GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director

Transmittal # 18-32

TO: DC Medicaid Providers

FROM: Melisa Byrd MB
Senior Deputy Director and State Medicaid Director

DATE: December 28, 2018

SUBJECT: **Hospice Billing & Reimbursement Process for Beneficiaries Residing in Nursing Homes**

Purpose

This transmittal provides notice and guidance to hospice and nursing home providers on the process for billing and reimbursement of room and board services for hospice beneficiaries under the new nursing home reimbursement methodology. Further, this document also serves as notice to retract Transmittal # 18-19: **Interim Process for Hospice Billing & Reimbursement for Beneficiaries Residing in Nursing Homes – issued on May 4, 2018.**

Background

The Department of Health Care Finance (DHCF) implemented a new Nursing Home reimbursement methodology pursuant to an approved State Plan Amendment (SPA) approved on March 19, 2018 by the Centers for Medicare and Medicaid Services (CMS) effective for services provided on or after February 1, 2018. Under the new methodology, DHCF shall reimburse in-District nursing homes through a prospective payment system (PPS) using the Resource Utilization Group (RUG-IV) Grouper 48 classification system.

On May 4, 2018, DHCF issued Transmittal # 18-19, outlining the interim process for hospice billing and reimbursement of room and board for beneficiaries residing in nursing homes. The revised transmittal was issued after DHCF determined that the billing process outlined in a previous transmittal (#18-02) conflicted with federal rules for hospice reimbursement. Federal rules stipulate that a Medicaid beneficiary who resides in a nursing home and elects the hospice benefit is considered a "hospice patient". Consequently, the room and board reimbursement must be made to the hospice provider, who in turn is required to pass-through the payment to the nursing home.

Guidance

DHCF has operationalized changes in the Medicaid Management Information System (MMIS) to now allow hospice providers to submit claims in accordance with federal law and the new nursing home reimbursement methodology. Please follow the process below for billing hospice room and board.

Billing Procedures - Hospice Claims for Room & Board for in-District Nursing Facilities

- Nursing homes should no longer use revenue code 0659 for claims submitted to DHCF
- The hospice providers will continue to submit PA requests to Qualis for inpatient hospice, revenue code 0659 for dates of service on or after February 1, 2018.
- For nursing home residents who are hospice patients, the nursing home will provide the appropriate HIPPS code for the resident and date span to the hospice provider. The hospice provider will pass-through the appropriate acuity-adjusted per diem rate for room and board, based on the resident's HIPPS code.
- The hospice provider will bill DHCF using revenue code 0659 in conjunction with the HIPPS code provided by the nursing home. An appropriate HIPPS code is required for hospice claims using revenue code 0659.

Claims Submission

- The claim line for room and board in a nursing home (revenue code 0659) will require a valid HIPPS code on the line for all services February 1, 2018 and later
- The HIPPS code must be valid for Medicaid—i.e., it must contain both:
  1. A valid Medicaid RUG-IV code (first three characters), plus
  2. A Medicaid-appropriate assessment indicator code (last two characters, usually "60" or "01")
- The HIPPS/RUG code must be from the resident's most current MDS assessment, which cannot be later than the last date of service on the claim
- Providers can "split bill" and use different MDS assessments if there is a valid assessment in the billing period, but are not required to do so
- Significant event MDS/RUG code can be used only for the dates of service from the significant event date onward

Add-On Services – Ventilator, Bariatric, and Behaviorally Complex

- The nursing home will submit claims for add-on services directly to DHCF. All claims should include a PA number. **For hospice patients, the add-on services must appear in a separate claim.**

Prior Authorization (PA)

- Nursing homes will still be required to obtain PAs for special needs "add-on" payments (including behavioral health, bariatric, and ventilator residents). New PA numbers will still be required for ongoing vent patients
- Patients with multiple PA-related conditions will require a single PA covering the full set of conditions. Multiply overlapping PAs cannot be used for the same patient
- PAs may be granted for up to 90 days

DHCF will continue to communicate information about the new payment methodology on the agency website: https://dhcf.dc.gov/page/2018-dhcf-medicaid-updates-01

If you have any questions, please contact Andrea Clark, Reimbursement Analyst, Office of Rates, Reimbursement and Financial Analysis, at (202) 724-4096 or email andrea.clark@dc.gov

Cc: Medical Society of the District of Columbia
DC Hospital Association
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DC Home Care Association
DC Behavioral Health Association
DC Coalition of Disability Service Providers