

Medi-Cal Provider Training 2016

Home Health & Hospice Care Program



Table of Contents

Home Health Agencies

Introduction.....	1
Description	3
Policies	4
Home Health Agencies Billing.....	7

Hospice Care

Introduction.....	1
Program Coverage	3
Policies	7
Hospice Billing	10
Learning Activity	17

Appendix

Acronyms	1
----------------	---

Home Health Agencies

Introduction

Purpose

The purpose of this module is to provide billing information applicable to Home Health Agencies (HHA) Services for Medi-Cal recipients and California Children's Services (CCS) clients. Restricted eligibility, aid codes, claim submission, documentation and the *Treatment Authorization Request* (TAR) are explained. Also included is a crosswalk from Healthcare Common Procedure Coding System (HCPCS) local Level III codes to Health Insurance Portability and Accountability Act (HIPAA)-compliant HCPCS Level II national codes.

Objectives

- Identify Medi-Cal HHA policy for Medi-Cal recipients and CCS clients
- Review HHA services
- Discuss the HIPAA-mandated changes to the billing requirements for the HHA conversion
- Examine the policy and billing requirements for HHA
- List the HHA HCPCS Level II national and revenue codes
- Detail appropriate HHA documentation requirements
- Describe the field requirements of the *UB-04* claim forms and billing issues with HHA claim examples

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

References

The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 1

Aid Codes Master Chart (aid codes)

OBRA and IRCA (obra)

Part 2

Home and Community-Based Services (HCBS) (home)

Home and Community-Based Services (HCBS) Billing Codes and Reimbursement Rates
(home cd)

Home Health Agencies (HHA) (home hlth)

Home Health Agencies (HHA) Billing Codes and Reimbursement Rates (home hlth cd)

Home Health Agencies (HHA) Billing Examples (home hlth ex)

UB-04 Completion: Outpatient Services (ub comp op)

Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook.

NOTES

Description

HHA is an outpatient benefit prescribed by a physician and provided at the recipient's home in accordance with a written treatment plan. The plan is reviewed by a physician every 60 days. The plan must indicate a need for one or more of the following services:

- Part-time or intermittent skilled nursing service by licensed nursing personnel
- In-home medical care services as defined in the *Welfare and Institutions Code* (W&I Code) Section 14132(t)
- Physical, occupational or speech therapy
- Medical social services
- Home health aide services
- Medical supplies other than drugs and biologicals
- Other home health services
- The use of medical appliances, provided for under an approved treatment plan

NOTE

Durable Medical Equipment (DME), such as an infusion pump, is reimbursable only when billed by a valid DME provider. DME cannot be billed by an HHA provider.

NOTES

Policies

HIPAA requires the use of revenue codes for billing and adjudication.

Effective for dates of service on or after June 1, 2016, HCPCS Level III local codes for HHA are discontinued and replaced with 10 new HIPAA-compliant codes shown in the following table.

There will be no change in rates for home health services in relation to the code conversion. The code conversion is date-of-service driven.

- Claims submitted with revenue codes in the revenue code field and a HCPCS Level II national home health service code in the HCPCS field for dates of service prior to June 1, 2016, will not be reimbursable.
- Claims submitted without a revenue code for dates of service on or after June 1, 2016, will be denied.

Discontinued HCPCS Code	Current CPT-4/HCPCS Level II Code Description	Revenue Code Description
Z6900	G0154 (direct skilled nursing services of a licensed nurse [LPN or RN] in the home health or hospice setting, each 15 minutes. Includes supplies that are used as part of the treatment visit.	0551 (skilled nursing/visit)
Z6902	G0156 (services of home health/hospice aide in home health or hospice setting, each 15 minutes)	0571 (aide/home health/visit)
Z6904	G0151 (services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes)	0421 (physical therapy/visits)
Z6906	G0152 (services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes)	0431 (occupational therapy/visit)
Z6908	G0153 (services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes)	0441 (speech pathology/visit)

Discontinued HCPCS Code	Current CPT-4/HCPCS Level II Code Description	Revenue Code Description
Z6910	G0155 (services of clinical social worker in home health or hospice setting, each 15 minutes)	0561 (medical social services/visit)
Z6914	G0162 (skilled services by a registered nurse [RN] in the delivery of management & evaluation of the plan of care; each 15 minutes)	0583 (visit/home health/ assessment)
Z6916	G0162 (skilled services by a registered nurse [RN] in the delivery of management & evaluation of the plan of care; each 15 minutes)	0589 (visit/home health/other)
Z6918	99600 (unlisted home visit service or procedure). The code combination 99600/0589 is for billing services. Respiratory therapist services can be authorized and billed under 99600.	0589 (visit/home health/other)
	A9999 (miscellaneous DME supply or accessory, not otherwise specified). The code combination A9999/0270 is for billing supplies.	0270 (medical/ surgical supplies and devices, general classification)
Z6920	99501 (home visit for postnatal assessment and follow-up care). For follow-up of early Obstetrics (OB) discharge. This is an OB service, not a typical home health service.	0580 (visit/home health)
	99502 (home visit for newborn care and assessment). For follow-up of early Obstetrics (OB) discharge. This is an OB service, not a typical home health service.	

Frequency Limitations

Revenue Code	HCPCS Level II/CPT-4 Code	Frequency Limitations
0270	A9999	As authorized
0421	G0151	As authorized, or as necessary to complete the initial or six-month case evaluation (HCPCS code G0162 and revenue code 0583)
0431	G0152	As authorized, or as necessary to complete the initial or six-month case evaluation (HCPCS code G0162 and revenue code 0583)
0441	G0153	As authorized, or as necessary to complete the initial or six-month case evaluation (HCPCS code G0162 and revenue code 0583)
0551	G0154	As authorized, or as necessary to complete the initial or six-month case evaluation (HCPCS code G0162 and revenue code 0583)
0561	G0155	As authorized, or as necessary to complete the initial or six-month case evaluation (HCPCS code G0162 and revenue code 0583)
0571	G0156	As authorized
0580	99501	Once in six months
	99502	Once in six months
0583	G0162	Four in six months (1 hour)
0589	G0162	Four in six months (1 hour)
	99600	As authorized

Home Health Agencies Billing

Physician Treatment Plan

Authorization requests for services beyond the case evaluation require prior approval and must include a written treatment plan that will be approved and signed by a physician within 30 working days of the treatment plan.

Since the ordering physician has 30 working days to sign a written treatment plan, an authorization request may be submitted to the TAR Processing Center with an unsigned written treatment plan. The unsigned written treatment plan must have a physician's verbal order for services, taken and recorded by a health care professional at the time services are ordered. A healthcare professional may be a registered nurse, qualified therapist, social worker or any other health professional responsible for furnishing or supervising care.

The treatment plan must include:

- The principal diagnosis and significant associated diagnoses
- Prognosis
- Date of onset of the illness
- Specific types of services to be rendered by each discipline
- Therapeutic goals to be achieved by each discipline and anticipated time for achievement of goals
- The extent to which HHA care has been previously provided and benefits or improvements demonstrated by such care
- A description of the home situation, to include whether assistance is available from household members, homemakers, attendants or others

A re-authorization request must include a statement describing the recipient's progress toward achieving the therapeutic goals.

NOTE

Upon request, the written treatment plan must be available to Department of Health Care Services (DHCS) staff by providing HHA documenting evidence of the ordering physician's signature within 30 working days of the treatment plan date.

TAR Requirements

Effective for dates of service on or after June 1, 2016, TARs containing HCPCS Level III local home health codes will no longer be permitted.

TARs submitted with dates of service on or after June 1, 2016, require the HCPCS Level II national home health codes.

NOTE

All home health services billing HCPCS Level II national codes require an approved TAR on or after June 1, 2016.

All TARs with home health local codes and a combination of HCPCS Level III and HCPCS Level II procedure codes, regardless of status (approved, retroactive or deferred) will be end-dated for dates of service on or after June 1, 2016.

Monthly case evaluation, extension of treatment plan and skilled care services (revenue code 0589 and HCPCS code G0162) are not subject to authorization; however any other skilled care services billed with these codes must be accompanied by an approved TAR on a separate claim form.

For dates of service on or after June 1, 2016, home health billing policy is updated to accommodate the following HCPCS Level II codes. The HCPCS codes are shown with their corresponding revenue code; however, only the HCPCS code will be used for TAR purposes.

Revenue Code	HCPCS Level II/CPT-4 Code	Authorization
0270	A9999	TAR required
0421	G0151	Required, except when performed in conjunction with the initial six-month case evaluation (HCPCS code G0162 and Revenue Code 0583)
0431	G0152	Required, except when performed in conjunction with the initial six-month case evaluation (HCPCS code G0162 and Revenue Code 0583)
0441	G0153	Required, except when performed in conjunction with the initial six-month case evaluation (HCPCS code G0162 and Revenue Code 0583)
0551	G0154	Required, except when performed in conjunction with the initial six-month case evaluation (HCPCS code G0162 and Revenue Code 0583)

Revenue Code	HCPCS Level II/CPT-4 Code	Authorization
0561	G0155	Required, except when performed in conjunction with the initial six-month case evaluation (HCPCS code G0162 and Revenue Code 0583)
0571	G0156	TAR required
0580	99501	TAR <u>not</u> required
	99502	TAR <u>not</u> required
0583	G0162	TAR <u>not</u> required
0589	G0162	TAR <u>not</u> required
	99600	TAR required

TAR Completion and Submission Information

Medi-Cal strongly encourages the use of an electronic Treatment Authorization Request (eTAR). Listed below are the benefits of submitting eTARs and tips on submitting paper TARs.

eTARs

- Faster response time
- Less expensive and less time consuming
- No mail delays or postage
- Check status of eTARs online anytime

Paper TARs

- TARs must be typed
- Include necessary medical justification
- Verify TAR information (provider number/National Provider Identifier [NPI])
- Include an original signature

Verify the status of the TAR through the Provider Telecommunications Network (PTN) at 1-800-786-4346 or on the Medi-Cal website (www.medi-cal.ca.gov).

Same Day Services

Skilled Care Services

If it is necessary to perform skilled care services (HCPCS codes G0151 – G0155) on the same date of service as the initial or six-month case evaluation (revenue code 0583 and HCPCS code G0162), both services must be billed on the same claim.

Service	HCPCS Code	Revenue Code
Physical therapy	G1051	0421
Occupational therapy	G0152	0431
Speech therapy	G0153	0441
Skilled nursing	G0154	0551
Medical social services	G0155	0561

When billing for one of the skilled care services on the same date as the initial or six-month case evaluation, both the evaluation and the skilled care services are reimbursable without authorization. If the skilled care service is billed separately, authorization is required.

NOTE

Only one skilled care service may be billed in conjunction with the initial evaluation.

Mother and Baby

- Services performed for a mother and baby on the same day require a separate *UB-04* claim form and a separate TAR for each recipient.
- HHA providers who render services to a mother and her newborn(s) during the neonatal period (month of delivery and subsequent month) may be reimbursed without authorization for only one initial skilled nursing visit (revenue code 0551 and HCPCS code G0154).
- A case evaluation and initial treatment plan (revenue code 0583 and HCPCS code G0162) is reimbursable for the mother without authorization.
- A case evaluation and initial treatment plan (revenue code 0583 and HCPCS code G0162) for the newborn using the mother's Medi-Cal ID number may be reimbursed without authorization when it is performed on a different date than the mother's case evaluation and initial treatment plan.
- If more than one visit is necessary or if services are rendered to mother and infant on the same date of service for the month of birth and the following month and the infant is using the mother's ID, authorization is required.

When completing claims, do not enter the decimal points in the ICD-10-CM diagnosis codes or dollar amounts. If requested information does not fit properly in the *Remarks* field (Box 80) of the claim, type it on an 8 ½ x 11-inch sheet of paper and attach it to the claim.

Home Health Psychiatric Nursing Services

HHA services are excluded from coverage by the Mental Health Program (MHP) as set forth in the *California Code of Regulations* (CCR). However, home health psychiatric nursing is a skilled nursing service that may be provided by an HHA to a Medi-Cal recipient with a psychiatric illness or condition.

NOTE

HHA psychiatric nursing service visits require the submission of a TAR for approval. The TAR must be accompanied by a written plan of care approved by a physician every 62 days. See the *Home Health Agencies (HHA)* (home hlth) section in the Part 2 manual for authorization requirements.

The following are examples of psychiatric services that may be provided by a home health nurse:

- Make an initial evaluation using observation and assessment skills
- Evaluate, review and teach the use of medications, emphasizing compliance
- Administer IM or I.V. medication, if necessary
- Manage situational (or other) crises; perform suicidal assessments, as necessary
- Provide psychotherapeutic assessments as ordered by the physician, which may include supportive counseling, behavior modification (for obsessive-compulsive behaviors such as hand washing) and cognitive retraining (positive thinking process)
- Provide psychological education such as teaching/training with disease process, symptom and safety management, coping skills and problem solving

Home Health Aide Services

Home health aide services (revenue code 0571 and HCPCS code G0156) are both Medicare and Medi-Cal benefits. These services may include personal care and household services that must be billed as part of a physician-approved treatment plan and must be supervised by a registered nurse therapist.

Personal care services include:

- Ambulation
- Bathing
- Catheter site care
- Feeding assistance
- Grooming
- Medical assistance
- Prescribed exercise assistance
- Range of motion exercises
- Skin care
- Transfers out of bed

Certain household services may also be included in the visit if they are incidental to medically necessary services and do not substantially increase the home health aide's service time.

Medical Supplies

Medical supplies sent to Medi-Cal recipients by HHA personnel may be covered as separately reimbursable items subject to authorization. Supplies are separately reimbursable if:

- They are not used as part of a treatment visit (that is, they are left with the recipient for later use)
- They are provided in accordance with the recipient's written treatment plan

Under Medi-Cal, the medical supply used in connection with the treatment visit (for example, bandages used to change dressings) is included in the reimbursement for the nursing visit. The reimbursement is intended to include the cost of incidental supplies. Medical supplies can be considered separately reimbursable only when they are left with the recipient.

Medical supplies are:

- Subject to authorization regardless of their cost
- Billed with revenue code 0270 and HCPCS code A9999
 - Billed "By Report"
 - An invoice, an itemized list and a TAR should be attached to the claim
- Treatment plan must state these supplies are consistent with the treatment proposed

Other HHA Services

Other services provided by HHA personnel that do not apply to any of the previous categories may be separately reimbursable and subject to authorization.

Example: Respiratory therapist services should be billed with CPT-4 code 99600 and revenue code 0589.

- Must be billed "By Report"
- An invoice, an itemized list and a TAR should be attached to the claim

Billing Examples

The examples in this module are to assist providers in billing HHA services on the *UB-04* claim form. For general policy information, refer to the *Home Health Agencies (HHA)* (home hlth) section in the Part 2 manual. Refer to the *UB-04 Completion: Outpatient Services* (ub comp op) section in the Part 2 manual for instructions to complete claim fields not explained in the following example. Examples are samples only. Please adapt to your billing situation.

Skilled Nursing Services

Figure 1. A physician has prescribed in-home medical care for a recipient who requires intermittent injections. The recipient has a written plan of care that is reviewed by the physician every 60 days. The agency that renders the services submits claims monthly. The skilled nursing visits are billed in the “from-through” format and require authorization.

NOTE

HHA claims do not require condition, occurrence or value code information (Boxes 18 – 28, 31 – 37 and 39 – 41).

On claim line 1:

- Enter the description of the service rendered (skilled nursing visits) in the *Description* field (Box 43).
- Enter the “from” date of service (June 1, 2016) in six-digit format as 060116 in the *Service Date* field (Box 45).

On claim line 2:

- Enter code “0551” in the *Revenue Code* field (Box 42) to indicate that this is a home health skilled nursing visit.
- Enter the specific days the services were rendered (6/1, 5, 8, 13, 20, 26 and 30) in the *Description* field (Box 43).
- Enter the procedure code (G0154) in the *HCPCS/Rate* field (Box 44).
- Enter the “through” date of service (June 30, 2016) in six-digit format as 063016 in the *Service Date* field (Box 45).
- Enter a “7” in the *Service Units* field (Box 46).
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

On claim line 3:

- Enter code “0589” to indicate that this is a home health visit in the *Revenue Code* field (Box 42).
- Enter the description of the service rendered (administered drugs) in the *Description* field (Box 43).
- Enter the procedure code (99600) in the *HCPCS/Rate* field (Box 44).
- Enter the service date in the *Service Date* field (Box 45).
- Enter a “1” in the *Service Units* field (Box 46).
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

On claim line 4:

- Enter code “0270” in the *Revenue Code* field (Box 42) to indicate that this home health visit involved providing medical supplies.
- Enter the description of the service rendered (medical supplies) in the *Description* field (Box 43).
- Enter the procedure code (A9999) in the *HCPCS/Rate* field (Box 44).
- Enter the service date in the *Service Date* field (Box 45).
- Enter a “1” in the *Service Units* field (Box 46).
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

On claim line 23:

- Enter code “001” to designate that this is the total charge line in the *Revenue Code* field (Box 42).
- Enter the total of all charges in the *Total Charges* field (Box 47).

Remaining Claim Fields

Box #	Field name	Instructions
4	Type of Bill	Enter the two-digit facility type code “33” (home health – outpatient) and one-character claim frequency code “1” as “331.”
50	Payer Name	Enter “O/P MEDI-CAL” to indicate the type of claim and payer.
56	NPI	Enter the HHA’s NPI.
63	Treatment Authorization Codes	Enter the 11-digit TAR number.
66	ICD Indicator (DX)	Because this claim is submitted with a diagnosis code, an ICD indicator of “0” is required in the white space below. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.
67	Unlabeled (Primary Diagnosis Code)	Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.
77	Operating	Enter the rendering provider’s NPI.
80	Remarks	HCPCS code A9999 must be billed “By Report,” which requires an invoice, itemized list of supplies and a TAR to be attached to the claim. Indicate that the claim has attachments. Refer to the <i>Home Health Agencies (HHA)</i> (home hlth) section of the Part 2 provider manual for additional code A9999 billing instructions.

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555	2		3a PAT. CNTRL # b. MED. REC. #		4 TYPE OF BILL 331	
8 PATIENT NAME a DOE, JOHN			9 PATIENT ADDRESS a			
10 BIRTHDATE 08241980	11 SEX M	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR
31 OCCURRENCE DATE	32 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE CODE	37 OCCURRENCE DATE
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0551	SKILLED NURSING VISITS 6/1, 5, 8, 13, 20, 26, 30	G0154	060116	7	770 00	
0589	ADMINISTERED DRUGS	99600	060116	1	100 00	
0270	MEDICAL SUPPLIES	A9999	063016	1	25 00	
001	PAGE OF	CREATION DATE	TOTALS	895 00		
50 PAYER NAME O/P MEDI-CAL	51 HEALTH PLAN ID	52 REL. INFO	53 ASST. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE 895 00	56 NPI 0123456789
58 INSURED'S NAME	59 P. REL.	60 INSURED'S UNIQUE ID 90000000A95001	61 GROUP NAME	62 INSURANCE GROUP NO.		
63 TREATMENT AUTHORIZATION CODES 01234567890	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME				
66 DX D1D1D1D 0	67	68				
69 ADMIT. DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73		
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI	80 REMARKS
		1234567890				SEE ATTACHMENTS
81CC a	b	c	d			

Figure 1: Skilled Nursing Services

Initial Case Evaluation Billed on Same Day as Skilled Nursing Visit

Figure 2. A physician has prescribed in-home medical care for a patient who had a stroke. The patient has a written plan of care that is reviewed by the physician every 60 days. This claim is submitted for initial case evaluation plus treatment plan services. No TAR is required for a skilled nursing visit rendered on the same day as the initial evaluation (HCPCS Level II code G0162). These services are billed on the same claim form.

NOTE

HHA claims do not require condition, occurrence or value code information (Boxes 18 – 28, 31 – 37 and 39 – 41).

On claim line 1:

- Enter code “0583” in the *Revenue Code* field (Box 42) to indicate that this is a visit/home health assessment.
- Enter the description of the service rendered (Initial case evaluation) in the *Description* field (Box 43).
- Enter the procedure code (G0162) in the *HCPCS/Rate* field (Box 44).
- Enter the date of service (June 1, 2016) in six-digit format as 060116 in the *Service Date* field (Box 45).
- Enter a “1.” in the *Service Units* field (Box 46). Quantities must be billed in whole units.
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

On claim line 2:

- Enter code “0551” in the *Revenue Code* field (Box 42) to indicate that this is a home health skilled nursing visit.
- Enter the description of the service rendered (skilled nursing visit) in the *Description* field (Box 43).
- Enter the procedure code (G0154) in the *HCPCS/Rate* field (Box 44).
- Enter the date of service (June 1, 2016) in six-digit format as 060116 in the *Service Date* field (Box 45).
- Enter a “1” in the *Service Units* field (Box 46). Quantities must be billed in whole units.
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

On claim line 23:

- Enter code “001” in the *Revenue Code* field (Box 42) to designate that this is the total charge line.
- Enter the total of all charges in the *Total Charges* field (Box 47).

Remaining Claim Fields

Box #	Field name	Instructions
4	Type of Bill	Enter the two-digit facility type code "33" (home health – outpatient) and one-character claim frequency code "1" as "331."
50	Payer Name	Enter "O/P MEDI-CAL" to indicate the type of claim and payer.
56	NPI	Enter the HHA's NPI.
66	ICD Indicator (DX)	Because this claim is submitted with a diagnosis code, an ICD indicator of "0" is required in the white space below. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.
67	Unlabeled (Primary Diagnosis Code)	Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.
77	Operating	Enter the rendering provider's NPI.

1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN CA 958235555	2		3a PAT. CNTL # b. MED. REC. #		4 TYPE OF BILL 331	
8 PATIENT NAME a DOE, JOHN			9 PATIENT ADDRESS a			
10 BIRTHDATE 08241980	11 SEX M	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR
17 STAT	18	19	20	21	22	23
24	25	26	27	28	29 ACCT STATE	30
31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 CODE	36 OCCURRENCE SPAN FROM	37
38	39 VALUE CODES AMOUNT	40 VALUE CODES AMOUNT	41 VALUE CODES AMOUNT	42	43	44
42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1 0583	INITIAL CASE EVALUATION	G0162	060116	1	60 00	
2 0551	SKILLED NURSING VISIT	G0154	060116	1	42 00	
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23	001	PAGE	OF	CREATION DATE	TOTALS	102 00
A	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASST. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE
B	O/P MEDI-CAL					102 00
C	56 NPI	57 OTHER PRV ID	58 INSURED'S NAME	59 P. REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME
A					90000000A95001	
B						
C						
A	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	66 DX	67	68
B				D1D1D1D		
C				O		
A	69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73	
B						
C						
A	74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI
B				1234567890		
C						
A	80 REMARKS	81CC a	82	83	84	85
B						
C						

Figure 2: Initial Case Evaluation Billed on Same Day as Skilled Nursing Visit

Hospice Care

Introduction

Purpose

The purpose of this module is to provide an overview of the hospice care program for Medi-Cal recipients and California Children's Services (CCS) clients. Restricted eligibility, aid codes, claim submission, documentation and the *Treatment Authorization Request* (TAR) are reviewed. HIPAA-compliant Healthcare Common Procedure Coding System (HCPCS) level II national codes are introduced.

Objectives

- Define Medi-Cal hospice care policy for Medi-Cal recipients and CCS clients
- Explain the hospice care program
- Detail appropriate hospice care documentation requirements
- Explain pain and symptom-management services related to a recipient's terminal condition
- Examine the policy and billing requirements for hospice care
- Describe the field requirements of the *UB-04* claim form and billing issues with hospice care claim examples
- Introduce billing examples for hospice care

Resource Information

Medi-Cal Subscription Service (MCSS)

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, *Medi-Cal Update* bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at (www.medi-cal.ca.gov/mcss).

References

The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 1

Aid Codes Master Chart (aid codes)

OBRA and IRCA (obra)

Part 2

Form: Hospice General Inpatient Information Sheet (DHS 6194)

Hospice Care (hospic)

Hospice Care Billing Codes (hospic bil cd)

Hospice Care Billing Examples (hospic bil ex)

Hospice Care: General Billing Instructions (hospic ge)

Hospice Care: General Inpatient Information Sheet (hospic ge inf)

Revenue Codes for Inpatient Services (rev cd ip)

TAR and Non-Benefit: Introduction to List (tar and non)

TAR Completion (tar comp)

UB-04 Completion: Inpatient Services (ub comp ip)

UB-04 Completion: Outpatient Services (ub comp op)

Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook.

Program Coverage

Hospice care is a form of medical multidisciplinary care that addresses the unique requirements of terminally ill individuals.

Hospice is used to alleviate pain and suffering, and treat symptoms rather than to cure the illness. Medical and nursing services are designed to maximize the patient's comfort, alertness and independence so the patient can reside in the home as long as possible.

Providers must enroll as a Medi-Cal hospice provider. All claims are submitted using the *UB-04* claim form.

Hospice providers may include the following:

- Hospitals
- Skilled nursing facilities
- Intermediate care facilities
- Home health agencies
- Any licensed health provider who has been certified by Medicare to provide hospice care and is enrolled as a Medi-Cal hospice care provider.

NOTE

All services must be rendered in accordance with Medicare requirements.

Hospice is a covered optional benefit under Medi-Cal with:

- two 90-day periods, beginning on the date of hospice election
- followed by unlimited 60-day periods
- a Medi-Cal eligible recipient who is certified by a physician as having a life expectancy of six months or less.

Hospice Care Eligibility

Any Medi-Cal recipient certified by a physician as having a life expectancy of six months or less may elect to receive hospice care in lieu of normal Medi-Cal coverage for services related to the terminal condition. Election of hospice care occurs when the patient (or representative) voluntarily files an election statement with the hospice provider. This statement acknowledges that the patient understands that the hospice care relating to the illness is intended to alleviate pain and suffering rather than to cure the illness and that certain Medi-Cal benefits are waived by this election.

In accordance with Section 2302 of the Patient Protection and Affordable Care Act (ACA), any Medi-Cal eligible recipient younger than 21 years of age and certified by a physician as having a life expectancy of six months or less may elect to concurrently receive hospice care in addition to curative treatment of the hospice-related diagnosis.

Non-hospice providers will be able to bill Medi-Cal for medically necessary, curative treatments that are provided within their scope of practice and that are considered a benefit under the Medi-Cal program. All services are subject to current hospice frequency and utilization review guidelines.

4 Hospice Care

A copy of the election statement signed by the patient (or authorized representative) must be forwarded to the address listed below within 30 calendar days of the patient electing hospice services:

Attn: Hospice Clerk
Department of Health Care Services
Medi-Cal Eligibility Division
MS 4607
1501 Capitol Avenue, Room 4063
P.O. Box 997417-7417
Sacramento, CA 95899-7417

Included with the election statement should be the patient's legal name, date of birth and Medi-Cal number so that the hospice clerk can identify the correct patient. If any of the information is missing or the election statement does not specifically mention the Medi-Cal benefit, the election statement will be returned to the hospice provider as not being satisfactory.

In order to protect the patient's privacy, no other information should be sent to the hospice clerk except the requested information listed above the election statement.

The hospice provider only needs to send the election statement once per election period. The same election statement does not need to be sent each month the patient is on hospice or after each recertification.

Service Restrictions

The response from the eligibility verification system for recipients who elect to receive hospice care in lieu of curative treatment and services will state "Primary diagnosis/limited to hospice." The recipient is not eligible to receive services related to the terminal diagnosis from providers other than a hospice provider or the attending physician.

When the response is returned from the eligibility verification system, the other provider should identify the name of the recipient's hospice provider and inform the provider that the hospice patient is seeking other medical assistance related to the terminal diagnosis.

The special message "Primary diagnosis/limited to hospice" does not specify that Medi-Cal recipients are prohibited from receiving other services that are unrelated to the primary diagnosis, such as physician examinations, drugs or other medical care.

Patient Certification/Recertification Requirements

The attending physician and the medical director or physician member of the hospice interdisciplinary team must certify in writing at the beginning of the first 90-day period that the patient is terminally ill. For all subsequent recertification periods, only a hospice physician may certify that the patient is terminally ill. Only a physician (primary or hospice medical director) can certify that the patient is terminally ill with a life expectancy of six months or less.

At the start of the first 90-day period of care, the hospice provider must maintain an initial certification that the patient is terminally ill in the patient's medical records. At the start of each subsequent period of care, the hospice provider must maintain a recertification in the patient's medical records.

A hospice physician or NP is required to have a face-to-face encounter with every hospice patient to determine the continued eligibility of that patient. The face-to-face encounter requirement is satisfied when the following criteria are met:

- An encounter must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to every subsequent benefit period.
- The hospice physician or NP who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter.
- A hospice physician or a hospice NP is a practitioner who can perform the encounter.
- The hospice must retain the certification statements and have them available for audit purposes.
- Timeframes for exceptional circumstances for new hospice admissions are in the third or later benefit period. In cases where a hospice newly admits a patient in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period.

Example: If the patient is an emergency weekend admission, it may be impossible for a hospice physician or NP to see the patient until the following Monday. Or, if CMS data systems are unavailable, the hospice may be unaware that the patient is in the third benefit period.

In such documented cases, a face-to-face encounter that occurs within two days after admission is considered timely. Additionally, for such documented exceptional cases, if the patient dies within two days of admission without a face-to-face encounter, a face-to-face encounter can be deemed as complete.

Example: When a Medi-Cal hospice patient transfers from one hospice to another, it is sometimes difficult to determine what benefit period a patient is currently in. In such cases, the receiving hospice may not know if a face-to-face recertification is necessary. The receiving hospice provider is required to document in the patient's medical records all efforts to obtain the previous hospice benefit period, either from the transferring hospice provider or from other sources.

If the receiving hospice cannot determine the correct benefit period, the face-to-face recertification clock starts from the time the receiving hospice provider completed the intake process. This information must be maintained in the patient's medical records for auditing purposes.

Hospice Revocation

A patient (or representative) may revoke the election or hospice care at any time in writing. However, a hospice cannot “revoke” a patient’s election. To revoke the election of hospice care, the patient, as well as the hospice provider, must inform DHCS in writing and must include the following:

- A signed statement that the individual revokes the election of hospice care for the remainder of that election period, and;
- The effective date of that revocation. An individual may not designate an effective date earlier than the date the revocation is made.

NOTE

Verbal revocation of benefits is not acceptable. The individual forfeits hospice coverage for any remaining days in that election period.

Upon revoking of hospice care for a particular election period, the patient is no longer covered under the Medi-Cal hospice benefit and he or she resumes Medi-Cal coverage of the benefits waived when hospice care was elected.

An individual may, at any time, elect to receive hospice coverage for any other election periods that he or she is eligible to receive.

Subsequently, if the patient re-elects hospice care, the hospice provider must submit a new patient hospice election to DHCS. The hospice provider retains the initial certification of terminal illness from the hospice physician in the terminally ill patient’s medical records.

The hospice care period starts again with the two 90-day periods followed by the unlimited 60-day periods.

Classification of Care

Each day of hospice care is classified into one of four levels of care:

- Routine home care
- Continuous home care
- Respite care
- General inpatient care

Refer to the *Hospice Care* (hospic) section of the Part 2 provider manual under the Levels of Care Core Services heading.

Policies

HIPAA-mandated changes to the billing requirements for the hospice code conversion are effective for dates of service on or after June 1, 2016. These changes include the use of revenue codes and/or HCPCS Level II national codes as shown in the code conversion table below.

Any provider submitting claims for hospice services on or after June 1, 2016, will be required to submit claims using the specified revenue codes and/or HCPCS Level II codes.

Revenue codes identify specific accommodations, ancillary services, unique billing calculations or arrangements. These codes permit facilities to bill for facility usage and services rendered. Many of these services do not have corresponding procedure codes. HIPAA requires that payers (including Medi-Cal) accept revenue codes and utilize them in claim adjudication. Hospice claims submitted without revenue codes will be denied.

Service Description	Revenue Code	Description	When to Bill Medi-Cal Directly	Discontinued HCPCS Code
Hospice care services	0651	Routine home care (per diem)	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	Z7100
Hospice care services	0652	Continuous home care	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	Z7102
Hospice general care	0655	Inpatient respite care	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	Z7104

8 Hospice Care

Service Description	Revenue Code	Description	When to Bill Medi-Cal Directly	Discontinued HCPCS Code
Hospice general care	0656	General inpatient care (no respite/hospice general care)	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	Z7106
Hospice general care	0657	Physician's services	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	Z7108
Hospice room and board	0658	Room and board codes	Always	Z7100, Z7102

Medi-Cal hospice providers are required, upon request, to make available to DHCS complete and accurate medical and fiscal records, signed and dated by appropriate staff, to fully substantiate all claims for hospice services submitted to the Fiscal Intermediary (FI), and to permit access to all record and facilities for the purpose of claim auditing, program monitoring and utilization review.

NOTE

Records must be held three years from the last service date.

Frequency Limitations

Frequency limitations will be applied to hospice revenue codes on or after June 1, 2016.

Revenue Code/HCPCS Code	Description	Frequency Limitations
0651	Routine home care (per diem)	One unit per claim line, per day
0652	Continuous home care	Minimum of eight hours (units) Maximum of 24 hours (units) per claim line, per day
0655	Inpatient respite care	One unit per claim line, per day <u>and</u> limit of five days for each episode (stay) NOTE Services billed beyond five days for each episode will be paid at the routine home care rate (revenue code 0651) for additional days
0656/T2045	General inpatient care (no respite)/hospice general care	One unit per claim line, per day
0657	Physician's services	One unit per claim line, per day

TAR/SAR Policy Update

Effective for dates of service on or after June 1, 2016, *Treatment Authorization Requests* (TARs)/Service Authorization Requests (SARs) submitted with HCPCS Level III local hospice codes are no longer accepted. Providers should prepare and submit TARs and SARs as follows:

- All TARs/SARs submitted with dates of service on or after June 1, 2016, require HCPCS Level II national hospice service codes.
- All TARs/SARs with HCPCS Level III local codes, regardless of status (approved, retroactive or deferred), will be end-dated for dates of service on or after June 1, 2016. Providers are encouraged to submit new TARs/SARs or electronic TARs (eTARs) with the appropriate Level II national code(s) prior to June 1, 2016.
- Providers should refer to the Hospice Care Service Code Conversion: TAR Policy Update article for more information.

SAR Policy Update

California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) providers should review hospice SARs that extend beyond June 30, 2016.

- Providers must submit a new SAR with the appropriate HCPCS Level II national code(s) to cover service periods after June 30, 2016.
- Providers can begin requesting SARs with HCPCS Level II national codes for dates of service on or after July 1, 2016, for SARs previously submitted with through dates beyond June 30, 2016.

NOTE

SAR requests using HCPCS Level III local codes may only be submitted for dates of service ending on or before June 30, 2016.

Revenue Code/HCPCS Level II Codes	Description	Authorization
0651	Routine home care (per diem)	TAR <u>not</u> required
0652	Continuous home care	TAR <u>not</u> required
0655	Inpatient respite care	TAR <u>not</u> required
0656/T2045	General inpatient care (no respite)/hospice general care	TAR required
0657	Special physician services	TAR <u>not</u> required

Hospice Billing

Special Physician Services

- Address pain and symptom management
- Require revenue code 0657 when services are related to the terminal condition
- Are provided by a physician employed by or under arrangement made by the hospice
- May be billed only for physician services to manage symptoms that cannot be remedied by the recipient's attending physician because of one of the following:
 - Immediate need
 - Attending physician does not have the required special skills
- Bill revenue code 0657 on a separate line for each date of service

If a recipient is receiving care for more than one day in a month, use the "from-through" billing method to bill per-diem service and room and board codes.

- If billing for a single day, bill that day on one line with a single date of service.
- Do not bill per-diem codes on a single line with a quantity greater than one (1), or the claim will be denied.

Medi-Cal requires that hospices document all coexisting or additional diagnoses related to the recipient's terminal illness on hospice claims. Hospice providers should not report coexisting or additional diagnoses unrelated to the terminal illness.

Same or Overlapping Dates of Service

Only one level of hospice care is allowed for any hospice recipient for the same date of service. Claims for more than one type of hospice service billed for the same recipient on the same or overlapping date(s) of service will be denied.

Exception: In cases where one hospice discharges a recipient and another hospice admits the same recipient on the same day, each hospice may bill for reimbursement and each will be reimbursed at the appropriate level of care for its respective day of discharge or admission.

Room and Board Billing

When billing for room and board codes, the following information is required in the *Remarks* field of the claim:

- The recipient resides in a certified NF or Intermediate Care Facility (ICF)
- The name and address of the NF or ICF
- A Minimum Data Set (MDS) on file at the NF verifies that the recipient meets the NF or ICF level of care

NOTE

A TAR is not required for hospice care room and board provided in a NF or ICF.

Share of Cost

Long Term Care Share of Cost (SOC) should be cleared by a hospice provider on the *UB-04* claim form by completing the *Value Codes* and *Amounts* fields (Boxes 39 and 41). The value code is "23" and the value amount is what has been paid or obligated by the patient for SOC.

NOTES

Billing Examples

The examples in this module are to assist providers in billing hospice care services on the *UB-04* claim form. The following examples are samples only. Please adapt to your billing situation.

“From-Through” Billing of General Inpatient Hospice Care

Figure 1. The recipient has elected Medi-Cal hospice coverage and is admitted to the hospital on three separate occasions (three days each visit) for monitoring and adjustment of pain medications. Authorization is required for general inpatient care days.

On Claim Line 1:

- Enter the description of the service rendered (inpatient care) in the *Description* field (Box 43).
- Enter the beginning service (June 1, 2016) in six-digit format as “060116” in the *Service Date* field (Box 45).

On Claim Line 2:

- Enter code “0656” to indicate that this is a general inpatient care (no respite)/hospice general care service in the *Revenue Code* field (Box 42).
- Enter the specific days the services were rendered (6/1, 3, 4, 16, 17, 18, 25, 26 and 27) in the *Description* field (Box 43).
- Enter the procedure code (HCPCS code T2045) in the *HCPCS/Rate* field (Box 44).
- Enter the “through” date of service (June 27, 2016) in six-digit format as “062716” in the *Service Date* field (Box 45).
- Enter a “9” to indicate the number of days the recipient received inpatient care in the *Service Units* field (Box 46).
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

On Claim Line 23:

- Enter code 001 to designate that this is the total charge line in the *Revenue Code* field (Box 42).
- Enter the total of all charges in the *Total Charges* field (Box 47).

Remaining Claim Fields

Box #	Field name	Instructions
4	Type of Bill	Enter the two-digit facility type code "81" (special facility – hospice [non-hospital based]) and one-character claim frequency code "1" as "811."
50	Payer Name	Enter "O/P MEDI-CAL" to indicate the type of claim and payer.
56	NPI	Place the hospice provider number.
63	Treatment Authorization Codes	Enter the 11-digit TAR number.
66	ICD Indicator (DX)	Because this claim is submitted with a diagnosis code, an ICD indicator of "0" is required in the white space below. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.
67	Unlabeled (Primary Diagnosis Code)	Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.

NOTES

14 Hospice Care

1 UPTOWN MEDICAL CENTER		2		3a PAT CNTL #		4 TYPE OF BILL	
140 SECOND STREET				b. MED REC. #		811	
ANYTOWN, CA 958235555				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
8 PATIENT NAME		a DOE, JOHN		9 PATIENT ADDRESS		a	
10 BIRTHDATE		11 SEX		12 DATE		13 HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 CODE		36 OCCURRENCE SPAN FROM THROUGH		37	
38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
42 REV. CD.		43 DESCRIPTION		44 HCPCS / RATE / HIPPS CODE		45 SERV. DATE	
46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1 0656		2 INPATIENT CARE		3 T2045		4 060116	
5 6/1 3 4 16 17 18 25 26 27		6		7 062716		8 9	
9		10		11		12	
13		14		15		16	
17		18		19		20	
21		22		23		24	
25		26		27		28	
29		30		31		32	
33		34		35		36	
37		38		39		40	
41		42		43		44	
45		46		47		48	
49		50		51		52	
53		54		55		56	
57		58		59		60	
61		62		63		64	
65		66		67		68	
69		70		71		72	
73		74		75		76	
77		78		79		80	
81		82		83		84	
85		86		87		88	
89		90		91		92	
93		94		95		96	
97		98		99		100	

Figure 1: "From-Through" Billing of General Inpatient Hospice Care

Room and Board Billing

Figure 2. A hospice provider is billing for room and board for a recipient who has no Medicare health coverage and has Alzheimer’s disease. The recipient has elected Medi-Cal hospice coverage for monitoring and adjustment of pain medications.

On Claim Line 1:

- Enter the description of the service rendered (Room and Board) in the *Description* field (Box 43).
- Enter the beginning service (June 1, 2016) in six-digit format as “060116” in the *Service Date* field (Box 45).

On Claim Line 2:

- Enter revenue code “0658” (room and board) in the *Revenue Code* field (Box 42).
- Enter the specific days the services were rendered (6/1, 2, 3, 4 and 5) in the *Description* field (Box 43).
- Enter the “through” date of service (June 5, 2016) in six-digit format as “060516” in the *Service Date* field (Box 45).
- Enter a “5” to indicate the number of days the recipient received room and board services in the *Service Units* field (Box 46).
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

On Claim Line 23:

- Enter code “001” to designate that this is the total charge line in the *Revenue Code* field (Box 42).
- Enter the total of all charges minus the SOC in the *Total Charges* field (Box 47).

Remaining Claim Fields

Box #	Field name	Instructions
4	Type of Bill	Enter the two-digit facility type code “26” (Nursing Facility Level B) and one-character claim frequency code “1” as “261.”
39	Code Value Codes Amount	Enter aid code “23” in the <i>Code</i> column and “10000” for a \$100 SOC in the <i>Value Codes Amount</i> column.
50	Payer Name	Enter “O/P MEDI-CAL” to indicate the type of claim and payer.
56	NPI	Place the hospice provider number.
66	ICD Indicator (DX)	Because this claim is submitted with a diagnosis code, an ICD indicator of “0” is required in the white space below. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.
67	Unlabeled (Primary Diagnosis Code)	Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.
77	Operating	Enter the NPI of the facility in which the recipient resides.

16 Hospice Care

1 UPTOWN MEDICAL CENTER		2		3a PAT CNTL #		4 TYPE OF BILL	
140 SECOND STREET				b. MED REC #		261	
ANYTOWN, CA 958235555				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
8 PATIENT NAME		a DOE, JANE		9 PATIENT ADDRESS		a	
10 BIRTHDATE		11 SEX		12 DATE		13 HR	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACCT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE DATE		37	
38		39 CODE		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
a		b		c		d	
e		f		g		h	
i		j		k		l	
m		n		o		p	
q		r		s		t	
u		v		w		x	
y		z		aa		ab	
ac		ad		ae		af	
ag		ah		ai		aj	
ak		al		am		an	
ao		ap		aq		ar	
as		at		au		av	
aw		ax		ay		az	
ba		bb		bc		bd	
be		bf		bg		bh	
bi		bj		bk		bl	
bm		bn		bo		bp	
bq		br		bs		bt	
bu		bv		bw		bx	
by		bz		ca		cb	
cc		cd		ce		cf	
cg		ch		ci		cj	
ck		cl		cm		cn	
co		cp		cq		cr	
cs		ct		cu		cv	
cw		cx		cy		cz	
da		db		dc		dd	
de		df		dg		dh	
di		dj		dk		dl	
dm		dn		do		dp	
dq		dr		ds		dt	
du		dv		dw		dx	
dy		dz		ea		eb	
ec		ed		ee		ef	
eg		eh		ei		ej	
ek		el		em		en	
eo		ep		eq		er	
es		et		eu		ev	
ew		ex		ey		ez	
fa		fb		fc		fd	
fe		ff		fg		fh	
fi		fj		fk		fl	
fm		fn		fo		fp	
fq		fr		fs		ft	
fu		fv		fw		fx	
fy		fz		ga		gb	
gc		gd		ge		gf	
gg		gh		gi		gj	
gk		gl		gm		gn	
go		gp		gq		gr	
gs		gt		gu		gv	
gw		gx		gy		gz	
ha		hb		hc		hd	
he		hf		hg		hh	
hi		hj		hk		hl	
hm		hn		ho		hp	
hq		hr		hs		ht	
hu		hv		hw		hx	
hy		hz		ia		ib	
ic		id		ie		if	
ig		ih		ii		ij	
ik		il		im		in	
io		ip		iq		ir	
is		it		iu		iv	
iw		ix		iy		iz	
ja		jb		jc		jd	
je		jf		jg		jh	
ji		jj		jk		jl	
jm		jn		jo		jp	
jq		jr		js		jt	
ju		jv		jw		jx	
jy		jz		ka		kb	
kc		kd		ke		kf	
kg		kh		ki		kj	
kk		kl		km		kn	
ko		kp		kq		kr	
ks		kt		ku		kv	
kw		kx		ky		kz	
la		lb		lc		ld	
le		lf		lg		lh	
li		lj		lk		ll	
lm		ln		lo		lp	
lq		lr		ls		lt	
lu		lv		lw		lx	
ly		lz		ma		mb	
mc		md		me		mf	
mg		mh		mi		mj	
mk		ml		mm		mn	
mo		mp		mq		mr	
ms		mt		mu		mv	
mw		mx		my		mz	
na		nb		nc		nd	
ne		nf		ng		nh	
ni		nj		nk		nl	
nm		nn		no		np	
nq		nr		ns		nt	
nu		nv		nw		nx	
ny		nz		oa		ob	
oc		od		oe		of	
og		oh		oi		oj	
ok		ol		om		on	
oo		op		oq		or	
os		ot		ou		ov	
ow		ox		oy		oz	
pa		pb		pc		pd	
pe		pf		pg		ph	
pi		pj		pk		pl	
pm		pn		po		pp	
pq		pr		ps		pt	
pu		pv		pw		px	
py		pz		qa		qb	
qc		qd		qe		qf	
qg		qh		qi		qj	
qk		ql		qm		qn	
qo		qp		qq		qr	
qs		qt		qu		qv	
qw		qx		qy		qz	
ra		rb		rc		rd	
re		rf		rg		rh	
ri		rj		rk		rl	
rm		rn		ro		rp	
rq		rr		rs		rt	
ru		rv		rw		rx	
ry		rz		sa		sb	
sc		sd		se		sf	
sg		sh		si		sj	
sk		sl		sm		sn	
so		sp		sq		sr	
ss		st		su		sv	
sw		sx		sy		sz	
ta		tb		tc		td	
te		tf		tg		th	
ti		tj		tk		tl	
tm		tn		to		tp	
tq		tr		ts		tt	
tu		tv		tw		tx	
ty		tz		ua		ub	
uc		ud		ue		uf	
ug		uh		ui		uj	
uk		ul		um		un	
uo		up		uq		ur	
us		ut		uu		uv	
uw		ux		uy		uz	
va		vb		vc		vd	
ve		vf		vg		vh	
vi		vj		vk		vl	
vm		vn		vo		vp	
vq		vr		vs		vt	
vu		vv		vw		vx	
vy		vz		wa		wb	
wc		wd		we		wf	
wg		wh		wi		wj	
wk		wl		wm		wn	
wo		wp		wq		wr	
ws		wt		wu		wv	
ww		wx		wy		wz	
xa		xb		xc		xd	
xe		xf		xg		xh	
xi		xj		xk		xl	
xm		xn		xo		xp	
xq		xr		xs		xt	
xu		xv		xw		xx	
xy		xz		ya		yb	
yc		yd		ye		yf	
yg		yh		yi		yj	
yk		yl		ym		yn	
yo		yp		yq		yr	
ys		yt		yu		yv	
yw		yx		yy		yz	
za		zb		zc		zd	
ze		zf		zg		zh	
zi		zj		zk		zl	
zm		zn		zo		zp	
zq		zr		zs		zt	
zu		zv		zw		zx	
zy		zz					

Figure 2: Room and Board Billing

Learning Activity

1. To be eligible for hospice care, a Medi-Cal-eligible recipient must be certified by a _____ or _____ as having a life expectancy of six months or less.
2. A hospice _____ or _____ is required to have a face-to-face encounter no more than _____ calendar days prior to the start of the third benefit period and not more than _____ calendar days prior to every subsequent benefit period thereafter.
3. HIPAA code conversion indicates that any provider submitting HCPCS Level III codes for hospice services will be required to submit claims using the specified _____ and/or _____ codes for dates of service on or after June 1, 2016.
4. If a HCPCS Level II code is used on the claim multiple times, the HCPCS Level II code is entered only _____ on the TAR with the total number of units in the field of the TAR.

Answer Key: 1) primary care physician or hospice medical director, physician member of the hospice interdisciplinary team;
 2) physician, nurse practitioner, 30, 30;
 3) revenue codes, HCPCS Level II;
 4) once

Acronyms

ACA	Patient Protection and Affordable Care Act
CCR	California Code of Regulations
CCS	California Children's Services
DHCS	Department of Health Care Services
DME	Durable Medical Equipment
FI	Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program
GHPP	Genetically Handicapped Persons Program
HCBS	Home and Community-Based Services
HCPCS	Health Care Procedure Coding System
HHA	Home Health Agencies
HIPAA	Health Insurance Portability and Accountability Act
ICD-10-CM	International Classification of Diseases – 10 th Revision, Clinical Modification
ID	Identification
MDS	Minimum Data Set
NP	Nurse Practitioner
NPI	National Provider Identifier
PCP	Primary Care Providers
PCPEA	Primary Care Provider Enrollment Agreement
PIN	Provider Identification Number
RN	Registered Nurse
SAR	Service Authorization Request
SOC	Share of Cost
TAR	Treatment Authorization Request

