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1. Section Modifications

Version	Section	Modification Description	Publish Date	SME
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7.1	2.3.2.1 Participant Hospice Eligibility	Deleted invalid content	1/22/2016	C Brock D Baker C Loveless
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6.1	2.3.4.2 Routine Home Care	Added Section	1/4/2016	A Coppinger D Baker
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5.1	2.2.8.3 Crossover Claims	Updated per December 2015 COB changes	12/1/15	C Coyle D Baker
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3.19	2.3.4.3 Restrictions	Updated to align with current policy	6/27/2013	A Farmer /J Ehrhart
3.18	2.3.4.2 Covered Services	Updated for clarity	6/27/2013	A Farmer /J Ehrhart
3.17	2.3.4.1 Customary Fees	Updated for clarity	6/27/2013	A Farmer /J Ehrhart
3.16	2.3.3.3 Agreements with RALF or CFH	Added CFH	6/27/2013	A Farmer /J Ehrhart
3.15	2.3.3.1 Participant Liability	Updated to align with current policy	6/27/2013	A Farmer /J Ehrhart
3.14	2.3.2.5 Hospice Revocation, Discharge,	Updated to align with current policy	6/27/2013	A Farmer /J Ehrhart

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	Transfer, or Notice of Death			
3.13	2.3.2.4 Election Period and Recertification Periods	Updated to align with current policy	6/27/2013	A Farmer /J Ehrhart
3.12	2.3.2.3 PA for SNF Room and Board	Updated to align with current policy	6/27/2013	A Farmer /J Ehrhart
3.11	2.3.2.2 Hospice Election and Recertification Notifications	Updated to align with current policy	6/27/2013	A Farmer /J Ehrhart
3.10	2.3.2.1 Participant Hospice Eligibility	Updated to align with current policy	6/27/2013	A Farmer /J Ehrhart
3.9	2.3.2 General Policy	Updated to align with current policy	6/27/2013	A Farmer /J Ehrhart
3.8	2.3 Hospice Service Policy	Updated for clarity	6/27/2013	A Farmer /J Ehrhart
3.7	2.2.8.3 Crossover Claims	Added for clarity	6/27/2013	J Siroky
3.6	2.2.8.2 Interim Payment	Added for clarity	6/27/2013	J Siroky
3.5	2.2.8.1 Customary Fees	Added for clarity	6/27/2013	J Siroky
3.4	2.2.5.1 Prior Authorization	Moved section under 2.2.5 Limits and added additional verbiage for clarity	6/27/2013	J Siroky
3.3	2.2.3 Program Abuse	Added section	6/27/2013	J Siroky
3.2	2.2.2 Participant Eligibility	Reworded for clarification	6/27/2013	J Siroky
3.1	2.2.1 Home Health Service Policy	Reworded for clarification	6/27/2013	J Siroky
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2.3	2.3.11.2 Agreements between Hospice Agencies and Nursing Facilities or ICF/ID	Changed Mentally Retarded (MR) to Intellectually Disabled (ID)	3/22/2013	C Taylor
2.2	2.3.11.1 Participant Liability	Changed Mentally Retarded (MR) to Intellectually Disabled (ID)	3/22/2013	C Taylor
2.1	2.3.11 Hospice Participants Residing in NH/ICF/ID Facilities or RALF	Changed Mentally Retarded (MR) to Intellectually Disabled (ID)	3/22/2013	C Taylor
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1.4	1.2.2	Updated to match policy	8/27/2010	J Siroky
1.3	All	Replaced member with participant	8/27/2010	T Kinzler
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1.1	All	Updated numbering for sections to accommodate Section Modifications	8/27/2010	TQD
1.0	All	Initial document – Published version	5/7/2010	TQD

2. Agency - Institutional

2.1. Introduction

The Agency-Institutional section covers policy information for the following specialties:

- Home Health
- Hospice

2.2. Home Health Service Policy

Home Health Program services include physician-ordered home health services delivered in the participant's residence under a written plan of care. Medicaid covered services include; skilled nursing, home health aide, physical therapy, occupational therapy, speech-language pathology, and durable medical equipment. Idaho requires that all enrolled home health agencies are first enrolled with Medicare.

All Medicare Conditions of Participation, including but not limited to the OASIS documentation and the requirement of a face-to-face visit by the ordering physician, apply to Medicaid participants.

2.2.1. Participant Eligibility

To be eligible for home health services, it must be necessary for a participant to receive services in the home. They must have a physician's order as part of a plan of care. All home health services must be medically necessary and may include; nursing services, supplies, home health aide services, durable medical equipment rentals, drugs, physical therapy, occupational therapy, and speech-language pathology.

The following criteria are used to define a medically necessary service:

- The service must be reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; and
- There is no other equally effective course of treatment, which is more conservative or costs substantially less, that is available or suitable for the participant requesting the service; and
- Medical services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records, including evidence of such medical necessity and quality.

2.2.2. Program Abuse

Providers are required to follow all state and federal regulations related to Medicaid including, but not limited to, the rules in *IDAPA 16.03.09 Medicaid Basic Plan Benefits, IDAPA 16.03.10 Medicaid Enhanced Plan Benefits,* and *IDAPA 16.05.07 The Investigation and Enforcement of Fraud, Abuse, and Misconduct.*

Program rules and regulations are strictly enforced and violators are subject to penalties for program fraud and abuse.

Note: All records must be made available to the Department upon request.

2.2.3. Advanced Directives

Home health service providers must explain to each participant their right to make decisions regarding their medical care. This includes the right to accept or refuse treatment. Home health care providers must inform the participant of their right to formulate advance directives, such as a Living Will or Durable Power of Attorney, before the participant is under the provider's care.

2.2.3.1. Evaluation Visit

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

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

2.2.4. Limits

Home health services are limited to a total of 100 medically necessary visits per participant, per calendar year.

2.2.4.1. Prior Authorization (PA)

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

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

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

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

2.2.5. Plan of Care

Federal and state Medicaid regulations require home health providers to have an established plan of care (POC) for each participant and to have each participant's plan reviewed by the attending physician every 60 days. A current POC must contain the physician's signature, dated within the required 60-day period. The home health agency must maintain a copy of the POC.

2.2.6. Medical Equipment and Supplies

Physician-ordered medical supplies and rented medical equipment must meet the following criteria for Medicaid payment.

- Medically necessary
- Suitable for use in the home
- Reevaluated at least once every 60 days

2.2.6.1. Rental Costs

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

2.2.6.2. Influenza Vaccinations

All routine injections are included in the reimbursement for home health agency scheduled nursing visits. The exception to this rule is the administration of the influenza vaccine. The Department of Health and Welfare will reimburse the agency "injection administration" costs if no other home health visit is billed on the same day as the vaccination. A description in the remarks section must indicate that influenza vaccine was administered.

2.2.7. Payment

2.2.7.1. Customary Fees

Medicaid reimburses home health services on a per visit basis. Usual and customary fees are paid up to the Medicaid maximum allowance. All home health services must be billed by the home health provider on the UB-04 claim form using the appropriate revenue and type of bill codes. See the *UB04 Instructions*, Idaho Medicaid Provider Handbook section for more information.

2.2.7.2. Interim Payment

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

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

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

Note: Mileage is included as part of the per-visit payment.

2.2.7.3. Crossover Claims

Medicare pays for some physician-ordered services for Medicare eligible participants. Participants may be dually eligible for Medicare and Medicaid. The provider must first bill Medicare for rendered services. A copy of the Medicare Remittance Notice (MRN) must be included with the Medicaid claim. If billing electronically, the information from Medicare must be entered on the appropriate screens.

QMB Only: Participants who are covered by QMB only are only eligible for Medicare covered services. Medicaid's payment for services will be calculated according to the "Member Responsibility" methodology.

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook *Coordination of Benefits (COB)* regarding Medicaid policy on billing all other third party resources before submitting claims to Medicaid. Participants cannot be billed for any non-reimbursed amount. Providers may only bill non-covered services to the participant if the provider has informed the participant of their responsibility to pay, preferably in writing, prior to rendering services.

2.3. Hospice Service Policy

Hospice is a public agency or private organization primarily engaged in providing care to terminally ill participants. Hospice agencies provide a holistic care concept designed to keep the participant comfortable, free of pain, and in the least restrictive environment possible by providing services that are reasonable and necessary for the palliation and management of a terminal illness, while honoring the individual's end-of-life care decisions. See hospice rules at Idaho Administrative Code, *IDAPA 16.03.10.450-460* at https://adminrules.idaho.gov/rules/current/16/160310.pdf.

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

The hospice agency is responsible for the overall management and coordination of the Hospice Plan of Care for participants who also have an Aged & Disabled (A&D) Waiver or Developmentally Disabled (DD) Waiver Plan of Care, or are receiving mental health services. The level of service within these Medicaid programs may be adjusted if the participant elects hospice. Rehabilitative services are not contained within the hospice philosophy of care, and therefore a service such as Psychosocial Rehabilitation is not covered once hospice is elected. The hospice Plan of Care supersedes any other Medicaid provider Plan of Care.

A participant may elect or revoke hospice services at any time during the benefit period. The hospice provider may not coerce or prevent a participant's termination of election.

Note: Hospice for Children under Age 21

Based on the Affordable Care Act pertaining to participants under age twenty-one (21), concurrent curative and hospice care are allowed. This means that children are not limited to palliative treatment only.

2.3.1. General Policy

This section covers all Medicaid services provided by hospice agencies as deemed appropriate by the Department of Health and Welfare. It addresses the following:

- 2.3.2.1 Participant Hospice Eligibility
- 2.3.2.2 Hospice Election and Recertification Notifications
- 2.3.2.3 Prior Authorization (PA) for Skilled Nursing Facility Room and Board

2.3.1.1. Participant Hospice Eligibility

Medicaid providers must first verify the participant's **Medicaid** eligibility through their Trading Partner Account (TPA) or by calling DXC Technology at 1 (866) 686-4272. In addition to verifying the participant's eligibility, the Medical Care Unit faxes an approval to the hospice agency. It is the hospice's responsibility to inform other providers the participant is eligible for hospice. The following are the eligibility requirements for hospice.

- The participant must be enrolled in Medicaid's Enhanced Plan. A physician must certify that the participant's life expectancy is six months or less.
- The participant must meet medical necessity criteria according to the CMS Local Coverage Determination.
- Hospice services must be reasonable and necessary for the palliation and management of the terminal illness and related conditions.
- The participant must elect hospice care.

2.3.1.2. Hospice Election and Recertification Notifications

For all Medicaid participants, the hospice provider is required to notify the Medical Care Unit (MCU) of all hospice Elections or Recertification regardless of other insurance coverage. Hospice participants may receive care where they live, including their own home, a certified home, a hospice house, or an assisted living or skilled nursing facility. The MCU Nurse Reviewer determines if the medical necessity criteria for hospice care are met based upon submitted documentation. If the participant is approved for the Hospice Medicaid Benefit, Election, and Recertification dates are entered into the Medicaid system as a Hospice Alert. When the Member Record contains a Hospice Alert, payment for routine home care, continuous home care, inpatient respite, and/or general inpatient care, Revenue Codes will occur as billed by the hospice agency.

Notify DHW of the election within 15 working days by faxing the required information on the Hospice Notification Form. Forms are available online on the Hospice webpage at www.medunit.dhw.idaho.gov.

Election Document Requirements

- The completed Idaho Medicaid Hospice Notification Form. The Hospice Notification Forms are available online at http://healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/HospiceServices/tabid/697/Default.aspx or as paper copies by request from Provider Services.
- The hospice election form signed by the participant or legal representative.
- The attending physician's recent history and physical. This requirement may also be met with a comprehensive physical assessment signed by the hospice Medical Director.
- The hospice agency's completed Interdisciplinary Plan of Care (POC), signed by the Hospice Medical Director.
- A certification which states that the individual's medical prognosis for life expectancy is six months or less and is signed by the Hospice Medical Director and the attending physician, if the participant has one.

Recertification Document Requirements

- The completed Idaho Medicaid Hospice Notification Form. Forms are available online at http://healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/HospiceServices/tabid/697/Default.aspx or as paper copies by request from Provider Services.
- The hospice agency's updated Interdisciplinary Plan of Care (POC), signed by the Hospice Medical Director.
- A certification which states that the individual's medical prognosis for life expectancy is six months or less and is signed by the Hospice Medical Director.
- Documentation of compliance with CMS eligibility standards for the participant's specific hospice diagnosis (e.g., Local Coverage Determination (LCD) or Criteria Worksheet).

Fax the Hospice Notification Form to the following number:

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

See *Section 2.3.2.4* for information concerning election and recertification periods.

In order to check if a participant is on the Hospice Medicaid Benefit, call DXC Technology at 1 (866) 686-4272. Ask the customer service representative to check the member record to see if a hospice alert is present for the claim date of service. The provider portal does not support viewing the Hospice Medicaid Benefit status through a Trading Partner Account.

2.3.1.3. Prior Authorization (PA) for Skilled Nursing Facility Room and Board

It is a federal requirement that room and board "pass through" the hospice agency when a hospice participant resides in a skilled nursing facility, if Medicaid's Long-Term Care Unit has authorized nursing facility payment.

If a hospice participant resides in a skilled nursing facility or intermediate care facility, an authorization number is required so that the hospice provider can be paid by Medicaid for room and board (revenue code 658).

Complete the Room and Board section of the Hospice Notification Form, noting the name of the facility and the date that hospice room and board payment responsibility begins. An

eight-month period of time is the usual approved time. It is very important to notify Medicaid if the hospice participant has been discharged from hospice, or revoked hospice care, and the end date of the authorization will be modified. Providers can view the authorization status online at www.idmedicaid.com.

See *Section 2.3.3* for more information for participants living in facilities.

2.3.1.4. Election Period and Recertification Periods

The initial election period is an eight-month period beginning at the start-of-care date. Recertification periods then extend authorization for eight-month increments. The hospice provider is responsible to track when the recertification is due. See *IDAPA 16.03.10.451.06 Hospice Definitions; Election Period* at https://adminrules.idaho.gov/rules/current/16/160310.pdf.

2.3.1.5. Hospice Revocation, Discharge, Transfer, or Notice of Death

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

Fax the Medicaid Hospice Notification Form to the following number:

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

2.3.1.6. Physician Certification

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

2.3.1.7. Physician Services

Notify the Medical Care Unit of any changes in physicians who are employees, contractors, or volunteers of the hospice agency.

Physicians who render hospice services who are not employees, contractors, or volunteers of the hospice agency, must bill Medicaid directly. The claim form should indicate that they have no affiliation with the hospice agency.

2.3.1.8. Reporting Requirements

Hospice agencies must report any change in physician affiliation with the hospice agency to the Medical Care Unit.

Additionally, hospice agencies must report any change in status (election or revocation of hospice, discharge, transfer, or death) to the Medical Care Unit within 15 working days.

2.3.1.9. Advance Directives/Physician Orders for Scope of Treatment (POST)

When accepting a participant into the Hospice Program, the hospice provider must:

- Explain to the participant and the participant's family or caregiver that all services (doctor visits, pharmacy, etc.) will be coordinated with the Hospice Program.

- Explain to the participant that they have the right to make decisions regarding their medical care, including the right to accept or refuse treatment.
- Inform the participant of their right to formulate advance directives, such as a Living Will or Durable Power of Attorney for health care, at the time the participant initially receives hospice care.

Note: It is recommended the Idaho Physician Orders for Scope of Treatment (POST) form be completed and placed at the care location so the hospice participant's end-of-life wishes are honored.

2.3.2. Hospice Participants Residing in Nursing Homes/Intermediate Care Facility/Intellectually Disabled (ICF/ID) Facilities or Residential Assisted Living Facilities (RALF)

2.3.2.1. Participant Liability

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

2.3.2.2. Agreements between Hospice Agencies and Nursing Facilities or ICF/ID

A written agreement should be developed by the hospice agency that explains the hospice provider's professional management responsibilities for the individual's hospice care and the facility's agreement to provide room and board to the individual. The term "Room and Board" includes all assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies. (*IDAPA 16.03.10.459.08*). This rule is available online at https://adminrules.idaho.gov/rules/current/16/160310.pdf.

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

2.3.2.3. Agreements with Residential Assisted Living Facilities (RALF) or Certified Family Homes (CFH)

A written agreement should be developed between the hospice agency and the RALF or CFH to delineate management responsibilities for the participant's care. The hospice agency is not responsible to reimburse the RALF for room and board payment.

2.3.3. Payment

2.3.3.1. Customary Fees

All hospice providers are paid through the use of hospice rates determined by the Department. Refer to the Provider Reimbursement Rates for Hospice. Hospice-based physician employee services are billed by the hospice provider on the UB-04 claim form using revenue code **0657** and the appropriate CPT procedure codes. Physicians not employed by the hospice must bill independently for their services. Those participants that have special rate pricing must bill revenue code **0658** and the appropriate CPT procedure codes.

2.3.3.2. Routine Home Care

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

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

Authorizations will be created and priced:

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

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

2.3.3.3. Covered Services

All services related to the terminal illness are included in the prospective rates paid. The following services are included in the hospice reimbursement rate regardless of the service location:

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

2.3.3.4. Restrictions

When hospice is approved, a restriction is placed on the participant's record and future claims are pended for review by DHW to determine whether the hospice agency or Medicaid is responsible for payment. Hospice prospective rates are designed to reimburse the Hospice Program for services required by the patient under the care of the hospice. This includes items related to the palliation and management of the patient's terminal illness. The hospice provider is responsible for all services and items related to the terminal illness regardless of whether they are supplied directly by the hospice provider or by a non-hospice provider. It is the hospice agency's responsibility to communicate and coordinate all services included in the patient's plan of care, including billing processes. Based on the Affordable Care Act, children up to the age of twenty-one (21) can receive concurrent curative and hospice care. Therefore, claims for children do not pend for hospice review.

Medicaid may authorize personal care services (PCS) for some participants to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance quality of life, to encourage individual choice, and to maintain community integration. The hospice must coordinate its hospice aide and homemaker services with the PCS agency and the regional Medicaid Nurse Reviewer. Medicaid PCS services may not be substituted for the primary care described in *Section 1.3.6.3, Covered Services* that is required by the hospice provider.

2.3.3.5. Timeliness of Authorization Requests

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

2.3.4. Medicare or Third-Party Insurance

The Medicaid Medical Care Unit must be notified by the Hospice Notification Form for all Medicaid participants electing hospice services, even if Medicare or another insurance is the primary payer.

The Centers for Medicare and Medicaid Services (CMS) requires a hospice agency to notify Medicaid when an individual who is dually eligible (Medicaid and Medicare) receives hospice services. It is the responsibility of the hospice agency to simultaneously notify both programs regarding election, discharge, revocation, or transfer between hospices. These requirements remain the same for other commercial insurance carriers.

Note: Election and recertification periods differ between Medicare and Medicaid.

2.3.5. Medicare Crossover

Hospice participants may be dually eligible for Medicare and Medicaid. When a dually eligible participant elects Medicare hospice, a copy of the Notice of Election must be sent to the Medical Care Unit. See *General Billing Instructions*, Idaho Medicaid Provider Handbook for more information.