



CHAPTER 509 HOSPICE SERVICES

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BACKGROUND

Hospices provide a continuum of care, directed by professionals, designed to optimize the comfort and functionality of terminally ill members for whom the possibilities of curative medicine have been exhausted or are not desired. Hospice emphasizes relief from distress for the member without actively shortening or prolonging life. Relief from distress includes palliation of physical, psychological and psychosocial symptoms of distress and a regular regimen for alleviation of physical pain. All efforts are directed to enriching life during the member's final days and to the provision of ongoing opportunities for the member 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.

This chapter sets forth requirements of the Bureau for Medical Services (BMS) regarding coverage under and payment for Hospice Services provided to eligible West Virginia Medicaid members.

POLICY

509.1 PROVIDER PARTICIPATION REQUIREMENTS

In order to participate in the West Virginia Medicaid program and receive payment from the BMS, Hospice providers must:

- Meet and maintain applicable licensures and certification requirements, including the Certificate of Need (CON);
- Meet and maintain all BMS enrollment requirements listed in BMS manual [Chapter 300, Provider Participation Requirements](#);
- Be physically located within the State of West Virginia;
- Meet and maintain Medicare enrollment conditions (in accordance with [42 CFR §418 Hospice Care](#), [West Virginia State Plan Supplement 2 to Appendix 3.1-A & 3.1-B page 6](#), and [§1905\(o\) of the Social Security Act](#).); and
- Ensure that all required documentation is maintained at the agency on behalf of the State of West Virginia and accessible for state and federal audits.

Additional information concerning enrollment can be found on the [BMS Hospice Services](#) website.

509.2 FINGERPRINT-BASED BACKGROUND CHECKS

Please see [Chapter 700, West Virginia Clearance for Access: Registry & Employment Screening \(WV CARES\)](#) for criminal background information and requirements.

509.3 STAFFING REQUIREMENTS

In accordance with [42 CFR §418.62](#) and [§418.64](#), Hospice staffing involves employing, contracting and otherwise obtaining the services of individuals who provide core services, supplemental services, and physician services. Federal regulations require that core Hospice functions and services be performed

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only by employees of the Hospice or by volunteers under the supervision of Hospice employees. Supplemental services may be provided by individuals who are either employed or contracted by the Hospice or who are volunteers.

509.3.1 Hospice Interdisciplinary Team

Each Hospice must have an Interdisciplinary Team (IDT) composed of individuals who provide or supervise the care and services offered by the Hospice. Each IDT must include at least the following individuals in accordance with [42 CFR §418.56](#) and [§418.64](#):

- A Doctor of Medicine (MD) or Osteopathy (DO);
- A registered nurse (RN);
- A licensed social worker (LSW); and
- A (pastoral or other) counselor.

The physician member of the IDT may be a volunteer or a Hospice employee, or the Hospice may contract with the physician.

The Hospice must designate an RN who is a member of the IDT to provide coordination of care and ensure continuous assessment of each member's and family's needs, and implementation of the interdisciplinary plan of care.

The RN, LSW, and the (pastoral or other) counselor must be employees of the Hospice, or volunteers under the supervision of designated employees of the Hospice.

If the Hospice has more than one IDT, it must identify a specifically designated IDT to establish policies governing the day-to-day provision of Hospice care and services.

The Hospice must try to provide consistent IDT membership and assignment of Hospice Medicaid members to an IDT. There must be a continuous and identifiable relationship between each Medicaid member and his or her IDT.

509.3.2 Service Requirements

Services that are covered by the Hospice program are those that are reasonable and necessary for the palliation and management of the terminal illness and related conditions. An interdisciplinary plan of care must be established before care begins and must detail the type, scope, and frequency of those services to address the needs of the member and the member's family. All care must be planned, delivered and coordinated in accordance with [42 CFR §418.56](#) and [§418.200](#).

There are two types of Hospice services:

1. Core Hospice Services: Are to be provided directly by Hospice employees/contractors/volunteers. Services include:
 - Nursing Care: Must be provided by an RN or by a licensed practical nurse (LPN) under the supervision of an RN.

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- Medical Social Services: Must be provided by an LSW working under the direction of a physician.
 - Physician Services: Must be provided by a professional who is acting within the scope of the physician's license and who is either an MD, a DO, Doctor of Podiatry (DPM), Doctor of Dentistry (DDS), Doctor of Optometry (OD), or a Doctor of Chiropractic (DC). The medical director of the Hospice or the physician member of the IDT must be a licensed MD or DO.
 - Counseling Services: Must be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the member's family or other caregivers to provide care, and for the purpose of helping the member and those caring for him or her to adjust to the member's approaching death. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required Hospice service, but it is not reimbursable (see [West Virginia State Plan Hospice Services Appendix 3.1-C](#)).
2. Other Hospice Services: A Hospice provider must make available, services that are not considered "core" services. These may be provided by the employees of the Hospice provider or they may be arranged by contractual agreement. They include:
- Drugs and Biologicals: Must be identified as those documented in the Hospice Plan of Care and provided by the Hospice while the member is under Hospice care. Hospice covered drugs are those related to the palliation and management of the terminal illness and related conditions necessary to meet the needs of the member (in accordance with [West Virginia State Plan Appendix 3.1-A and 3.1-B](#), and [42 CFR §418.56\(c\)\(4\)](#), [§418.106](#), and [§418.202 \(f\)](#)):
 - Management, ordering, dispensing, administration, labeling, disposition, and storing of drugs and biologicals must follow the policies and procedures in accordance with [42 CFR §418 Hospice Care](#);
 - Home Health program services, drugs, and biologicals obtained through the West Virginia Medicaid Pharmacy program for the palliation and management of symptoms related to the member's terminal illness;
 - Coverage of medications to control pain and nausea unless justified by pre-existing conditions;
- NOTE:** The West Virginia Pharmacy program will provide medications that are unrelated to the member's terminal illness. The Hospice provider must submit the appropriate documentation to justify the member's condition is unrelated to his/her terminal illness. (Refer to the Glossary section regarding Pre-existing Conditions and Related Condition).
- Durable Medical Equipment and Supplies: Are to be available for comfort or self-help related to the palliation of the terminal illness and related conditions (in accordance with [West Virginia State Plan Appendix 3.1-A and 3.1-B page 7](#), and [42 CFR §418.56](#), [§418.202 \(f\)](#), and [§418.106](#)).
 - Short-term inpatient care: Is to be provided either to provide respite for family or other persons caring for the member at home, or for control of pain or symptoms arising from the terminal illness and related conditions that is not possible in any other setting (in accordance with [West Virginia State Plan Appendix 3.1-A and 3.1-B page 7](#), and [42 CFR §418.202 \(e\)](#)).

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- Home Health and Homemaker Services: Must meet the specifications of [42 CFR §484.36](#), and must be provided under the supervision of an RN. Home health aides and homemaker service providers may provide personal care services and household services for safety and sanitation of the member, appropriate for the Plan of Care.
- Rehabilitation Services: include physical and occupational therapies and speech pathology used for symptom control or to maintain activities of daily living and functional skills (in accordance with [West Virginia State Plan Appendix 3.1-C](#) and [42 CFR §418.202](#)).

When a Hospice contracts or arranges for any service, the Hospice must maintain professional, financial, and administrative responsibility for the services and must ensure that all staff members meet the regulatory qualification requirements.

For out-of-state services, refer to [Chapter 300, Provider Requirements](#) and [West Virginia State Plan, Attachments 3.1-D](#).

The Hospice must maintain and document an effective infection control program that protects members, families, visitors, and Hospice personnel by preventing and controlling infections and communicable diseases in accordance with [42 CFR §418.60 \(a\)\(b\)\(c\)](#).

The Hospice must comply with all applicable federal, state, and local emergency preparedness requirements. The Hospice must establish and maintain an emergency preparedness program that meets the requirements according to [42 CFR §418.113 \(a thru e\)](#).

509.3.3 Service Exceptions

Hospice services may be provided to children under age 21 concurrently with curative treatment in accordance with the [Affordable Care Act 2302 Concurrent Care for Children](#).

509.3.4 Physician Services Staffing

The following functions may be performed by a physician designee including a physician employee, volunteer physician, or a contracted physician:

- Hospice medical director services (must be an MD or DO);
- Physician services related to the palliation and management of the member's terminal illness and related conditions;
- Care for general medical needs when the attending physician is not available (if the member has an attending physician); and
- Physician participation in the IDT (must be an MD or DO).

The Hospice or the physician member of the IDT may designate another physician or other physicians to be "on call" during the hours the IDT assigned physician is not on duty:

- The on-call physician may assist with urgent, emergency or otherwise unscheduled plan of care revisions.

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- The Hospice or the IDT assigned physician member of the IDT may not designate substitute physicians to routinely assist with initial plans of care and scheduled plan of care reviews and revisions.
- When the “on call” physician provides a service to a member, it must be documented in that member’s health record.

509.3.5 Hospice Volunteers

Hospice providers may use volunteers in defined roles and under the supervision of designated Hospice employees. Volunteers may perform administrative functions or direct-care services as outlined in the Federal Regulations. In the Hospice program, “employee” also refers to a volunteer under the jurisdiction of the Hospice. All use of volunteers must be in accordance with [42 CFR §418.78](#) and [§418.304 \(b\)](#).

Volunteer hours of service must equal at least five percent of the hours of direct-member care furnished by paid personnel, employed or contracted.

If a physician volunteers some services and is reimbursed by the Hospice for other services, the terms and conditions of such service must be described in a written agreement or contract between the physician and the Hospice.

Services provided by volunteers may not be billed to Medicaid when those services are provided at no charge for individuals who are not eligible for Medicaid.

Examples of equitable ways for physicians to donate or volunteer services may include:

- Donating a percentage of their time; or
- Providing a particular service (e.g., treatment of decubitus ulcers or psychotherapy) or a particular occurrence of a service (donating one visit per week/month, etc. to each member in their care).

509.3.6 Hospice Employee Training Requirements

A Hospice must:

- Provide orientation that includes explaining the Hospice philosophy to all employees, including contracted and volunteer staff who have member and family contact.
- Provide an initial orientation for each employee, including contracted and volunteer staff that addresses the employee’s specific job duties.
- Assess the skills and competence of all employees furnishing care, including contracted and volunteers furnishing services, and, as necessary, provide in-service training and education programs where required.
- Provide ongoing educational opportunities for all employees, including contracted and volunteer staff.
- Have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months (in accordance with [42 CFR §418.78\(a\)](#) and [§418.100\(g\) 1-3, p. 122](#)).

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509.4 BENEFIT PERIODS

In accordance with [42 CFR §418.21](#), a member may elect to receive Hospice care during one or more of the following election periods:

1. An initial 90-day period;
2. A subsequent 90-day period;
3. An unlimited number of subsequent 60-day periods that will continue as long as the member lives unless he or she revokes or is discharged from Hospice care.

The periods of care are available in the order listed and may be elected separately at different times. Having once elected Hospice, it is not necessary for a member to elect Hospice again after the initial election unless he or she revokes Hospice care or is discharged from Hospice care.

- Members who have elected Hospice care may revoke Hospice coverage. In that event, the remainder of that benefit period is forfeited. If the member then re-enrolls, coverage begins immediately under the next benefit period.
- Members who revoke Hospice services four times are not eligible to enroll again.

Example: A member enrolls in Hospice services on January 1 and revokes their Hospice coverage on February 15, after 46 days. The remainder of the 90 days of that first period is forfeited. Should circumstances lead the member to enroll again, even the next day on February 16, the member is now in the second benefit period. If the member revokes again before that 90-day period is concluded, the member also forfeits the remainder of that second period. A third enrollment will be for the 60-day period. If that period is revoked, the remainder is forfeited and only the unlimited 60-day periods remain. If the member elects again during a subsequent 60-day period, the member may continue to receive Hospice services for as long as they live unless the member revokes the fourth time. The member who revokes Hospice services four times is not eligible to enroll again.

509.5 MEMBER ENROLLMENT IN HOSPICE

The Hospice is responsible for enrolling the member who is certified as eligible for Hospice care and who gives consent to enter the program. Member enrollment in the Hospice Services program requires all of the following:

1. The **physician** must determine that the member has a life expectancy of six months or less if the illness runs its normal course and certifies that assessment in writing;
2. The **Hospice provider** must complete a plan of care, inform the enrolling member of what Hospice services will be provided, document the member's informed consent, and complete a [West Virginia Medicaid Hospice Election Form \(HEF-01\)](#). The provider must also inform the member how to disenroll from Hospice care, change providers, and transfer services to another Hospice; and
3. The **member/legal representative**, after explanation of Hospice services by the Hospice provider, must sign and date consent on the completed [HEF-01](#).

To complete the enrollment of the member in Hospice services, the provider must furnish the member with the following:

- A copy of the completed and signed [HEF-01](#);

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- A copy of the Plan of Care upon member's and/or the member's legal representative's request, with descriptions of the nature and scope of the services to be provided, a schedule for providing them, and a telephone number for contacting the Hospice;
- A copy of the conditions of enrollment in the Hospice Services program explained to the member/legal representative by the provider and signed by the member/legal representative; and
- A copy of the terms of revocation explained to the member/legal representative by the provider and signed by the member/legal representative.

The member is responsible for reporting other insurance and obtaining health care that is not related to the terminal illness or disease.

509.5.1 Physician Certification

For the first 90-day election period of Hospice coverage, the Hospice medical director or IDT assigned physician and the attending physician (if the member has an attending physician) must certify and document the member's diagnosis and that the member has a terminal illness which is defined as having a life expectancy of six months or less if the illness runs its normal course (in accordance with [42 CFR §418.22](#)).

509.5.2 Physician Certification Timeline

The Hospice must obtain a copy of this written certification no later than two calendar days after Hospice care is initiated.

- For the initial 90-day period, if the Hospice cannot obtain a written certification within two calendar days, it must obtain oral certifications within two calendar days and written certification no later than eight calendar days after the period begins (see [West Virginia State Plan Appendix 3.1-A](#) and [3.1-B](#)).

If these requirements are not met within the set timeline, the provider is not eligible for reimbursement of Hospice services furnished before the date on which written certification is obtained.

Subsequent Recertification Periods:

A Hospice physician or Hospice advanced practice registered nurse (APRN) must conduct a face-to-face recertification visit for each Hospice member whose total stay across all Hospices is anticipated to reach 180 days. The visit must occur no more than 30 calendar days prior to the 180-day recertification. The physician and/or Hospice APRN must continue to visit that member no more than 30 calendar days prior to every recertification thereafter, to gather clinical findings to determine continued eligibility for Hospice care (in accordance with [42 CFR §418.22](#)).

The written narrative associated with the 180-day recertification and every subsequent recertification must include:

- Date of the member's face-to-face visit with the Hospice physician or Hospice APRN;
- Clinical findings to determine whether the member continues to have a life expectancy of six months or less;

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- The Hospice APRN must document all clinical findings and submit to the certifying Hospice physician, signed and dated on a separate and distinct section of, or an addendum to, the recertification form; and
- Signature and date of signature by the Hospice physician(s) and the benefit period dates to which the certification or recertification applies.

Authorization is required for all Hospice certifications and re-certifications. Appropriate documentation must be submitted to the utilization management contractor (UMC) within eight calendar days of the member's election of Hospice. It is understood that due to the nature of Hospice services, services may need to begin before the initial authorization is finalized and, in these instances, retrospective authorization will be granted for members who meet the requirements of the program.

If the Hospice is not able to complete the face-to-face visit according to the above specifications, the Hospice must discharge the member and Medicaid will no longer reimburse the Hospice for the member's Hospice services. Medicaid is not responsible for reimbursement of Hospice services during the period of discharge.

When the face-to-face evaluation is completed by the Hospice physician or Hospice APRN, the Hospice provider will be able to bill the Medicaid program for services.

509.5.3 Waiver of Certain Medicaid Services

The Hospice provider must develop a Plan of Care designed to meet the member's individual needs. Members must be informed that by electing Hospice services, they must waive Medicaid coverage of the following services if they are related to the member's terminal condition:

- Hospice care provided by a Hospice other than the Hospice designated by the member, unless provided under arrangements made by the designated Hospice; and
- 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 services:
 - Provided (either directly or under arrangement) by the designated Hospice;
 - Provided as room and board by a nursing facility or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) if the individual is a resident; and
 - Provided by the member's attending physician if that physician is not an employee of the designated Hospice or receiving compensation from the Hospice for those services.

When an election period ends or the Hospice discharges a member according to reasons for discharge under [42 CFR §418.26 \(a thru d\)](#), the member's waiver of other Medicaid benefits expires. Also, regular Medicaid coverage is reinstated if the member revokes Hospice care for the subsequent election period (in accordance with [42 CFR §418.24](#) and [§418.28](#)).

Hospice care does not include, but is not limited to the following:

- Services furnished before or after a Hospice election period;
- Services of the member's attending physician, if the attending physician is not an employee of or working under an arrangement with the Hospice; or

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- Medicaid services received for the treatment of an illness or injury not related to the member's terminal condition (please see [42 CFR §418.402](#)).

Once a member elects to receive Hospice services, Medicaid will not reimburse for other Medicaid services that treat the terminal condition. However, Medicaid may reimburse for services that are required to treat conditions that are unrelated to the terminal illness.

An exception to this rule is that Hospice services may be provided to children under age 21 concurrently with curative treatment in accordance with the [Affordable Care Act 2302 Concurrent Care for Children](#).

509.5.4 Informed Consent of the Member

The Hospice provider must assure that the consent to enroll in Hospice services is an informed consent. An informed consent form detailing the type and scope of the care is to be given to the member or the member's representative to be read and signed.

The Hospice provider must complete the BMS [Hospice Election Form HEF-01](#) and have the member or the member's legal representative sign and date it.

509.6 NOTIFICATION OF ENROLLMENT

The completed, signed, and dated physician certification, the signed and dated [HEF-01](#), and the signed and dated Plan of Care must be received by the UMC within eight calendar days of the initiation of Hospice care.

Authorization by the UMC is required for the initial and subsequent certifications. Authorization will not be approved for Hospice services without appropriate enrollment documentation.

509.7 TERMINATION OF HOSPICE SERVICES

In accordance with [42 CFR §418.26](#), [§418.28](#), and [§418.30](#), Hospice services may be terminated for any of the following reasons:

- The member chooses to revoke Hospice care;
- The Hospice chooses to terminate its provision of services;
- The member no longer meets enrollment criteria;
- The member moves out of the Hospice's service area;
- The member transfers to another Hospice provider;
- The member's environment becomes unsafe for Hospice staff; or
- The member dies.

When a member revokes Hospice services or is discharged by the Hospice provider, the Hospice provider must send a copy of the [HEF-01](#), with original member signature and the date of the termination of services written in the box marked Revoked, to the UMC. This must be received by the UMC within eight calendar days of revocation to allow the member to resume Medicaid benefits waived upon election of Hospice care. When a member is being discharged and will be in need of medication and/or medical



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supplies upon discharge, then the Hospice provider must expedite the discharge election form to the UMC.

The Hospice provider must send a copy of the [HEF-01](#) to the UMC following the death of the member with the date of death noted in the appropriate box.

509.7.1 Transfer of Member to Another Hospice Provider

A member or legal representative may change the Hospice provider from which Hospice care is received only once in each election period. A transfer does not constitute a revocation of the election period during which the change is made. Transfers must be conducted in accordance with [42 CFR §418.30](#).

509.8 BILLING AND REIMBURSEMENT

Reimbursement by the BMS for covered Hospice services will be at rates set by the Centers for Medicare and Medicaid Services (CMS) for the following categories of care:

- Routine Home Care (RHC)
- Continuous Home Care (CHC)
- Inpatient Respite Care (IRC)
- General Inpatient Care (GIC)
- Service Intensity Add-on Payments (SIA)

509.8.1 Routine Home Care (RHC)

Revenue Code: 0651
Service Unit: Unit = 1 Day
Service Limit: 1 unit per day

Definition of Service: This level of care consists of providing Hospice services as described under [Section 509.3.2, Hospice Service Requirements](#), except for those referring to inpatient care, or services provided when the member's needs are so intensive as to require continuous care as described below.

The Hospice is paid the RHC rate for each day the member is under the care of the Hospice and not receiving one of the other three more specialized categories of Hospice care (CHC, IRC, and GIC).

This rate is paid without regard to the volume or intensity of routine home care services provided on any given day, and is also paid when the member is receiving hospital care for a condition unrelated to the terminal condition.

509.8.2 Service Intensity Add-On (SIA) Payments

Revenue Code: 0651 (RHC)
Service Unit: Unit = 15 minutes
Service Limit: Minimum of 15 minutes up to a maximum of 4 hours per day (16 units)



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Effective for Hospice services with dates of service on and after January 1, 2016, a SIA payment will be made for social worker visits and nursing visits provided by an RN, when provided during RHC in the last seven days of life. The SIA payment is in addition to the RHC rate.

The SIA payment is provided for visits of a minimum of 15 minutes and a maximum of four hours per day, i.e. from one unit to a maximum of 16 units combined for both nursing visit time and/or social worker visit time per day. The time of a social worker's phone calls is not eligible for an SIA payment.

509.8.3 Continuous Home Care (CHC)

Revenue Code: 0652

Service Unit: Unit = 1 hour

Service Limit: Minimum of 8 hours, up to a maximum of 24 hours a day

Definition of Service: This code is billable for a minimum of eight hours on a given day, and up to 24 hours a day. Reimbursement is based on the number of hours provided for the service in a day. Continuous home care is provided to the member during brief periods of crisis.

Continuous home care may be provided for up to 24 hours, but these services must be predominantly nursing services. Home health aide or homemaker services may be provided in addition to nursing care.

509.8.4 Inpatient Respite Care (IRC)

Revenue Code: 0655

Service Unit: Unit = 1 Day

Service Limit: Up to 5 consecutive days

Definition of Service: An IRC is a day on which the individual who has elected Hospice receives care in an approved facility (freestanding Hospice, hospital, or nursing facility) on a short-term basis to provide respite to family or other persons who are involved in daily care of the member.

Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time (in accordance with [42 CFR §418.204](#)).

509.8.5 General Inpatient Care (GIC)

Revenue Code: 0656

Service Unit: Unit = 1 Day

Service Limit: 1 unit per day

Definition of Service: General inpatient care may be provided in an approved freestanding Hospice, hospital, or nursing facility. This care is usually for pain control or for acute or chronic symptom management which cannot be successfully treated in another setting.

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509.9 REIMBURSEMENT PROCEDURES

Hospice services are billed using the UB-04 paper form or electronic form 837i. Only one level of care under one Medicaid Revenue Code may be billed for a given day. Reimbursement is made for each day an eligible Medicaid member is under Hospice care.

Inpatient rates for revenue codes 0655 and 0656 are paid for the date of admission and all subsequent inpatient days with the exception of the date of discharge. The date of discharge will be paid at the RHC rate.

If the member dies as an inpatient, then the date of death will be reimbursed at the inpatient rate if the inpatient care was related to the terminal illness. Reimbursement will be based upon the county in which the Hospice service is rendered.

The SIA payment amount is calculated by multiplying the CHC rate (per 15 minutes) by the number of units for the combined visits for the day (payment not to exceed 16 units) and adjusted for geographic differences in wages according to [Medicare Chapter 11 30.2.2 Service Intensity Add-on Payments](#).

509.10 INPATIENT CARE PROVIDED DIRECTLY BY THE HOSPICE

The participating Hospice that provides inpatient care directly must comply with all of the following standards for nursing, for member care, and for disaster preparedness:

- Nursing services must be provided 24 hours a day;
- Each shift must provide an RN who provides direct member care; and
- Nursing care must be sufficient to meet any plan of care.

509.11 NURSING FACILITY RESIDENTS

West Virginia Medicaid maintains a separate program of Hospice services for members who are residents of nursing facilities.

West Virginia requires a pre-admission screening (PAS) be completed on every individual who enters a Medicaid certified nursing facility (refer to the BMS manual [Chapter 514, Nursing Facility Services](#)). If a member electing Hospice care is a resident of a West Virginia Medicaid certified nursing facility, the nursing facility may contract with a Medicare/Medicaid certified Hospice agency to provide room and board for dually eligible members and for members who are Medicaid-only who qualify medically for both the Hospice benefit and Medicaid nursing facility benefits.

Medicare certification of a nursing facility is not a requirement of this program. The Hospice agency must enroll with the Medicaid agency to be a provider of this benefit in nursing facilities. The room and board component provided by the nursing facility shall include the provision of a living space, nutrition, and ancillary services normally provided for residents.

Ancillary services may include, but are not limited to, the basic activities of daily living, social and activity programs, laundry, and housekeeping.

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The Hospice provider is responsible for specialized services covered by Medicare or Medicaid including, but not limited to, medications associated with the terminal illness, assistance with care planning, and emotional support for the member and the member's family.

The Hospice must bill Medicare/Medicaid for all covered services as well as Nursing facility room and board (in accordance with [42 CFR §418.112](#), see the BMS manual [Chapter 514 Nursing Facility Services](#)).

A Hospice physician or Hospice nurse practitioner must visit each Hospice member face-to-face whose total stay across all Hospices is anticipated to reach 180 days, no more than 30 calendar days prior to the 180-day recertification, and must continue to visit that member no more than 30 calendar days prior to every recertification thereafter in accordance with [Affordable Care Act, section 3131\(b\)](#).

If the Hospice is not able to complete the face-to-face visit prior to the above specifications, the Hospice must discharge the individual and Medicaid will no longer reimburse the Hospice for the individual's treatment or room and board. The nursing facility will need to resume billing Medicaid for the care of the individual; and once the face-to-face evaluation is completed by the Hospice physician or Hospice nurse practitioner, the Hospice provider may bill the Medicaid program for services, including the pass-through payment to the Nursing facility for room and board.

In accordance with [42 CFR §418.22](#), the written narrative associated with the 180-day recertification and every subsequent recertification must meet the same requirements that are in place for Hospice enrollees who are not residents in a nursing facility.

The nursing facility cannot charge Medicaid a bed hold if the resident/member is under the Hospice benefit. The bed hold must be contracted between the nursing facility and the approved Hospice provider.

509.11.1 Documentation Requirements for Nursing Facility Authorization

For each individual who applies for Hospice coverage in a nursing facility, election of services and physician certification documentation is required (refer to BMS manual [Chapter 514, Nursing Facility Services](#)). The Hospice provider must submit the following information to the UMC for review:

- An agreement between the specific nursing facility and the Hospice provider specifying the appropriate services each will provide to qualified members;
- Documentation to support the individual's medical necessity for each covered service;
- Financial eligibility documentation for the specific individual regarding the Medicare and the Medicaid programs.

As with Hospice services provided in other settings, those provided in nursing facilities apply only to the terminal illness and related conditions. For health needs not related to the terminal diagnosis, additional West Virginia Medicaid policies and procedures are to be followed.

The authorization information must be submitted with the first claim for payment.



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509.11.2 Billing and Reimbursement for Nursing Facility Hospice

Revenue Code: 0658
Service Unit: Unit = 1 Day
Service Limit: 1 unit per day

Definition of Service: The West Virginia Medicaid program will remit to the Hospice provider 95% of the daily rate which would have been paid to the nursing facility for care of the member had he or she not elected Hospice coverage.

The Hospice will in turn reimburse the nursing facility for the cost of room and board, as identified in their contract. The amount of reimbursement will be based on the nursing facility base per diem rate with the Medicaid adjustment for the acuity of the member.

Services must be billed on a UB-04 paper form. A printout of the computerized report identifying the specific case mix class of the individual must be attached. The Hospice must provide all of the claim information to the BMS fiscal agent.

509.12 APPEALS PROCESS/FAIR HEARING

If the UMC denies prior authorization for Hospice services, a reconsideration request with additional supportive documentation may be submitted to the UMC.

The member or provider may submit an appeal request to the BMS upon receipt of the prior authorization denial. A request for retrospective review is available for members with back dated medical cards and/or primary insurance denials. Please refer to BMS manual [Chapter 400, Member Eligibility](#).

509.13 CARE PLAN OVERSIGHT

The care plan oversight (CPO) consists of physician supervision of members receiving Hospice care when the member requires complex or multidisciplinary care modalities with ongoing physician involvement.

The BMS provides payment for one CPO service per calendar month, per member, per provider.

CPO services are also not payable to physicians having a five percent or greater ownership interest in or a relationship with a Hospice provider that is directly providing services to Medicaid members.

The physician who bills for CPO services must be the same physician who signed the Hospice plan of care.

509.14 COORDINATION OF CARE AND PAYMENT LIMITS

Hospice providers must determine whether Medicaid eligible members referred for Hospice services are authorized to receive similar services under other Medicaid programs or benefits. Hospice providers

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must coordinate the provision of Hospice services with other Medicaid service providers in order to avoid duplication of similar services and subsequent disallowance of payments.

509.14.1 Home and Community-Based Services (HCBS) Waivers

Members who have been determined eligible for and are enrolled in the HCBS Waiver programs may receive services from a Hospice provider that do not duplicate waiver services at the same time. An agreement between the waiver coordination agency and the Hospice provider must be on record. The need for Hospice services must be documented in the member's Individual Program Plan (IPP). Documentation of the referral from the member's attending physician must be maintained in the member's records of both the waiver program coordination agency and the Hospice provider.

Refer to the following Provider Manual Chapters for additional information:

- [*Chapter 513, Intellectual and/or Developmental Disabilities Waiver Services*](#)
- [*Chapter 501, Aged and Disabled Waiver Services*](#)
- [*Chapter 512, Traumatic Brain Injury Waiver Services*](#)

Note: Operating a program of services under the authority of Section 1915 (c) of the Social Security Act, known as the Home and Community Based Waiver services, requires that BMS have authority over the services. If the member is receiving any other Medicaid service, the Waiver service is considered primary.

509.14.2 Personal Care Services (PCS)

Members who are receiving direct-care services through the PCS program may also receive services from a Hospice provider that do not duplicate PCS services at the same time. Hospice services are limited to services which can only be performed by a skilled nurse and/or a licensed therapist for Physical Therapy (PT), Occupational Therapy (OT) and/or Speech Therapy (ST). The Hospice provider must maintain documentation regarding the need for both services as well as the plan of care for the member. The PCS RN must reflect the Hospice services on the PCS plan of care. PCS and the Hospice provider. Please refer to [*Chapter 517, Personal Care Services*](#) for additional information.

509.14.3 MANAGED CARE ORGANIZATION (MCO)

If the Medicaid member is enrolled in an MCO, coverage and prior authorization requirements of the managed care plan must be followed. Please refer to [*Chapter 527 Mountain Health Trust \(Managed Care\)*](#) for additional information.

509.15 HOW TO OBTAIN INFORMATION

Please refer to the [Hospice Program website](#), which includes the following:

- [Hospice Services Manual](#)
- [Hospice Approved Forms](#)
- [Program Contact Information](#)

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GLOSSARY

Definitions in the BMS Manual [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Attending Physician: In accordance with [42 CFR §418.3\(1\)\(i\)](#), a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs that function or action.

Nurse Practitioner (NP): A nurse who meets the training, education and experience requirements as described in [§410.75\(b\)](#). (2) Is identified by the member, at the time he or she elects to receive Hospice care, as having the most significant role in the determination and delivery of the member's medical care.

Bereavement Counseling: Emotional, psychosocial, and spiritual support and services provided before and after the death of the member to assist with issues related to grief, loss, and adjustment (see [42 CFR §418.3](#)).

Employee: A person (including contractors and volunteers who works for the Hospice and for whom the Hospice is required to issue a W-2 form on his or her behalf; if the Hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the Hospice; or is a volunteer under the jurisdiction of the Hospice (in accordance with [42 CFR §418.3](#)).

Hospice Aide (formally referred to as Home Health Aide): A person specially trained to assist sick, disabled, infirm, or frail persons at home when no family member is fully able to assume this responsibility. Aides are supervised by health professionals, and provided as part of a continuing medical care plan in accordance with the West Virginia State Plan on Hospice services.

Homemaker Aide: A person specially trained to provide direct care and support services that are necessary in order to enable a member to remain at home rather than enter a nursing facility, or to enable an individual to return home from a nursing facility. Homemaker services include assistance with personal hygiene, nutritional support, and environment maintenance. These aides are supervised by health professionals and provided as part of a continuing medical care plan in accordance with the West Virginia State Plan on Hospice Services.

Hospice Care: A comprehensive set of services described in [1861\(dd\)\(1\) of the Social Security Act](#), identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill member and/or family members, as delineated in a specific patient plan of care (see [42 CFR §418.3](#)).

Hospice Discharge: A Hospice provider determines that the patient is no longer terminally ill, expires, moves out of the Hospice's service area, transfers to another Hospice, or the patient (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the Hospice to operate effectively is seriously impaired (in accordance with [42 CFR §418.26](#)).

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Hospice Informed Consent: A written agreement to receive Hospice care made by the member or representative that specifies in writing the type of care and services to be provided. The informed consent form shall be signed by the member or the member's legal representative prior to service.

Hospice Interdisciplinary Team (IDT): An IDT of professionals comprised at minimum, of a physician, a social worker, and nurse who plan and direct the care of each Hospice member, along with home health aides and counseling/clergy persons who provide additional services (in accordance with [42 CFR §418.56](#)).

Interdisciplinary Team Plan of Care: A group of interdisciplinary professionals (physician, nurse, social worker, counselor/clergy) that collaborates continuously with the member's attending physician (if the member has an attending physician) to develop and maintain a member-directed, individualized plan of care. The plan is based on the interdisciplinary team assessments which recognize the member and family's physiological, social, religious, and cultural variables and value (in accordance with [42 CFR §418.56](#)).

Palliative Care: Member and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate member autonomy, access to information, and choice (see [42 CFR §418.3](#)).

Physician Designee: A Doctor of Medicine or Osteopathy designated by the Hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available. (See [42 CFR §418.3](#)).

Pre-Existing Conditions: The health status existing prior to the diagnosis of the terminal illness arising in organs that are not typically affected by the terminal illness.

Related Condition: A medical condition that arises as a direct logical consequence of the terminal illness.

Revocation: To cancel or withdraw the election of Hospice care (in accordance with [42 CFR §418.28](#)).

Terminally ill: A medical prognosis that the patient's life expectancy is 6 months or less if the illness runs its normal course (see [42 CFR §418.3](#)).

Transfer: Changing the Hospice provider from which a member is receiving services to another Hospice provider.

REFERENCES

The West Virginia state plan references Hospice Services in sections [3.1-A\(18\)](#), [3.1-B\(18\)](#), [Supplement 2 to Attachment 3.1-A](#) and [3.1-B \(pages 6-10\)](#).

West Virginia Medicaid references Hospice Services in the Code of Federal Regulations [42 CFR §418](#)

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Note: Hospice providers must refer to the Code of Federal Regulations [42 CFR §418 – Hospice Services](#) periodically for future updates and final rulings.

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Hospice Services	June 1, 2015
Entire Chapter	Updated language throughout 509.2 Criminal Background Checks – Language updated, and link added for reference to WV CARES Policy - Chapter 700. 509.3.2 Section on Hospice Service Requirements added statements on Infection Control, Emergency Preparedness, and out-of-state services. 509.8.1 Added Sections on Service Intensity Add-on Payments according to 42 CFR §418.302 509.9 Added SIA payment Methodology language to Reimbursement Procedures Section 509.12 Appeals Process/Fair Hearing section added 509.14-509.14.2 Added Coordination of Care and Payment Limits section with list of HCBS Waiver programs 509.13 Added Managed Care Organization (MCO) section References: Added the Code of Federal Regulations on Hospice Care references link and note.	May 1, 2020