

# HOSPICE SERVICES

## ELIGIBLE PROVIDERS

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

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

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

## ELIGIBLE RECIPIENTS

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

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

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

Refer to the [Recipient Eligibility](#) manual for additional information regarding eligibility including information regarding limited coverage aid categories.

### Level of Care Requirements

A recipient may live in a home in the community or in a long-term care facility while receiving hospice care. A recipient receiving hospice services in a skilled nursing facility, ICF-IID, swing bed, assisted living center, community support provider, or inpatient hospice must meet the level of care requirements in [ARSD Ch. 67:45:01](#).

### Physician Certification

A written certification statement of terminal illness signed by the medical doctor of the hospice or a physician member of the hospice interdisciplinary group and the recipient's attending physician or other licensed practitioner should be obtained within two calendar days after hospice care is initiated. If the hospice does not obtain written certification within two calendar days after hospice care is initiated, a verbal certification must be obtained within the two calendar days and a written certification must then be obtained no later than eight days after care is initiated. If the certification requirements are not met, no payment can be made for hospice care provided prior to the date of any subsequent certification. The certification statement must include a statement indicating the recipient's medical prognosis is a life expectancy of six months or less.

### Physician Recertification

The hospice must obtain written recertification of terminal illness for each benefit period, even if a single election continues in effect. The first two benefit periods are for 90 days. After the initial two benefit periods, all subsequent benefit periods are 60 days. Recertifications may be completed up to 15 calendar days before the start of the next benefit period and no later than 2 calendar days after the beginning of the period. For the re-certification (for subsequent hospice benefit periods), only the hospice medical director or the physician member of the interdisciplinary group is required to sign and date the certification. The recipient's attending physician is not required to sign and date the recertification. The certification must include the statement that the recipient's life expectancy is 6 months or less if the terminal illness runs its normal course. The hospice must retain the certification statements.

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

### Election of Hospice Care Statement

A recipient who is eligible for hospice care and who wishes to elect hospice care must sign an election statement. The election statement must include:

- The name of the hospice provider;
- An acknowledgment that the recipient understands that hospice provides palliative, not curative care for the terminal illness;
- An acknowledgment that the recipient waives all rights to Medicaid payments for the duration of the election of hospice care for the following services:
  - Hospice care provided by a hospice other than the designated hospice unless the care is provided under arrangement made by the designated hospice; and
  - Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected, a related condition or the equivalent to hospice care except services:
    - Provided directly or under arrangements by the designated hospice;

- Provided by the recipient's attending physician if the physician is not an employee of or receiving compensation from the designated hospice;
- Provided as room and board by a nursing facility or ICF-IID if the recipient is a resident of the facility;
- The effective date of the election; and
- The signature of the recipient.

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

#### Revocation of Election of Hospice Care

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

## COVERED SERVICES AND LIMITS

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### **General Coverage Principles**

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

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

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

### **Notification to the Department**

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

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

### **Change of Designated Hospice Provider**

A recipient may change the designation of the hospice provider from which the recipient chooses to receive care. A change of the designated hospice provider is not a revocation of the election. The recipient must sign a statement indicating the name of the hospice provider from which the recipient was receiving care, the name of the newly designated hospice provider, and the effective date of the change. A copy of the statement must be maintained by both hospice providers.

### **Hospice Coverage**

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

### Plan of Care

An interdisciplinary team must assess a recipient's needs and develop a written plan of care before hospice services are provided. At least two members of the interdisciplinary team must be involved in the development of the initial plan of care, and one of these individuals must be a nurse or physician or other licensed practitioner. The other members of the interdisciplinary team must review and provide input to the plan of care within two working days following the day of assessment. Services provided by the hospice must be consistent with the plan of care and must be reasonable and necessary for palliation or management of the terminal illness and related conditions.

### Core and Supplemental Services

The hospice must provide both core services and supplemental services to the recipient based upon the recipient's individual needs. Core services must routinely be provided directly by hospice employees. The hospice may contract for supplemental services provided during periods of peak patient load or for extraordinary circumstances. All services must be performed by appropriately qualified personal.

Core services include:

- Nursing services provided by or under the supervision of a registered nurse;
- Social services provided by a social worker under the direction of a physician or other licensed practitioner;
- Services performed by a physician or other licensed practitioner, dentist, optometrist, or chiropractor; and
- Counseling services provided to the recipient and family member or other persons caring for the recipient at the recipient's home. Counseling, including dietary counseling, may be provided to train the recipient's family or caregiver to provide care and help the recipient, family members, and caregivers adjust to the recipient's approaching death.

Supplemental services include:

- Inpatient hospice care including procedures necessary for pain control or acute or chronic system management;
- Inpatient respite care;

- Medical equipment supplies and drugs. Medical equipment including self-help and personal comfort items related to the palliation or management of the recipient's terminal illness must be provided by hospice for use in the recipient's home. Medical supplies include supplies specified in the written plan of care. Drugs include those used to relieve pain and control symptoms for the recipient's terminal illness;
- Home health aide services and homemaker services which include personal care services and household services, such as changing a bed, light cleaning and laundering, necessary to maintain a safe and sanitary environment in areas of the home used by the recipient. Aide services must be provided under the supervision of a registered nurse; and
- Physical therapy, occupational therapy, and speech and language pathology services provided for symptom control or to maintain activities of daily living and basic functional skills.

### HCBS Waiver Services

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

### Treatment of Terminal Condition

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

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

### **Categories of Hospice Care**

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

### Routine Home Care Day (Revenue Code 651)

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

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

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

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

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

#### Continuous Home Care Day (Revenue Code 652)

A continuous home care day is a day on which an individual who has elected to receive hospice care is not in an inpatient facility (inpatient hospital) and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Home health aide (also known as a hospice aide) or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill patient at home. A period of crisis is a period in which the individual requires continuous care to achieve palliation and management of acute medical symptoms.

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

A minimum of 8 hours of care per day must be provided more than half of which must be nursing services. The hospice provider is reimbursed on an hourly basis for every hour of continuous home care furnished up to a maximum of 24 hours a day. If the criteria for a continuous home care day is not met, it is considered a routine home care day.

#### Inpatient Respite Care (Revenue Code 655)

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

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

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

### General Inpatient Care Day (Revenue Code 656)

A general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings. This level of hospice care may only be provided in a skilled nursing facility, ICF-IID, swing bed, inpatient hospice, or hospital. Inpatient care is provided for a limited period of time as determined by the physician and interdisciplinary team.

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

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

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

### **Room and Board (Revenue Code 659)**

Once a nursing facility resident elects hospice, the recipient is considered a hospice patient and no longer a nursing facility patient for billing purposes.

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

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

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

## NON-COVERED SERVICES

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### General Non-Covered Services

Providers should refer to [ARSD 67:16:01:08](#) or the [General Coverage Principles](#) manual for a general list of services that are not covered by South Dakota Medicaid.

### Non-Covered Hospice Services

#### Volunteer Physician Services

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

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

## DOCUMENTATION REQUIREMENTS

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### General Requirements

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

## REIMBURSEMENT AND CLAIM INSTRUCTIONS

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### Timely Filing

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

### Third-Party Liability

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



## **Reimbursement**

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

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

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

### Services Included in the Fee Schedule Rate

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

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

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

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

### Inpatient Care Days Limits

Payments for inpatient care days will be limited according to the number of inpatient care days furnished to medical assistance recipients by the hospice in a year. The maximum number of payable inpatient respite and general inpatient days may not exceed 20 percent of the total number of hospice care days provided to all Medicaid recipients by the hospice. If the maximum number of days exceeds

twenty percent of total days, an adjustment will be made to pay the excess days at the routine home care rate and the difference will be recovered from the hospice provider. The limitation on inpatient care days does not apply to recipients diagnosed with acquired immunodeficiency syndrome (AIDS).

#### Room and Board

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

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

#### Post-Eligibility Treatment of Income

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

### **Claim Instructions**

#### Hospice Services

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

#### Physician Services Unrelated to the Terminal Illness

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

## **DEFINITIONS**

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1. "Assisted living center," a facility as defined in [SDCL 34-12-1.1\(2\)](#);
2. "Continuous home care day," a category of care as defined in [42 CFR 418.302](#) (as amended to January 1, 2010);
3. "Community support provider," a nonprofit facility as defined in [SDCL 27B-1-17\(4\)](#);
4. "General inpatient care day," a category of care as defined in [42 CFR 418.302](#) (as amended to January 1, 2010).

5. "Hospice facility," an agency or organization engaged in providing care to terminally ill individuals;
6. "Inpatient respite care day," a category of care as defined in [42 CFR 418.302](#) (as amended to January 1, 2010);
7. "Inpatient hospice," a facility as defined in [SDCL 34-12-1.1\(10\)](#);
8. "ICF-IID," a facility as defined in [ARSD 67:54:03:01](#);
9. "Nursing facility," a facility as defined in [SDCL 34-12-1.1\(7\)](#);
10. "Residential hospice," a facility as defined in [SDCL 34-12-1.1\(11\)](#);
11. "Routine home care day," a category of care as defined in [42 CFR 418.302](#) (as amended to January 1, 2010);
12. "Swing bed," a licensed hospital bed approved by the Department of Health to provide short-term nursing facility care pending the availability of a nursing facility bed; and
13. "Terminally ill," a medical prognosis that an individual's life expectancy is six months or less if the illness runs its normal course.

## REFERENCES

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- [Administrative Rule of South Dakota \(ARSD\)](#)
- [South Dakota Medicaid State Plan](#)
- [Code of Federal Regulations](#)

## QUICK ANSWERS

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

Yes, providers are required to notify the Division of Economic Assistance that the recipient had been discharged or revoked their election of hospice services. If the recipient is electing hospice services again, the provider must notify the Division of Economic Assistance of the new election using the form available on our [website](#).

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

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

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

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