Medi-Cal Provider Training 2019

Home Health & Hospice Care Program
The Outreach and Education team includes Regional Representatives, the Small Provider Billing Unit (SPBU) and Coordinators who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment.

The Medi-Cal Learning Portal (MLP) brings Medi-Cal learning tools into the 21st Century. Simply complete a one-time registration to gain access to the MLP’s easy-to-use resources. View online tutorials, live and recorded webinars from the convenience of your own office and register for provider training seminars. For more information call the Telephone Service Center (TSC) at 1-800-541-5555 or go to the MLP at http://www.medi-cal.ca.gov/education.asp.

Free Services for Providers

Provider Seminars and Webinars
Provider training seminars and webinars offer basic and advanced billing courses for all provider types. Seminars are held throughout California and provide billing assistance services at the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Regional Representative.

Regional Representatives
The 24 Regional Representatives live and work in cities throughout California and are ready to visit providers at their office to assist with billing needs or provide training to office staff.

Small Provider Billing Unit
The four SPBU Specialists are dedicated to providing one-on-one billing assistance for one year to providers who submit fewer than 100 claim lines per month and would like some extra help. For more information about how to enroll in the SPBU Billing Assistance and Training Program, call 916-636-1275 or 1-800-541-5555.

All of the aforementioned services are available to providers at no cost!
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Home Health Agencies & Home and Community-Based Services

Introduction

Purpose

The purpose of this module is to provide billing information applicable to Home Health Agencies (HHA) and Home and Community-Based Services Programs (HCBS).

Objectives

- Define HHA and HCBS
- Highlight HHA and HCBS Level II national and revenue codes
- Provide HHA claim examples
- Detail documentation requirements for Physician Treatment Plans
- Identify who can provide HCBS services
- Highlight the eligibility and authorization requirements for HCBS
- Provide special billing instructions for HCBS claim submission

Acronyms

A list of current acronyms is located in the Appendix section of each complete workbook.
Home Health Program Description

An HHA is a public agency that is primarily engaged in providing skilled services as outpatient services prescribed by a physician and provided at the recipient's home. Services are conducted in accordance with a written treatment plan and are reviewed by a physician every 60 days. The treatment 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.
Policies

Coverage Requirements

HHAs are covered subject to the requirements specified in the California Code of Regulations, CCR, Title 22, Section 51003, 51125, 51129, 51146, 51217, 51337, 51455 and 51523 in the following general situations:

- During the convalescent phase of post hospital or institutional discharge or during the convalescent phase following an acute episode or exacerbation of an illness of a homebound recipient.
- When the homebound patient can be maintained at home in lieu of institutional placement with skilled nursing or other care. Medi-Cal does not require that the patient receive any particular therapeutic service as prerequisite for any other therapeutic service.

Refer to Criteria for Home Health Agency Services on the DHCS website (www.dhcs.ca.gov/services/medi-cal/Documents/ManCriteria_29_HmeHlthAgen.htm)

HCPCS Level II Local Code Conversion

HCPCS Level III local codes were discontinued and replaced with 10 new Health Insurance Portability and Accountability Act (HIPAA)-compliant HCPCS Level II codes for dates of service on or after June 1, 2016. HIPAA now requires the use of revenue codes when submitting claims for adjudication. Claims submitted without a revenue code will be denied.

<table>
<thead>
<tr>
<th>Current CPT/HCPCS Level II Code Description</th>
<th>Revenue Code Description</th>
<th>Frequency Limitations &amp; Authorization Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0151 (services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes)</td>
<td>0421 (physical therapy/visits)</td>
<td>As authorized, or as necessary to complete initial or six month case evaluation (HCPCS code G0162 and revenue code 0583)</td>
</tr>
<tr>
<td>G0152 (services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes)</td>
<td>0431 (occupational therapy/visit)</td>
<td>Same as previous</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>G0153 (services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes)</td>
<td>0441 (speech pathology/visit)</td>
<td>Same as previous</td>
</tr>
<tr>
<td>G0154 (direct skilled nursing services of a licensed nurse [LPN or RN] in the home health or hospice setting, each 15 minutes)</td>
<td>0551 (skilled nursing/visit)</td>
<td>As authorized, or as necessary to complete initial or six month case evaluation (HCPCS code G0162 and revenue code 0583)</td>
</tr>
<tr>
<td>G0155 (services of clinical social worker in home health or hospice settings, each 15 minutes)</td>
<td>0561 (medical social services/visit)</td>
<td>Same as previous</td>
</tr>
<tr>
<td>G0156 (services of home health/hospice aide in home health or hospice setting, each 15 minutes)</td>
<td>0571 (aide/home health/visit)</td>
<td>As authorized/TAR required</td>
</tr>
<tr>
<td>G0162 (skilled services by a registered nurse [RN] delivery of management/evaluation of plan of care, each 15 minutes)</td>
<td>0583 (visit/home health/assessment)</td>
<td>Four in six months (1 hour)/TAR not required</td>
</tr>
<tr>
<td>G0162 (same as previous)</td>
<td>0589 (visit/home health/other)</td>
<td>Four in six months (1 hour)/TAR not required</td>
</tr>
<tr>
<td>99501 (home visit for postnatal assessment and follow-up care)</td>
<td>0580 (visit/home health)</td>
<td>Once in six months/TAR not required</td>
</tr>
<tr>
<td>99502 (home visit for newborn care and assessment)</td>
<td>0580 (visit/home health)</td>
<td>Once in six months/TAR not required</td>
</tr>
<tr>
<td>99600 (unlisted home visit service or procedure)</td>
<td>0589 (visit/home health/other)</td>
<td>As authorized/TAR required</td>
</tr>
</tbody>
</table>
TAR Reminders

Effective for dates of service on or after June 1, 2016, Treatment Authorization Requests (TARs) containing HCPCS Level III were end-dated and no longer permitted.

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

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

NOTE
Refer to the HCPCS Level II Local Code Conversion table for code description, revenue code and TAR requirements. All home health services billing HCPCS Level II national codes require an approved TAR on or after June 1, 2016.
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.
Knowledge Review

1. HHA services are provided as outpatient services.
   True ☐    False ☐

2. Treatment plans must be reviewed every:
   a. 15 days
   b. 30 days
   c. 60 days
   d. As appropriate
   Answer: c. 60 days

3. HHA claims require the use of revenue codes when submitting claims for adjudication.
   True ☐    False ☐

4. A healthcare professional may be a registered nurse, qualified therapist, social worker or any other health professional responsible for furnishing or supervising care.
   True ☐    False ☐

Answer Key: 1) True; 2) c. 60 days; 3) True; 4) True
Same Day Services

Skilled Care Services
When performing any of the skilled care services (HCPCS codes G0151 – G0155) listed below 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 and are reimbursable without authorization. If the skilled care service is billed separately, authorization is required.

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS Code</th>
<th>Revenue Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical therapy</td>
<td>G1051</td>
<td>0421</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>G0152</td>
<td>0431</td>
</tr>
<tr>
<td>Speech therapy</td>
<td>G0153</td>
<td>0441</td>
</tr>
<tr>
<td>Skilled nursing</td>
<td>G0154</td>
<td>0551</td>
</tr>
<tr>
<td>Medical social services</td>
<td>G0155</td>
<td>0561</td>
</tr>
</tbody>
</table>

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 utilizing revenue code 0551 and HCPCS code G0154.
- A case evaluation and initial treatment plan is reimbursable for the mother without authorization using revenue code 0583 and HCPCS code G0162.
- A case evaluation and initial treatment plan 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 using revenue code 0583 and HCPCS code G0162.
- 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.
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.

Refer to 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.
Each “per visit allowance” is measured in units of 15-minute increments. Four units equal one hour of service, which equates to one “per visit allowance.” A maximum of four units may be billed as a “per visit allowance.” Each “per visit allowance” billed represents a minimum of one hour of service to the recipient, with the exception of “Home Health Aide Services,” which represent a minimum of two hours of the service to the recipient. The total number of services billed should be indicated in the Service Units field (Box 46) of the UB-04 claim in 15-minute increments. For example, two hours of service should be billed as eight units.

NOTE
For rates regarding HHA services, refer to the chart in the Home Health Agencies (HHA) Billing Codes and Reimbursement Rates (home hlth cd) section of the Part 2 manual.

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

Homebound Recipient
A homebound recipient is essentially confined to his or her home due to illness or injury, and if ambulatory or otherwise mobile, is unable to be absent from his or her home except for brief or infrequent periods of time. Homebound Medi-Cal eligible recipients must have full-scope eligibility for the month(s) that service is rendered.

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 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
Home Health Agencies Billing Scenarios

The billing scenario examples in this module are provided to assist providers in billing HHA services on the UB-04 claim form. Please adapt to your billing situation.

Refer to the UB-04 Completion: Outpatient Services (ub comp op) section in the Part 2 provider manual for instructions to complete claim fields not explained in the following example. Examples are samples only.

Skilled Nursing Services: “From-Through Billing”

Figure 1 and Figure 1a. 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).

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, 2018) in six-digit format as 060118 in the Service Date field (Box 45).

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, 2018) in six-digit format as 063018 in the Service Date field (Box 45).
- Enter a “28” in the Service Units field (Box 46).
- Enter the usual and customary charges in the Total Charges field (Box 47).
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).

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).

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).

NOTES
# Remaining Claim Fields

<table>
<thead>
<tr>
<th>Box #</th>
<th>Field name</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Type of Bill</td>
<td>Enter the two-digit facility type code “33” (home health – outpatient) and one-character claim frequency code “1” as “331.”</td>
</tr>
<tr>
<td>50</td>
<td>Payer Name</td>
<td>Enter “O/P MEDI-CAL” to indicate the type of claim and payer.</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>Enter the HHA’s NPI.</td>
</tr>
<tr>
<td>63</td>
<td>Treatment Authorization Codes</td>
<td>Enter the 11-digit TAR number.</td>
</tr>
<tr>
<td>66</td>
<td>ICD Indicator (DX)</td>
<td>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.</td>
</tr>
<tr>
<td>67</td>
<td>Unlabeled (Primary Diagnosis Code)</td>
<td>Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.</td>
</tr>
<tr>
<td>77</td>
<td>Operating</td>
<td>Enter the rendering provider’s NPI.</td>
</tr>
<tr>
<td>80</td>
<td>Remarks</td>
<td>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 Home Health Agencies (HHA) (home hlth) section of the Part 2 provider manual for additional code A9999 billing instructions.</td>
</tr>
</tbody>
</table>

**NOTES**

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<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Occurrence Date</th>
<th>Occurrence Code</th>
<th>Value Codes</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0551</td>
<td>SKILLED NURSING VISITS</td>
<td>01/01/2018</td>
<td>G0154</td>
<td>060118</td>
<td>770.00</td>
</tr>
<tr>
<td>0589</td>
<td>ADMINISTERED DRUGS</td>
<td>01/01/2018</td>
<td>99600</td>
<td>060118</td>
<td>100.00</td>
</tr>
<tr>
<td>0270</td>
<td>MEDICAL SUPPLIES</td>
<td>01/01/2018</td>
<td>A9999</td>
<td>063018</td>
<td>25.00</td>
</tr>
</tbody>
</table>

Figure 1: Partial Skilled Nursing Services

NOTES
Figure 1a: Partial Skilled Nursing Services

NOTES
Initial Case Evaluation Billed on Same Day as Skilled Nursing Visit

Figure 2 and Figure 2a. 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).

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, 2018) in six-digit format as 060118 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).

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, 2018) in six-digit format as 060118 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).

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).
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<td>66</td>
<td>ICD Indicator (DX)</td>
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</tr>
<tr>
<td>67</td>
<td>Unlabeled (Primary Diagnosis Code)</td>
<td>Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.</td>
</tr>
<tr>
<td>77</td>
<td>Operating</td>
<td>Enter the rendering provider’s NPI.</td>
</tr>
</tbody>
</table>

### NOTES

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

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________________________________________________________________________
Figure 2a: Partial Initial Case Evaluation Billed on Same Day as Skilled Nursing Visit
Home and Community-Based Services

Program Description

Home and Community-Based Services (HCBS) waiver services are designed to provide in-home care and support to recipients who would otherwise require institutionalization in a medical facility for a prolonged period of time.

Another goal is to ensure recipients’ medical needs can be met appropriately and safely in a home environment by providing recipients an enhanced and enriched quality of life rather than receiving services in an institution.

Background

The Department of Health Care Services (DHCS) administers the In-Home Operations (IHO) and the Nursing Facility/Acute Hospital (NF/AH) HCBS waivers for Medi-Cal eligible frail seniors and persons with disabilities.

These programs are approved by the Centers for Medicare & Medicaid Services (CMS), and must continuously provide cost-effective alternatives to institutionalized care in order for the state to receive federal matching funds.

HCBS Provider Participants

The following is a list of professionals allowed to provide HCBS waiver services:

- Registered Nurse (RN)
- Licensed Vocational Nurse (LVN)
- Home Health Aide
- Nursing Care, in the home. Private Duty Nursing provided in home by RN or LVN.
- HCBS Waiver RN or LVN that provides individual nursing services. Individual nurse provider cannot be a parent, stepparent, foster parent, spouse or legal guardian of patient.
- HCBS Benefit Provider. A Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT) or licensed psychologist. The provider cannot be a parent, stepparent, foster parent, spouse or legal guardian of patient.
- Profession Corporation. A provider who employs a LCSW, MFT or licensed psychologist, meets HCBS waiver requirements.
- HCBS Nursing Facility. A congregate Living Health Facility or Intermediate Care Facility for the Developmentally Disabled/Continuous Nursing.
- Personal Care Services. An unlicensed individual employed by a HHA, Employment or Personal Care Agency.
Home and Community-Based Eligibility

To be eligible to receive HCBS waiver services, recipients must meet Medi-Cal’s financial eligibility requirements. Medi-Cal eligibility can be met through the regular Medi-Cal eligibility or the special waiver eligibility rules.

Regular Medi-Cal Eligibility Rules
Regular Medi-Cal rules require the income and resources of the family in determining whether the potential waiver service recipient is eligible for Medi-Cal when residing in the home.

The appropriate County Welfare Department or Supplemental Security Income (SSI) office is responsible for making Medi-Cal eligibility determinations.

Special Waiver Eligibility Rules
Special waiver eligibility rules require only the income and resources of the individual seeking HCBS waiver services in determining Medi-Cal eligibility. When using special waiver eligibility, In Home Operations (IHO) first must assess the individual’s income and resources to determine if they meet the medical necessity criteria for the HCBS waiver. If the determination is made, IHO coordinates with the appropriate County Welfare Department for the Medi-Cal eligibility determination.

Authorization of HCBS Services
The authorization of HCBS waiver services depends on the agreement of the following in the decision to provide services in the home in lieu of institutional care:

- Recipient
- Guardian or authorized representative
- Primary care physician
- HCBS waiver provider

A recipient may be enrolled in only one HCBS waiver program at a time. If enrolled in the Multi-Purpose Senior Services Program (MSSP), Developmentally Disabled (DD) Waiver or AIDS Waiver, a recipient must first disenroll to be eligible for one of IHO’s HCBS waivers.

Recipients are not required to disenroll from managed care plans (MCPs) to remain or enroll in a Medi-Cal waiver program (MCWP) authorized under Section 1915(c) of the Social Security Act.

HCBCS Waivers and IHO and NF/AH Waivers Defined
HCBS waiver services provide in-home care to recipients who otherwise require prolonged institutionalization in one of the following facility types:

- Acute care hospital
- Adult or pediatric subacute nursing facility
- Nursing Facility Level A (NF-A) or Nursing Facility Level B (NF-B)
- Intermediate Care Facility for Developmentally Disabled
In-Home Operations (IHO) and Nursing Facility/Acute Hospital (NF/AH) Waivers

In-Home Operations (IHO) and the Nursing Facility/Acute Hospital (NF/AH) waivers provide services in the home to Medi-Cal recipients who would otherwise receive care in an intermediate care facility. IHO and the NF/AH waivers also provide services to Medi-Cal recipients in an intermediate care facility for the developmentally disabled who require continuous nursing, a skilled nursing facility, a subacute nursing facility or an acute care hospital.

Special Billing Instruction Reminders

- All HCBS services require an approved Treatment Authorization Request (TAR).
- All services billed on the claim must be approved on the TAR for the dates of service referenced on the claim.
- TAR Control Numbers (TCN) for services that have a negotiated reimbursement rate must end in “3.”
- Provider number on the claim must be identical to the provider number on the TAR or claims will receive Remittance Advice Details (RAD) code 0267.
- Providers are reimbursed only for prior authorized waiver services for recipients enrolled in one of IHO’s HCBS waivers. Claims for non-authorized waiver services will be denied.

For more information, refer to the Home and Community Based Services (HCBS) (home) and Home and Community-Based Services (HCBS) Billing Codes and Reimbursement Rates (home cd) in the Part 2 provider manual.

NOTES
Knowledge Review

1. Home and Community-Based Services (HCBS) provide in-home care to recipients who require services for a short duration period.
   True □   False □

2. Who administers the HCBS waiver services to Medi-Cal eligible frail seniors and persons with disabilities? ____________________________

3. Two goals of the Medi-Cal Waiver Program are:
   a. ____________________________
   b. ____________________________

4. All HCBS services require prior authorization.
   True □   False □

NOTES

Answer Key: 1) False; 2) Department of Health Care Services (DHCS); 3) Ensure recipients’ medical needs can be met safely in a home environment; For the recipients to experience enhanced and enriched quality of life in their homes 4) True
Resource Information

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)

Other References
Department of Health Care Services (DHCS) Criteria for Home Health Agency Services
Hospice Care

Introduction

Purpose

The purpose of this module is to provide an overview of the hospice care program for Medi-Cal recipients.

Objectives

Provide an overview of the Medi-Cal hospice care program coverage
Discuss hospice care program eligibility
Examine the policy and billing requirements
Introduce and review billing examples

Acronyms

A list of current acronyms is located in the Appendix section of each complete 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.

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.
Hospice care starts the day the recipient receives hospice care and ends when the 90-day or 60-day period ends.

Hospice Eligibility, Billing and Payment Requirements

Hospice Providers are reminded that once the election, revocation or re-election is made they are required to complete and submit the Hospice Notification and Election forms to the Department of Health Care Services, Medi-Cal Eligibility Division- Attn: Hospice Clerk. The hospice election form cannot be processed by DHCS unless it is signed by the patient, authorized representative or physician. By choosing Hospice election, the recipient will receive specific services. Send all forms to the address below:

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

Hospice providers are also reminded of the binding federal regulations and the requirement to accept responsibility for the management, billing and payments associated with hospice services in a long term care (LTC) setting (room, board and hospice service). The federal regulations further describe the requirements for a hospice plan of care and criteria for participation in providing hospice services within an LTC setting, and are located in:

- Title 42, CFR sections 418.100, 418.108 and 418.112 of the Centers for Medicare & Medicaid Services (CMS)
- Medicare Benefits Policy Manual, Chapter 9 – Coverage of Hospice Services under Hospital Insurance, section 20.3, Election of Skilled Nursing Facility (SNF) and Nursing Facilities (NFs) Residents and Dually Eligible Beneficiaries
- Social Security Act Section 1905 paragraph (o)(3)

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.
Hospice 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.
Knowledge Review

1. A patient has an end-stage liver disease and her attending physician told her she has six months to live. The patient elects hospice in lieu of curative treatment. She completes the election package and her attending doctor and the hospice medical director or the physician member of the hospice interdisciplinary team certifies she is terminally ill. The woman elects hospice on September 1, 2017, and begins receiving hospice care.

1. What is the date of the initial certification? ___________________________
2. What would be the date of the first recertification? _____________________
3. What would be the date of the next recertification? _____________________

NOTES

_________________________________________________________________
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Answer Key: 1) September 1, 2017; 2) November 30, 2017; 3) February 28, 2018
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
- Inpatient respite care
- General inpatient care (no respite)/hospice general care

Refer to the *Hospice Care* (hospic) section of the Part 2 provider manual under the Classification of Care heading.
Policies

HIPAA mandates the use of revenue codes and/or HCPCS Level II national codes as shown in the code conversion table below.

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. Frequency limitations also apply to hospice revenue codes.

Hospice Routine Home Care Updates


Reimbursement rates will be based on a recipient’s length of stay. The first 60 days of routine home care in a recipient’s certification period will utilize revenue code 0650 (routine home care high rate). Any subsequent days of care beyond the 60-day period, will utilize revenue code 0659 (routine home care low rate). In addition, revenue code 0552 (routine home care service intensity add-on [SIA] rate) payment for services provided by a registered nurse or social worker in the last seven days of a recipient’s life for at least 15 minutes and up to four hours total per day has also been added.

Effective retroactively for dates of service on or after January 1, 2016, hospice providers are required to bill new revenue codes for routine home care services and SIA.

The existing local Medi-Cal revenue code 0651 (hospice service, routine home care) will be end-dated and replaced by the following three new applicable, HIPAA-compliant revenue codes:

0552 (routine home care [SIA rate])
0650 (routine home care [high rate])
0659 (routine home care [low rate])
Hospice Care

Providers will be instructed to complete two new fields on the Outpatient UB-04 claim form: Admission Date (Box 12) and Status (Box 17). The data captured in these fields will be used to assist Audits and Investigation (A&I) in verifying the validity of routine home care claims. Some applicable date values allowed for the Status field (Box 17) are as follows:

01 – Discharge to home or self-care
30 – Still a patient (for continuing hospice care for same recipient)
40 – Expired at home
41 – Expired in a medical facility
42 – Expired – place unknown
50 – Hospice – home
51 – Hospice – medical facility

NOTE
Providers are instructed to include any transfer information for the recipient from their previous hospice stay, including the National Provider Identifier (NPI) of the facility and admission and transfer dates in the Remarks field (Box 80) or on an attachment. A&I will address any text placed in the field.

NOTES

_________________________________________________________
_________________________________________________________
_________________________________________________________
_________________________________________________________
_________________________________________________________
_________________________________________________________
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Revenue Code</th>
<th>Description</th>
<th>When to Bill Medi-Cal Directly</th>
<th>Frequency Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice care services</td>
<td>0552</td>
<td>Routine home care (service intensity add-on [SIA] rate)</td>
<td>For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service</td>
<td>15 minute increments, up to 4 hours per day, maximum of seven days</td>
</tr>
<tr>
<td>Hospice care services</td>
<td>0650</td>
<td>Routine home care (high rate) (per diem)</td>
<td>For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service</td>
<td>One unit per claim line, per day</td>
</tr>
<tr>
<td>Hospice care services</td>
<td>0659</td>
<td>Routine home care (low rate) (per diem)</td>
<td>For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service</td>
<td>One unit per claim line, per day</td>
</tr>
<tr>
<td>Hospice care services</td>
<td>0652</td>
<td>Continuous home care</td>
<td>For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service</td>
<td>Minimum of eight hours (units) Maximum of 24 hours (units) per claim line, per day</td>
</tr>
<tr>
<td>Hospice general care</td>
<td>0655</td>
<td>Inpatient respite care</td>
<td>For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service</td>
<td>One unit per claim line, per day and 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</td>
</tr>
<tr>
<td>Hospice general care</td>
<td>0656</td>
<td>General inpatient care (no respite/hospice general care)</td>
<td>For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service</td>
<td>One unit per claim line, per day</td>
</tr>
</tbody>
</table>

**NOTE**
Revenue code 0656 must be billed in conjunction with HCPCS code T2045. A TAR is required.
## Hospice Care

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Revenue Code</th>
<th>Description</th>
<th>When to Bill Medi-Cal Directly</th>
<th>Frequency Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice general care</td>
<td>0657</td>
<td>Physician’s services</td>
<td>For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service</td>
<td>One unit per claim line, per day</td>
</tr>
<tr>
<td>Hospice room and board</td>
<td>0658</td>
<td>Room and board codes</td>
<td>Always</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE**
Hospice providers rendering services in an RCFE may not be reimbursed for room and board revenue code 0658.

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. This is to fully substantiate all claims for hospice services submitted to the California Medicaid Management Information System (California MMIS) Fiscal Intermediary 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.

### NOTES
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 (Box 80) or as an attachment to the UB-04 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.
Hospice 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

Scenario. 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.

Claim Line 1:
Enter the description of the service rendered (inpatient care) in the Description field (Box 43).
Enter the beginning service (June 1, 2018) in six-digit format as “060118” in the Service Date field (Box 45).

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 required TAR number).
Enter the “through” date of service (June 27, 2018) in six-digit format as “062718” 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).

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

<table>
<thead>
<tr>
<th>Box #</th>
<th>Field name</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Type of Bill</td>
<td>Enter the two-digit facility type code “81” (special facility – hospice [non-hospital based]) and one-character claim frequency code “1” as “811.”</td>
</tr>
<tr>
<td>50</td>
<td>Payer Name</td>
<td>Enter “O/P MEDI-CAL” to indicate the type of claim and payer.</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>Place the hospice provider number.</td>
</tr>
<tr>
<td>63</td>
<td>Treatment Authorization Codes</td>
<td>Enter the 11-digit TAR number.</td>
</tr>
<tr>
<td>66</td>
<td>ICD Indicator (DX)</td>
<td>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.</td>
</tr>
<tr>
<td>67</td>
<td>Unlabeled (Primary Diagnosis Code)</td>
<td>Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.</td>
</tr>
<tr>
<td>77</td>
<td>Operating</td>
<td>Enter the NPI of the facility in which the recipient resides.</td>
</tr>
</tbody>
</table>
**Sample: “From-Through” Billing of General Inpatient Hospice Care**

<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
<th>Description</th>
<th>HCPCS Code</th>
<th>Value</th>
<th>Unit Price</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/1 3 4 16 17 18 25 26 27</td>
<td>T2045</td>
<td>Inpatient Care</td>
<td>060118</td>
<td>062718</td>
<td>9</td>
<td>45000</td>
</tr>
</tbody>
</table>

0656

Hospice Care

December 2018

15
Room and Board

Scenario. 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.

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, 2018) in six-digit format as “060118” in the Service Date field (Box 45).

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, 2018) in six-digit format as “060518” 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).

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

<table>
<thead>
<tr>
<th>Box #</th>
<th>Field name</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Type of Bill</td>
<td>Enter the two-digit facility type code “26” (Nursing Facility Level B) and one-character claim frequency code “1” as “261.”</td>
</tr>
<tr>
<td>39</td>
<td>Code Value Codes Amount</td>
<td>Enter aid code “23” in the Code column and “10000” for a $100 SOC in the Value Codes Amount column.</td>
</tr>
<tr>
<td>50</td>
<td>Payer Name</td>
<td>Enter “O/P MEDI-CAL” to indicate the type of claim and payer.</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>Place the hospice provider number.</td>
</tr>
<tr>
<td>66</td>
<td>ICD Indicator (DX)</td>
<td>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.</td>
</tr>
<tr>
<td>67</td>
<td>Unlabeled (Primary Diagnosis Code)</td>
<td>Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.</td>
</tr>
<tr>
<td>77</td>
<td>Operating</td>
<td>Enter the NPI of the facility in which the recipient resides.</td>
</tr>
<tr>
<td>80</td>
<td>Remarks</td>
<td>Enter any appropriate information or on attachment.</td>
</tr>
</tbody>
</table>
**Sample: Room and Board**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0658</td>
<td>Room and Board</td>
<td>145000</td>
</tr>
</tbody>
</table>
Routine Home Care High Rate, Low Rate and SIA Billing

Scenario. The recipient has elected Medi-Cal hospice coverage and is admitted to hospice routine care for 67 days in a row, up until the recipient’s death on the 67th day.

Claim Line 1:
Enter revenue code “0650” (routine home care high rate) in the Revenue Code field (Box 42).
Enter the description of the service rendered (Routine Home Care High) in the Description field (Box 43).
Enter the beginning service (May 4, 2018) in six-digit format at “050418” in the Service Date field (Box 45).

Claim Line 2:
Enter the “through” date of service (July 2, 2018) in six-digit format as “070218” in the Service Date field (Box 45).
Enter a “60” to indicate the number of days the recipient received routine home care high rate services in the Service Units field (Box 46).
Enter the usual and customary charges in the Total Charges field (Box 47). In this example, each day/unit for this per-diem routine home care high rate service is $25 per day/unit.

Claim Line 4:
Enter revenue code “0659” (routine home care service low rate) in the Revenue Code field (Box 42).
Enter the description of the service rendered (routine home care low rate) in the Description field (Box 43).
Enter the beginning service (July 3, 2018) in six-digit format as “070318” in the Service Date field (Box 45).

Claim Line 5:
Enter the “through” date of service (July 9, 2018) in six-digit format as “070918” in the Service Date field (Box 45).
Enter a “7” to indicate the number of days the recipient received routine home care low rate services in the Service Units field (Box 46).
Enter the usual and customary charges in the Total Charges field (Box 47). In this example, each day/unit for this per-diem routine home care low rate service is $10 per day/unit.

Claim Line 7:
Enter revenue code “0552” (routine home care service intensity add-on) in the Revenue Code field (Box 42).
Enter the description of the service rendered (routine home care service intensity add-on) in the Description field (Box 43).
Enter the beginning service (July 3, 2018) in six-digit format as “070318” in the Service Date field (Box 45).
Claim Line 8:
Enter the specific days the services were rendered (07/3, 4, 5, 6, 7, 8, 9) in the Description field (Box 43).
Enter the “through” date of service (July 9, 2018) in six-digit format as “070918” in the Service Date field (Box 45).
Enter a “112” to indicate the number of units of routine home care SIA services the recipient received in the Services Units field (Box 46).
Enter the usual and customary charges in the Total Charges field (Box 47). In this example, each unit for the 15-minute increment routine home care SIA service is $50 per unit, up to 4 hours (16 units max) per day.

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

<table>
<thead>
<tr>
<th>Box #</th>
<th>Field name</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Type of Bill</td>
<td>Enter the two-digit facility type code “81” (Special Facility Inpatient) and one-character claim frequency code “1” as “811.”</td>
</tr>
<tr>
<td>12</td>
<td>Admission Date</td>
<td>Start of recipient’s hospice certification period</td>
</tr>
<tr>
<td>17</td>
<td>Patient Status</td>
<td>“41” – Expired in a medical facility, such as hospital, SNF, ICF or freestanding hospice</td>
</tr>
<tr>
<td>31</td>
<td>Occurrence Code/Date</td>
<td>“55” – Death of the recipient, happened on 7/9/2018</td>
</tr>
<tr>
<td>50</td>
<td>Payer Name</td>
<td>Enter &quot;O/P MEDI-CAL” to indicate the type of claim and payer.</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
<td>Place the hospice provider number.</td>
</tr>
<tr>
<td>63</td>
<td>Treatment Authorization Codes</td>
<td>Enter the 11-digit TAR number.</td>
</tr>
<tr>
<td>66</td>
<td>ICD Indicator (DX)</td>
<td>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.</td>
</tr>
<tr>
<td>67</td>
<td>Unlabeled (Primary Diagnosis Code)</td>
<td>Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.</td>
</tr>
<tr>
<td>77</td>
<td>Operating</td>
<td>Enter the NPI of the facility in which the recipient resides.</td>
</tr>
</tbody>
</table>
**Sample: Routine Home Care High Rate, Low Rate and SIA Billing**

### Routine Home Care High

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Start Date</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>0650</td>
<td>050418</td>
<td>60</td>
</tr>
<tr>
<td>050418</td>
<td>70218</td>
<td>1500.00</td>
</tr>
</tbody>
</table>

### Routine Home Care Low

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Start Date</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>0659</td>
<td>070318</td>
<td>7</td>
</tr>
<tr>
<td>070318</td>
<td>070918</td>
<td>70.00</td>
</tr>
</tbody>
</table>

### RHC Service Intensity Add-On

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Start Date</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>0552</td>
<td>07/3456789</td>
<td>112</td>
</tr>
<tr>
<td>070918</td>
<td>070918</td>
<td>5600.00</td>
</tr>
</tbody>
</table>

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**UPTOWN MEDICAL CENTER**

**140 SECOND STREET**

**ANYTOWN, CA 95823-1200**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Start Date</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>0650</td>
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<td>60</td>
</tr>
<tr>
<td>050418</td>
<td>70218</td>
<td>1500.00</td>
</tr>
</tbody>
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<td>070318</td>
<td>070918</td>
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<tr>
<td>0552</td>
<td>07/3456789</td>
<td>112</td>
</tr>
<tr>
<td>070918</td>
<td>070918</td>
<td>5600.00</td>
</tr>
</tbody>
</table>

---

**O/P MEDI-CAL**

**71700.00**

**DAVID B. DOE**

**90000000A95001**

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**Hospice Care**

**December 2018**
Knowledge Review

1. 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.
   True □    False □

2. When billing for any subsequent days of care beyond the 60-day period, providers must utilize revenue code 0659 (routine home care low rate).
   True □    False □

3. Hospice care starts the day the recipient receives hospice care and ends when the 90-day or 60-day period ends.
   True □    False □

4. A recipient or representative may verbally revoke the election of hospice care at any time.
   True □    False □

5. Hospice care is intended to alleviate pain and suffering rather than to cure the illness.
   True □    False □

6. What are the two new fields required to be completed on the UB-04 claim form?
   a. ___________________________________________________________
   b. ___________________________________________________________

7. Each day of hospice care is classified into one of four levels of care: routine home care, continuous home care, inpatient care and general inpatient care (no respite)/hospice general care.
   True □    False □

8. Hospice reimbursement rates will now be based on the recipient’s length of stay.
   True □    False □

9. Hospice providers should not report coexisting or additional diagnose unrelated to the terminal illness on claims.
   True □    False □

10. Records must be kept for three years from the last service date.
    True □    False □

Answer Key: 1) True; 2) True; 3) True; 4) False; 5) True; 6) A. Admission Date, B. Status; 7) True; 8) True; 9) True; 10) True
Resource Information

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)
# Appendix

## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA</td>
<td>Patient Protection and Affordable Care Act</td>
</tr>
<tr>
<td>CCR</td>
<td>California Code of Regulations</td>
</tr>
<tr>
<td>CCS</td>
<td>California Children's Services</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>DHCS</td>
<td>Department of Health Care Services</td>
</tr>
<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>FI</td>
<td>Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program</td>
</tr>
<tr>
<td>GHPP</td>
<td>Genetically Handicapped Persons Program</td>
</tr>
<tr>
<td>HCBS</td>
<td>Home and Community-Based Services</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Health Care Procedure Coding System</td>
</tr>
<tr>
<td>HHA</td>
<td>Home Health Agencies</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
</tr>
<tr>
<td>ICD-10-CM</td>
<td>International Classification of Diseases – 10th Revision, Clinical Modification</td>
</tr>
<tr>
<td>ID</td>
<td>Identification</td>
</tr>
<tr>
<td>IHO</td>
<td>In-Home Operations</td>
</tr>
<tr>
<td>LCSW</td>
<td>Licensed Clinical Social Worker</td>
</tr>
<tr>
<td>LVN</td>
<td>Licensed Vocational Nurse</td>
</tr>
<tr>
<td>MFT</td>
<td>Marriage and Family Therapist</td>
</tr>
<tr>
<td>MDS</td>
<td>Minimum Data Set</td>
</tr>
<tr>
<td>NF-A</td>
<td>Nursing Facility Level A</td>
</tr>
<tr>
<td>NF-B</td>
<td>Nursing Facility Level B</td>
</tr>
<tr>
<td>NFT/AH</td>
<td>Nursing Facility/Acute Hospital</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Providers</td>
</tr>
<tr>
<td>PCPEA</td>
<td>Primary Care Provider Enrollment Agreement</td>
</tr>
<tr>
<td>PIN</td>
<td>Provider Identification Number</td>
</tr>
<tr>
<td>RCFE</td>
<td>Residential Care Facilities for the Elderly</td>
</tr>
</tbody>
</table>
RAD  Remittance Advice Details
RN   Registered Nurse
SAR  Service Authorization Request
SOC  Share of Cost
TAR  Treatment Authorization Request
TCN  TAR Control Number