C.1 and in accordance with an authorized Hospice plan of care, for a nursing facility or ICF/IID resident who has elected Hospice home care in that setting.
 3. Medicaid pays the Hospice provider for Routine Home Care as described in subpart C.1 for a day of the election period during which a patient with an authorized Hospice plan of care receives outpatient services for conditions related or unrelated to his or her terminal illness.
 4. Effective January 01, 2016, Routine Home Care will have a higher base rate for the first 60 days of hospice care and a reduced base payment rate for days 61 and after. A beneficiary may choose to leave or change hospice providers or may be discharged from a provider's care; this is termed a "live discharge." If the beneficiary is readmitted or chooses to come back under care of any hospice provider within 60 days of discharge, or if a provider bills revenue code 0652 (continuous home care), the count of days for routine home care will continue from the last date used while under care and not start over.

5. Effective January 01, 2016, a new Service Intensity Add-on (SIA) payment can be billed for a home visit by an RN or Clinical Social Worker during the last seven days of life. This is in addition to the Routine Home Care rate. Date of death must be present for the SIA payment to be paid.

240.120**Continuous Home Care**

12-1-07

- A. Medicaid pays Hospices for Continuous Home Care according to the hours of care provided on a given day.
 1. Reimbursement for Continuous Home Care requires a minimum of (not required by Medicaid to be consecutive) eight hours of on-site care in a twenty-four hour period comprising a calendar day, and it also requires that half or more of the care (by the clock and documented) be performed by a Licensed Practical Nurse (LPN) or a Registered Nurse (RN).
 2. For Hospice care, a twenty-four hour period is always a single calendar day from midnight through 11:59 P.M.
- B. The Continuous Home Care base prospective rate annually set and published by CMS is a *daily* prospective rate (i.e., not yet locally adjusted and converted to an hourly rate) for *twenty-four* hours of Continuous Home Care in a single calendar day.
 1. The *daily* prospective rate allowed for the locality of the patient's address is calculated by multiplying the wage component of the base daily prospective rate by the applicable Hospice Wage Index multiplier and then adding the resulting adjusted wage component to the non-wage component.
 2. The Continuous Home Care hourly rate is one twenty-fourth of the locally adjusted daily prospective rate.
 - a. The Hospice bills Medicaid for the hours of direct care, not to exceed twenty-four hours per calendar day.
 - b. When billing Medicaid for Continuous Home Care, one hour equals one unit of service.
 - i. When the provider totals the hours of Continuous Home Care on a given calendar day, a *final* remainder of one to fifty-nine minutes may be billed as one unit (one hour) of service.
 - ii. Medicaid allows only one such "rounded off" unit per calendar day. Refer to part C of this section for examples.
 3. Service logs containing the exact times of day that services begin and end must support the billing.
 - a. An interruption or a break in service is considered an ending time of service and must be documented.
 - b. Resumption of service must be recorded as a beginning time of service.
- C. Examples of calculating units of service for Continuous Home Care.
 1. A nurse logs in to attend a patient four times in a particular day:
 - a. Once for 3 hours and 13 minutes,
 - b. Once for 2 hours and 5 minutes,
 - c. Once for 2 hours and 33 minutes and
 - d. Once for 1 hour and 26 minutes.
 2. The nurse's total service time is 557 minutes, which is 9 hours and 17 minutes.
 3. Medicaid's rules give the provider permission to bill the 17 minutes as a full hour of care (resulting in 10 billable hours) if the nurse's services are the only Hospice services furnished the patient in the 24-hour period.

4. To continue the example to account for services furnished in addition to the nurse's care: A Home Health Aide performed personal care services.
 - a. The aide's log indicates 137 minutes (2 hours and 17 minutes) of service time on that date.
 - b. The provider
 - i. Adds the whole hours furnished of each service ($9 + 2 = 11$),
 - ii. Then adds the odd minutes from each shift ($17 + 17 = 34$) and
 - iii. Reports the day's 34 odd minutes of service as a whole hour, for a total of 12 billable hours ($9 + 2 + 1 = 12$) or 12 units of service.
 - c. An alternative method of calculating the units of service is to add the service times in minutes.
 - i. 557 minutes plus 137 minutes equals 694 minutes.
 - ii. 694 minutes divided by 60 equals 11 hours and 34 minutes.
 - iii. The provider may round the final remainder of 34 minutes to 1 hour, which is 1 unit of service.
 - iv. $11 + 1 = 12$, for 12 billable units of Continuous Home Care service.

240.130 Inpatient Respite Care

12-1-07

- A. Medicaid pays Hospice at the Inpatient Respite Care rate for each day (up to five) Inpatient Respite Care in a hospital, a licensed Hospice inpatient facility or a skilled nursing facility that meets the standards at 42 CFR § 418.100(a) and § 418.100(e).
- B. Payment for Inpatient Respite Care may be made for a maximum of five days per stay, counting the date of admission but not the date of discharge.
 1. The discharge day is payable at the Inpatient Respite Care rate only when the patient is discharged deceased on that day.
 2. Reimbursement for the sixth day (whether or not the patient is discharged that day, unless discharged deceased) and any subsequent days of the same stay is at the Routine Home Care rate, except for the day a patient is discharged deceased.
- C. The daily rate paid the Hospice provider for Inpatient Respite Care is calculated in the same manner as is the daily rate paid for Routine Home Care, except that the local wage index multiplier used in reimbursement calculations is that of the county or parish in which the Hospice provider is located.

240.140 General Inpatient Care

12-1-07

- A. Reimbursement for General Inpatient Care is at the inpatient daily rate.
- B. None of the other Hospice payment rates applies to a day of Hospice General Inpatient Care except for the date of discharge (unless the patient is discharged deceased).
 1. For the day of discharge from General Inpatient Care, the appropriate home care rate applies unless the patient dies as an inpatient.
 2. When a patient is discharged deceased from General Inpatient Care, Medicaid reimburses the Hospice for the discharge day at the General Inpatient Care rate.
- C. The General Inpatient Care daily rate is calculated in the same manner as is the daily rate for Routine Home Care, except that the local wage index multiplier used in inpatient reimbursement calculations is that of the county or parish in which the Hospice provider is located.

240.200 Method of Reimbursement for Hospice Physician Services 10-13-03

- A. Hospice care daily rates for home care, continuous home care and inpatient respite care include reimbursement for hospice medical director, physician participation in the IDG and physician supervision of core services and supplemental services.
- B. The hospice may bill for other physician's services such as direct patient care services furnished to individual patients by physicians employed by, or who have an arrangement with the hospice, unless the patient care services are furnished on a volunteer basis.
- C. Medicaid covers direct care of hospice patients by physicians through the Arkansas Medicaid Physician Program.
 - 1. A Medicaid-enrolled physician may bill Medicaid for general medical care provided to a hospice patient, if the physician is not providing the care as an employee of the hospice (which includes volunteer status) or under an arrangement with the hospice.
 - 2. The hospice must bill Medicaid for general medical care provided to hospice patients by physicians employed by the hospice or working under an arrangement with the hospice.
 - a. In order to bill Medicaid for general medical care, the hospice must enroll with Medicaid as a billing intermediary. See Section 201.400 for enrollment information.
 - b. The hospice is reimbursed in accordance with the Medicaid physician fee schedule.
 - c. This reimbursement is in addition to the hospice rates.
 - 3. Neither individual physicians nor physician billing intermediaries may bill Medicaid for hospice physician services that physicians donate or provide on a volunteer basis.
 - 4. The only services to be billed by the attending physician are the physician's personal professional services. Costs for services such as lab or X-ray are not to be included on the attending physician's bill.

240.300 Method of Service Reimbursement for Hospice Patients Residing in Nursing Facilities or ICF/IIDs 11-1-06

- A. Reimbursement for Medicaid-eligible patients residing in nursing facilities or ICF/IIDs is limited to room and board.
 - 1. Medicaid pays the hospice provider an amount equal to 95% of the Medicaid nursing facility/ICF/IID room and board payment.
 - 2. The hospice pays that amount to the nursing facility or ICF/IID.
- B. Nursing facility or ICF/IID residents may elect hospice if their nursing facility or ICF/IID has an agreement with a Medicaid hospice provider.
 - 1. Medicaid pays the hospice for their care along with a separate rate to cover room and board.
 - 2. Medicaid will not pay the nursing facility or ICF/IID directly for room and board.
- C. The Arkansas Medicaid Program remits reimbursement for room and board to the hospice.
- D. The hospice then remits that amount to the nursing facility or ICF/IID.
 - 1. Room and board services include the performance of personal care services including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

2. Room and board is reimbursable only in conjunction with routine home care or continuous home care.
- E. Billing for routine home care and continuous home care for patients residing in nursing facilities or ICF/IIDs requires a special procedure. See Section 250.221 for special billing instructions.
- F. See Section 250.240 for billing instructions related to nursing facility or ICF/IID room and board reimbursement.

240.310 Fee Schedules

12-1-12

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at <https://medicaid.mmis.arkansas.gov/> under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

240.400 Rate Appeal Process

11-1-06

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program/provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the program/provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Health and Human Services (DHHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

250.000 BILLING PROCEDURES

250.100 Introduction to Billing

7-1-20

- A. Hospice providers use Uniform Billing form (red-lined sensor paper) CMS-1450 (UB-04) for paper claims.
 1. Each claim may contain charges for only one (1) beneficiary.
 2. A Hospice claim must be for charges incurred within a single calendar month.

- B. Section III of this manual contains information about available options for filing electronic claims.
- C. Medicaid does not supply providers with Uniform Billing claim forms. Numerous vendors sell UB-04 claim forms. [View a sample CMS-1450 \(UB-04\) claim form.](#)
- D. Complete Arkansas Medicaid Hospice Program claims in accordance with the National Uniform Billing Committee *Official UB-04 Data Specifications Manual* (UB-04 Manual) and Arkansas Medicaid's billing instructions and rules.
- E. The National Uniform Billing Committee (NUBC) is a voluntary committee whose work is coordinated by the American Hospital Association (AHA).
 - 1. The NUBC is the official source of information regarding the UB-04 claim form. [View or print NUBC contact information.](#)
 - 2. The committee develops, maintains, and distributes to its subscribers the UB-04 Manual and periodic updates.
 - 3. The NUBC is also a vendor of UB-04 claim forms.

250.200 Paper Claim Processing and Remittance **11-1-17**

- A. There may be occasional instances when submitting a paper claim is necessary, for instance, to include a letter or an attachment to resolve a timely filing or eligibility issue.
- B. Claims that are submitted on paper solely because they require attachments or special handling are usually paid in less than 30 days after adjudication.

250.210 Hospice Revenue Codes **1-1-16**

The following revenue codes must be used to bill for the six categories of Medicaid Hospice care and for Hospice Nursing Facility or ICF/IID Room and Board.

Revenue Code	Description	Unit of Service
0651	Routine Home Care	1 Day
0652	Continuous Home Care	1 Hour
0655	Inpatient Respite Care	1 Day
0656	General Inpatient Care	1 Day
0658	Nursing Facility or ICF/IID Room and Board	1 Day
0659	Home Style Facility	1 Day
G0155	Services of Clinical Social Workers	15 Min
G0299	Services of Registered Nurse	15 Min

250.211 Hospice Physician Services **12-1-07**

This provider manual does not contain billing instructions for physician services for Hospice patients. See the Arkansas Medicaid Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual for physician billing information.

250.220 Hospice Care Paper Claims **12-1-07**

- A. The Hospice Program has two sets of instructions for completing paper claims, and each Hospice claim must be completed in accordance with only one of those sets of instructions.
 - 1. The Medicaid Management Information System (MMIS) uses Institutional Outpatient business rules to process Hospice claims for Routine Home Care, Continuous Home Care, Inpatient Respite Care and General Inpatient Care.
 - 2. The MMIS uses Nursing Facility business rules to process Hospice claims for Nursing Facility and ICF/IID Room and Board.
- B. Medicaid's billing rules and instructions in this provider manual, supplemented by all applicable data specifications and requirements of the NUBC UB-04 Manual, must be followed to the highest level of specificity required for Medicaid.
- C. See Section 250.230 for UB-04 billing instructions to claim reimbursement for the Hospice Program's four categories of care.
- D. See Section 250.240 for instructions for claiming reimbursement for Nursing Facility or ICF/IID Room and Board for Hospice patients who reside in nursing facilities or ICF/IIDs.
- E. Submit to the program's fiscal agent correctly and legibly completed UB-04 claims (red-ink sensor technology only). [View or print Claims Department contact information](#). Retain claim copies with patients' records.
- F. Any provider furnishing services without verifying a beneficiary's eligibility for each date of service does so at the risk of being denied Medicaid reimbursement. Providers are strongly encouraged to print electronic eligibility verifications and retain them until paid.

250.221

General Hospice Billing Rules

12-1-07

- A. Medicaid covers and pays for only one Hospice service per beneficiary per day, unless the beneficiary is a nursing facility or ICF/IID resident (as defined in part A1 of this section) and resides at the facility each day for which Medicaid pays the Hospice provider Nursing Facility or ICF/IID Room and Board.
 - 1. In the Hospice Program, a "nursing facility or ICF/IID resident" is
 - a. A Medicaid beneficiary who has applied for long-term care assistance through the Arkansas Medicaid Program,
 - b. Who has been found eligible for Arkansas Medicaid long-term care assistance and
 - c. For whose long-term care the Medicaid Program would be making a vendor payment directly to the nursing facility or ICF/IID had the beneficiary not elected Hospice care.
 - 2. Nursing Facility or ICF/IID Room and Board (revenue code **0658**) must be billed as the only Hospice service on a claim, because this type of claim is processed differently from Hospice home and inpatient care claims: however, a single Nursing Facility or ICF/IID Room and Board claim may include multiple dates of service within the same calendar month.
 - 3. Hospice providers may bill Medicaid for Nursing Facility or ICF/IID Room and Board on one claim form for a period of consecutive residential days, subject to the following conditions.
 - a. The period of Nursing Facility or ICF/IID Room and Board begins on a day the beneficiary receives, in accordance with a Hospice plan of care, Routine Home Care or Continuous Home Care at the facility.
 - b. The period ends on the date of the *earliest* of the days described in subparts b, i through b, ii.
 - i. The last day of the calendar month of the claim's beginning date, even if

- the last day has the same date as the beginning date
- ii. The day the patient revokes Hospice, is discharged from Hospice or expires at the facility.
 - iii. The first day after the room-and-board claim's beginning date that the beneficiary receives any category of Hospice care other than Routine Home Care or Continuous Home Care.
- B. Inpatient Respite Care (revenue code **0655**) may never be billed for the same date of service as the service date of any other Hospice service, including Nursing Facility or ICF/IID Room and Board.
- C. General Inpatient Care (revenue code 0656) may never be billed for the same date of service as that of any other Hospice service, including Nursing Facility or ICF/IID Room and Board.
- D. Routine Home Care or Continuous Home Care, as applicable and as defined, may be billed for services performed in the patient's home or other residence, a nursing facility or ICF/IID or a hospice facility accommodation (not inpatient) that meets standards for "home-like" environment.
1. For Routine Home Care, one day (less than 8 hours of care on the same calendar day) is 1 unit of service.
 2. For Continuous Home Care, one hour (not to exceed 24 on the same calendar day) is 1 unit of service.

250.230

Completing a CMS-1450 (UB-04) Paper Claim for Hospice Care

8-1-18

Field #	Field name	Description
01.	(blank)	Required: Enter the Hospice provider's name, (physical address – service location) city, state, ZIP code and telephone number.
02.	(blank)	The address that the provider submitting the bill intends payment to be sent if different from FL 01. (Use this address for provider's return address for returned mail.)
03a.	PAT CNTL #	Required: This field is for accounting purposes. Enter the patient's financial account number; the number the Hospice uses to retrieve individual patients' financial account information. The account ("PAT CNTL") number appears on the RA, labeled " MRN ." This number ensures correct identification when reconciling the Medicaid remittance with patients' accounts. The Arkansas Medicaid fiscal agent accepts up to 16 alphanumeric characters in this field.
03b.	MED REC #	Required: Enter the patient's medical record number; the number the Hospice uses to file and retrieve individual patients' medical records. The Arkansas Medicaid fiscal agent accepts up to 15 alphanumeric characters in this field.
04.	TYPE OF BILL	Required: The first two digits must be 08 (Special Facility). The third digit must be 1 (Hospice, non-hospital based) or 2 (Hospice, hospital based). Use the applicable code from the UB-04 Manual for the third (i.e., frequency) digit.

Field #	Field name	Description
05.	FED TAX NO	The number assigned to the provider by the Federal government for tax reporting purposes. Also known as tax identification number (TIN) or employer identification number (EIN).
06.	STATEMENT COVERS PERIOD— FROM and THROUGH	Required: Enter the first and last service dates on this claim. In the Hospice Program, these dates must be within the same calendar month. The format is MMDDYY .
07.	Not used	Reserved for assignment by the NUBC.
08a.	PATIENT NAME	Required: Enter the patient's last name, first name and middle initial.
08b.	(blank)	Not required.
09.	PATIENT ADDRESS	Optional.
10.	BIRTH DATE	Required: Enter the patient's date of birth. The format is MMDDCCYY .
11.	SEX	Required: Enter M for male, F for female, or U for unknown.
12.	ADMISSION DATE	Enter the date that hospice services began or the date that the hospice plan of care was approved, whichever date is more recent. If the beneficiary has elected, then revoked hospice in the past, and then later re-elected hospice, enter the date services began under the most recent re-election or the date that the most recent new plan of care was authorized, whichever is more recent. The format is MMDDYY .
13.	ADMISSION HR	Not applicable to Hospice
14.	ADMISSION TYPE	Not applicable to Hospice
15.	ADMISSION SRC	Not applicable to Hospice
16.	DHR	Not applicable to Hospice
17.	STAT	Required: From the UB-04 manual, enter the code indicating the patient's disposition or discharge status on the Statement Covers Period THROUGH date (field 6).
18.-28.	CONDITION CODES	Enter when applicable. See the UB-04 Manual for requirements and for the codes used to identify conditions or events relating to this bill.
29.	ACDT STATE	Not required.
30.	(blank)	Unassigned data field.
31.-34.	OCCURRENCE CODES AND DATES	Enter when applicable. See the UB-04 Manual.
35.-36.	OCCURRENCE SPAN CODES AND DATES	Not applicable to Hospice
37.	Not used	Reserved for assignment by the NUBC.

Field #	Field name	Description
38.	Responsible Party Name and Address	Not applicable to Hospice
39.	VALUE CODES	<p>Required when the claim is for only one consecutive period (within the same calendar month) of one Hospice care category (except Continuous Home Care) and that consecutive period is identical to the period identified by the Statement Covers Period (field 6) FROM and THROUGH dates. Enter number of days (units billed) to the left of the vertical dotted line and enter two zeroes (00) to the right of the vertical dotted line.</p> <p>Not applicable to Continuous Home Care.</p>
a.	CODE	When applicable, as determined by the VALUE CODES requirement rule, enter 80.
b.	AMOUNT	When applicable, as determined by the VALUE CODES requirement rule, enter the number of days between the Statement Covers Period FROM date and THROUGH date (field 6), inclusive. Enter number of days (units billed) to the left of the vertical dotted line and enter two zeroes (00) to the right of the vertical dotted line.
40.	VALUE CODES	Not required.
41.	VALUE CODES	Not required.
42.	REV CD	Required: Enter the applicable Hospice Program revenue code. When the claim is for Continuous Home Care, enter revenue code 0652 once for each date of service
43.	DESCRIPTION	Required: From the UB-04 Manual, enter the Hospice revenue code's Standard Abbreviation. Required only on paper claims
44.	HCPCS/RATE/HIPPS CODE	Not applicable to Hospice
45.	SERV DATE	<p>Required on claims for Continuous Home Care. Enter the applicable date of service for each entry of revenue code 0652. Every service date must be within the Statement Covers Period FROM and THROUGH dates (field 6), inclusive.</p> <p>Required when the claim is for non-sequential service dates for one Hospice care category (excluding Continuous Home Care, which has its own billing rules) or for more than one Hospice care category.</p> <p>When required, enter a service date for each entry of each Hospice revenue code. Service dates must be within the Statement Covers Period FROM and THROUGH dates (field 6), inclusive.</p>
46.	SERV UNITS	When service dates are required in field 45, service units are required in field 46. For Continuous Home Care, enter total hours of service for each service date. For the other three categories of Hospice care, enter "1" for each service date when service dates are required.

Field #	Field name	Description
47.	TOTAL CHARGES	Required: Enter the total charge for the revenue code on each line (Units times the charge for one unit of service).
48.	NON-COVERED CHARGES	Not applicable to Hospice
49.	Not used	Reserved for assignment by the NUBC.
50.	PAYER NAME	Required: Enter "Medicaid"
51.	HEALTH PLAN ID	Report the HIPAA National Plan Identifier; otherwise report the legacy/proprietary number.
52.	REL INFO	Required: One of two alternative entries 1) "I" ("Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes") when the Hospice provider has not collected a Release of Information Certification Signature from the patient or the patient's representative, or 2) "Y" ("Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim"). This is a HIPAA Privacy Rule requirement.
53.	ASG BEN	Not applicable to Hospice
54.	PRIOR PAYMENTS	Required when applicable. Enter all payments made by any other parties toward this bill. See the UB-04 Manual
55.	EST AMOUNT DUE	Not applicable to Medicaid
56.	NPI	Either NPI or Medicaid Provider ID Required: Enter NPI of the billing provider or if submitting with the 9 digit Medicaid Provider ID enter the number in field 57.
57.	OTHER PRV ID	Required: Enter the 9-digit Arkansas Medicaid provider ID number of the billing Hospice provider.
58. A, B, C	INSURED'S NAME	Not applicable to Medicaid.
59. A, B, C	P REL	Not applicable to Medicaid.
60. A, B, C	INSURED'S UNIQUE ID	Required; Enter the patient's Medicaid identification number.
61. A, B, C	GROUP NAME	Required when the patient is insured by another payer or other payers. Refer to the UB-04 manual.
62. A, B, C	INSURANCE GROUP NO	Required when applicable. See the UB-04 Manual.
63. A, B, C	TREATMENT AUTHORIZATION CODES	Required only when a benefit extension was required for an Inpatient Respite Care stay. When required, enter the benefit extension control number.
64. A, B, C	DOCUMENT CONTROL NUMBER	Field used internally by Arkansas Medicaid. No provider input.
65. A, B, C	EMPLOYER NAME	Required when a beneficiary is covered by other insurance through an employer. Enter the employer's name.

Field #	Field name	Description
66.	DX	Diagnosis Version Qualifier. See the UB-04 Manual. Qualifier Code "9" designating ICD-9-CM diagnosis required on claims. Qualifier Code "0" designating ICD-10-CM diagnosis required on claims. Comply with the UB-04 Manual's instructions on claims processing requirements.
67.	(blank)	Required when applicable. Enter any ICD-9-CM or ICD-10-CM diagnosis codes for other conditions that coexist with the terminal condition.
68.	Not used	Reserved for assignment by the NUBC.
69.	ADMIT DX	Required. Enter the most specific ICD-9-CM or ICD-10-CM diagnosis code that corresponds to the beneficiary's terminal condition.
70.	PATIENT REASON DX	Not applicable to Hospice
71.	PPS CODE	Not required.
72.	ECI	Not applicable to Hospice.
73.	Not used	Reserved for assignment by the NUBC.
74.	PRINCIPAL PROCEDURE CODE AND DATE and OTHER PROCEDURE CODES AND DATES	Not applicable to Hospice.
75.	Not used	Reserved for assignment by the NUBC.
76.	ATTENDING NPI QUAL LAST FIRST	Enter NPI for primary attending physician. Enter the 9-digit Arkansas Medicaid provider ID number of the primary attending physician. Required: Enter the last name of the primary attending physician during this episode of care. Required: Enter the primary attending physician's first name. Note: Either the NPI or the 9-digit Arkansas Medicaid provider ID number is required in field 76.
77.	OPERATING NPI QUAL LAST FIRST	Not applicable to Hospice Not applicable to Hospice Not applicable to Hospice Not applicable to Hospice
78.	OTHER NPI QUAL LAST	NPI only required for referring provider: Enter NPI of the referring provider. Not Required. Required: Enter the referring physician's last name.

Field #	Field name	Description
	FIRST	Required: Enter the referring physician's first name. NOTE: When there is no referring physician, enter the same information entered in field 76.
79.	OTHER NPI	Required for Inpatient Respite Care and General Inpatient Care claims. Enter NPI of the Inpatient Facility.
	QUAL	Enter the 9-digit Arkansas Medicaid provider ID number of the inpatient facility. Note: Either the NPI or the 9-digit Arkansas Medicaid provider ID number is required in field 79.
	LAST	Not applicable
	FIRST	Not applicable.
80.	REMARKS	For provider's use. Providers may enter the inpatient facility's name and/or other notes here.
81.	Not used	Reserved for assignment by the NUBC.

250.240

Completing a CMS-1450 (UB-04) Claim Form for Nursing Facility or ICF/IID Room and Boards

8-1-18

Field #	Field name	Description
01.	(blank)	Required: Enter the billing (i.e., Hospice) provider's name, (physical address – service location) city, state, zip code, and telephone number.
02.	(blank)	The address that the provider submitting the bill intends payment to be sent if different from FL 01. (Use this address for provider's return address for returned mail.)
03a.	PAT CNTL #	Required: Enter the patient's financial account number; the number the Hospice uses to retrieve individual patients' financial account information. This account number appears on the RA, labeled " MRN. " Use this number to ensure correct identification when reconciling the Medicaid remittance with patients' accounts. The Arkansas Medicaid fiscal agent accepts up to 16 alphanumeric characters in this field.
03b.	MED REC #	Required: Enter the patient's medical record number; the number the Hospice uses to file and retrieve individual patients' medical records. The Arkansas Medicaid fiscal agent accepts up to 15 alphanumeric characters in this field.
04.	TYPE OF BILL	Required: The first two digits must be 81 (Special Facility/Hospice, non-hospital based) or 82 (Special Facility/Hospice, hospital based). Use the applicable code from the UB-04 Manual for the third (i.e., frequency) digit.
05.	FED TAX NO	The number assigned to the provider by the Federal government for tax reporting purposes. Also known as tax identification number (TIN) or employer identification number (EIN).

Field #	Field name	Description
06.	STATEMENT COVERS PERIOD— FROM and THROUGH	<p>Required</p> <p>The FROM date in field 06 is the date of the first day on this claim for which the Hospice provider claims reimbursement for nursing facility or ICF/IID room and board. The format is MMDDYY.</p> <p>The THROUGH date in field 06 is either the patient's discharge date or the last day on this claim for which the Hospice provider claims reimbursement for Nursing Facility or ICF/IID Room and Board. When a patient is temporarily transferred to a hospital, an Inpatient Hospice Facility or home, the transfer date is a discharge date with respect to Nursing Facility or ICF/IID Room and Board reimbursement. The date that Hospice home care in the facility resumes or the date that the patient's Hospice plan of care is approved, whichever is more recent, is the FROM date in field 06 of the next claim for that patient's Nursing Facility or ICF/IID Room and Board.</p> <p>In the Hospice Program, the "STATEMENT COVERS PERIOD" FROM and THROUGH dates must always be within the same calendar month. The format is MMDDYY.</p>
07.	Not used	Reserved for assignment by the NUBC.
08a.	PATIENT NAME	Required: Enter the patient's last name, first name and middle initial.
08b.	(blank)	Not required.
09.	PATIENT ADDRESS	Optional.
10.	BIRTH DATE	Required: Enter the patient's date of birth. The format is MMDDYYYY .
11.	SEX	Required: Enter M for male, F for female, or U for unknown.
12.	ADMISSION DATE	<p>Required: Enter the date that nursing facility or ICF/IID Hospice services began at this facility or the date that the plan of care was approved for nursing facility or ICF/IID Hospice home care, whichever date is more recent.</p> <p>When a Hospice client has been discharged and temporarily transferred to a hospital, an Inpatient Hospice Facility, a different nursing facility or ICF/IID or home, and then readmitted to this facility, enter the readmission date, the date that nursing facility or ICF/IID Hospice services resumed at this facility or the date that a new or revised plan of care for Hospice home care in this facility was approved, whichever date is more recent.</p> <p>If the beneficiary has elected, and then revoked nursing facility or ICF/IID Hospice home care in the past; and then later re-elected nursing facility or ICF/IID Hospice home care, enter the date that Hospice care resumed under the re-election or the date that the new plan of care was authorized, whichever is more recent. The format is MMDDYY.</p>
13.	ADMISSION HR	Not applicable to Hospice

Field #	Field name	Description
14.	ADMISSION TYPE	Not applicable to Hospice
15.	ADMISSION SRC	Not applicable to Hospice
16.	DHR	Not applicable to Hospice
17.	STAT	Required: From the UB-04 manual, enter the patient status code indicating the patient's disposition or discharge status on the "STATEMENT COVERS PERIOD" THROUGH date (field 06).
18.-28.	CONDITION CODES	Required when applicable. See the UB-04 Manual for any applicable requirements and for the NUBC-authorized codes that identify conditions or events relating to this bill. Use only condition codes that are NUBC-approved for the service date(s).
29.	ACDT STATE	Not applicable to Hospice
30.	(blank)	Unassigned data field.
31.-34.	OCCURRENCE CODES AND DATES	Not applicable to Hospice nursing facility or ICF/IID Room and Board.
35.-36.	OCCURRENCE SPAN CODES AND DATES	Not applicable to Hospice nursing facility or ICF/IID Room and Board.
37.	Not used	Reserved for assignment by the NUBC.
38.	Responsible Party Name and Address	Not applicable to Hospice nursing facility or ICF/IID Room and Board.
39.	VALUE CODES	Required
a.	CODE	Enter 80 .
	AMOUNT	Required: Enter the number of days for which nursing facility or ICF/IID room and board is due, as indicated by the "STATEMENT COVERS PERIOD" FROM and THROUGH dates. The THROUGH date is covered unless it is a transfer date or a discharge date. Enter number of days (units billed) to the left of the vertical dotted line and enter two zeros (00) to the right of the vertical dotted line.
40.	VALUE CODES	Not required.
41.	VALUE CODES	Not required.
42.	REV CD	Required: Enter 0658 or 0659
43.	DESCRIPTION	Required: Enter the revenue code's standard abbreviation, "HOSPICE/R&B NURSE FAC."
44.	HCPCS/RATE/HIPPS CODE	Not applicable to Hospice
45.	SERV DATE	Not applicable to Hospice Nursing Facility or ICF/IID Room and Board
46.	SERV UNITS	Not applicable to Hospice Nursing Facility or ICF/IID Room and Board
47.	TOTAL CHARGES	Required: Enter the total charge. The daily room and board rate times the covered days equals the total charge.

Field #	Field name	Description
48.	NON-COVERED CHARGES	Not applicable to Hospice
49.	Not used	Reserved for assignment by the NUBC.
50.	PAYER NAME	Required: Enter "Medicaid."
51.	HEALTH PLAN ID	Report the HIPAA National Plan Identifier; otherwise report the legacy/proprietary number.
52.	REL INFO	<p>Required: One of two alternative entries;</p> <p>1) "I" ("Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes") when the Hospice provider has not collected a Release of Information Certification Signature from the patient or the patient's representative, and state or federal laws do not supersede the HIPAA Privacy Rule by requiring that a signature be collected; or</p> <p>2) "Y" ("Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim").</p> <p>Completing this field as instructed is a HIPAA Privacy Rule requirement.</p>
53.	ASG BEN	Not applicable to Medicaid
54.	PRIOR PAYMENTS	Required when applicable. Enter the total amount paid by any parties (other than Medicaid) toward this bill. See the UB-04 Manual for details.
55.	EST AMOUNT DUE	Not applicable to Medicaid
56.	NPI	Either NPI or Medicaid Provider ID Required: Enter NPI of billing provider or if submitting with the 9-digit Medicaid Provider ID enter the number in field 57.
57.	OTHER PRV ID	Enter the 9-digit Arkansas Medicaid provider ID number of the billing Hospice provider.
58. A, B, C	INSURED'S NAME	Not applicable to Medicaid.
59. A, B, C	P REL	Not applicable to Medicaid.
60. A, B, C	INSURED'S UNIQUE ID	Enter the patient's Medicaid identification number.
61. A, B, C	GROUP NAME	If the patient is insured by another payer or other payers, see the UB-04 manual.
62. A, B, C	INSURANCE GROUP NO	When applicable, see the UB-04 Manual.
63. A, B, C	TREATMENT AUTHORIZATION CODES	Not applicable to Hospice nursing facility or ICF/IID room and board.
64. A, B, C	DOCUMENT CONTROL NUMBER	Field used internally by Arkansas Medicaid. No provider input is permitted.
65. A, B, C	EMPLOYER NAME	When a beneficiary is covered by other insurance through an employer, enter the employer's name.

Field #	Field name	Description
66.	DX	Diagnosis Version Qualifier. See the UB-04 Manual. Qualifier Code "9" designating ICD-9-CM diagnosis required on claims. Qualifier Code "0" designating ICD-10-CM diagnosis required on claims. Comply with the UB-04 Manual's instructions on claims processing requirements.
67.	(watermarked)	Enter the ICD-9-CM or ICD-10-CM diagnosis code corresponding to the beneficiary's terminal condition.
67 A-Q	(watermarked)	Enter the ICD-9-CM or ICD-10-CM diagnosis codes corresponding to other conditions that coexist with the terminal condition.
68.	Not used	Reserved for assignment by the NUBC.
69.	ADMIT DX	Not applicable to Hospice nursing facility or ICF/IID room and board.
70.	PATIENT REASON DX	Not applicable to Hospice
71.	PPS CODE	Not applicable to Hospice
72	ECI	Not applicable to Hospice.
73.	Not used	Reserved for assignment by the NUBC.
74.	PRINCIPAL PROCEDURE CODE AND DATE and OTHER PROCEDURE CODES AND DATES	Not applicable to Hospice.
75.	Not used	Reserved for assignment by the NUBC.
76.	ATTENDING NPI QUAL LAST FIRST	Enter NPI of primary attending physician. Enter the 9-digit Arkansas Medicaid provider ID number of the primary attending physician. Enter the primary attending physician's last name. Enter the primary attending physician's first name. Note: Either the NPI or the 9-digit Arkansas Medicaid provider ID number is required in field 76.
77.	OPERATING NPI QUAL LAST FIRST	Not applicable to Hospice Not applicable to Hospice Not applicable to Hospice Not applicable to Hospice
78.	OTHER NPI QUAL	Enter NPI of the nursing facility or the ICF/IID in which the patient resides, or enter the Medicaid ID. Enter G2, indicating Medicaid ID. Enter, in the second part of the field, the 9 digit Medicaid provider ID number of the nursing facility or ICF/IID in which the patient resides.

Field #	Field name	Description
	LAST	Enter the name of the nursing facility or the ICF/IID in which the patient resides
	FIRST	Not applicable. Note: Either the NPI or the 9-digit Arkansas Medicaid provider ID number is required in field 78.
79.	OTHER NPI	Not applicable to Hospice
	QUAL	Not applicable to Hospice
	LAST	Not applicable to Hospice
	FIRST	Not applicable to Hospice
80.	REMARKS	For provider's use.
81.	Not used	Reserved for assignment by the NUBC.