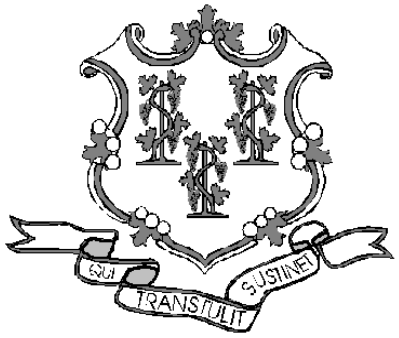
Connecticut Department of Social Services

Making a Difference

2016 Hospice Workshop



Presented by

The Department of Social Services

& Hewlett Packard Enterprise

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Training Topics

- Hospice Payment Changes – Effective January 1, 2016
  - Routine Home Care (RHC) Per Diem Rates
  - Service Intensity Add-On (SIA)
- Client Eligibility – Determining the Hospice Benefit
- On-line Hospice Transactions
  - Locking in the Hospice Benefit
  - Important Points to Remember in Order to Effectively Manage Your Lock-In
- Claim Submission Guidelines
- Non-Covered Hospice Services
- Prior Authorization Requirements
- Patient Liability
- Explanation of Benefit (EOB) Code Descriptions, Cause & Resolution
- Hospice Reminders
- ICD 10 Information
- Program Resources/Contacts/Wrap Up & Questions

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Hospice Payment Changes – Effective January 1, 2016

- Routine Home Care (RHC) Per Diem Rates

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Hospice Payment Changes – Effective January 1, 2016

What are the Changes?

Consistent with the Medicare Hospice Payment reforms (MLN Matters MM9201), the Department of Social Services (DSS) has made changes to the Hospice fee schedule to support the implementation of a *two-tiered payment system for Routine Home Care (RHC)* which has replaced the current single RHC per diem payment. Days 1 – 60 will be paid at the "High" rate while days 61 + will be paid at the RHC "Low" rate and an End of Life (EOL) *Service Intensity Add-On (SIA)* for patients in the last seven (7) days of life when certain criteria are met.

Both Changes are Effective Retroactively to January 1, 2016.

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Hospice Payment Changes – Effective January 1, 2016

Routine Home Care (RHC) Per Diem Rates:

Hospice services with dates of services *on or after January 1, 2016*, billed at the Routine Home Care (RHC) level of care will be paid one of two RHC rates, RHC "High" or RHC "Low", which has replaced the single RHC per diem payment, as follows:

- The day billed must be an RHC level of care.
- If the service day occurs during the **first 60 days of an episode**, the RHC rate will be equal to the RHC "High" rate.
- If the service day occurs during days **61 and beyond of an episode**, the RHC rate will be equal to the RHC "Low" rate.
- *For a Hospice client who is discharged and readmitted to hospice within 60 days of that discharge*, his/her prior Hospice days will continue to follow the patient and count toward his/her patient days for the receiving Hospice in the determination of whether the receiving Hospice will receive payment at the "High" or "Low" rate, upon Hospice re-election.
- *For a Hospice patient who has been discharged from Hospice care for more than 60 days*, a new election to Hospice will initiate a reset of the patient's 60-day window, paid at the RHC "High" rate upon the new Hospice election.

Note: Transfers that occur between agencies are counted as 1 day, the receiving agency can bill for the client, not the transferring agency.

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Hospice Payment Changes – Effective January 1, 2016

Routine Home Care (RHC) Per Diem Rates

Note: Hospice elections that occurred prior to January 1, 2016, will be reimbursed the default rate reflected on the Hospice fee schedule that is in effect until **December 31, 2015**.

Hospice RCC Code	RCC description	Region	Rate Type	Max Fee or High	Low	Effective Date	End Date
651	HOSPICE/RTN HOME	2	DEF	174.56		10/1/2015	12/31/2015
651	HOSPICE/RTN HOME	2	MSA	201.46		01/01/2016	12/31/2299
651	HOSPICE/RTN HOME	2	MSA		158.32	01/01/2016	12/31/2299

The "High" rate will apply to the first 60 days within each episode and the "Low" rate will apply to days 61 and beyond from the beginning date of each episode that include date of service January 1, 2016 and forward. *This calculation will be based on the start of episode even if days are **not submitted** or **not submitted in chronological order**.*

Claim Examples: Slides Seven through Fourteen

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Hospice Payment Changes – Effective January 1, 2016

Routine Home Care (RHC) Per Diem Rates

Claim Example 1:

Hospice Lock-In Segment With a Start Date prior to 1/1/16:

The system will determine the effective dates of the episode using the Hospice lock-in data. Dates of service prior to 1/1/16 will be reimbursed the default rate reflected on the Hospice fee schedule that is in effect until 12/31/15. The system will then calculate the remaining days at the "**High"** rate within the episode from the start of the lock-in segment for the first 60 days for dates of service on on/or after 1/1/16 and the "**Low"** rate will apply to dates that are 61 days and beyond from the beginning date of each episode.

Dates of Service 12/15/15 – 2/15/16 - **(63 total days)**

- 12/15/15 – 12/31/15 – **Rate on fee schedule** through 12/31/15 ***(days 1-17)***
- 1/1/16 – 1/31/16 – RHC **"High"** rate ***(days 18 – 48)***
- 2/1/16 – 2/12/16 – RHC **"High"** rate ***(days 49 – 60)***
  - 2/13/16 – 2/15/16 – RHC **"Low"** rate ***(days 61 – 63)***

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Hospice Payment Changes – Effective January 1, 2016

Routine Home Care (RHC) Per Diem Rates

Claim Example 2:

Hospice Lock-In Segment With a Start Date after 1/1/16:

The system will calculate the days at the "**High**" rate within the episode from the start of the lock-in segment for the first 60 days for dates of service on/or **after** 1/1/16 and the "**Low**" rate will apply to dates that are 61 days and beyond from the beginning date of each episode.

Dates of Service 3/1/16 – 5/31/16 - **(92 total days)**

- 3/1/16 – 3/31/16 – RHC **"High"** rate ***(days 1 – 31)***
- 4/1/16 – 4/29/16 – RHC **"High"** rate ***(days 32 – 60)***
  - 4/30/16 – 4/30/16 – RHC **"Low"** rate ***(day 61 – 61)***
  - 5/1/16 – 5/31/16 – RHC **"Low"** rate ***(days 62 – 92)***

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Hospice Payment Changes – Effective January 1, 2016

Routine Home Care (RHC) Per Diem Rates

Claim Example 3:

There is a Gap Between the Hospice Lock-In Segments of less Than 60 Days (Same Provider):

The system will calculate the days between the end date of Hospice lock-in 1 and the effective date of Hospice lock-in 2. When the number of days between these two dates is **less** than 60 days, it is considered one episode.

Episode 1

Dates of Service 1/1/16 – 2/29/16 – **(60 total days)**

- 1/1/16 – 1/31/16 – RHC **"High"** rate ***(days 1 – 31)***
- 2/1/16 – 2/29/16 – RHC **"High"** rate ***(days 32 – 60)***

Episode 2

Dates of Service 3/5/16 – 4/30/16 – **(57 total days)**

- 3/5/16 – 3/31/16 – RHC **"Low"** rate ***(days 1 – 27)***
- 4/1/16 – 4/30/16 – RHC **"Low"** rate ***(days 28 – 57)***

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Hospice Payment Changes – Effective January 1, 2016

Routine Home Care (RHC) Per Diem Rates

Claim Example 4:

There is a Gap Between the Hospice Lock-In Segments of less Than 60 Days (Different Providers):

The system will calculate the days between the end date of Hospice lock-in 1 and the effective date of Hospice lock-in 2. When the number of days between these two dates is **less** than 60 days, it is considered one episode, (***even when the lock-in segments are for different providers)***.

Episode 1

Dates of Service 1/1/16 – 2/29/16 - **(60 total days)**

- 1/1/16 – 1/31/16 – RHC **"High"** rate ***(days 1 – 31)***
- 2/1/16 – 2/29/16 – RHC **"High"** rate ***(days 32 – 60)***

Episode 2

Dates of Service 4/30/16 – 5/31/16 - **(32 total days)**

- 4/30/16 – 4/30/16 – RHC **"Low"** rate ***(days 1 – 1)***
- 5/1/16 – 5/31/16 – RHC **"Low"** rate ***(days 2 – 32)***

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Hospice Payment Changes – Effective January 1, 2016

Routine Home Care (RHC) Per Diem Rates

Claim Example 5:

There is a Gap Between the Hospice Lock-In Segment of 60 Days or more (Same Provider):

The system will calculate the days between the end date of Hospice lock-in 1 and the effective date of Hospice lock-in 2. When the number of days between these two dates is greater than 60 days, each episode is considered its own episode.

Episode 1

Dates of Service 1/1/16 – 3/31/16 – **(91 total days)**

- 1/1/16 – 1/31/16 – RHC **"High"** rate ***(days 1 – 31)***
- 2/1/16 - 2/29/16 – RHC **"High"** rate ***(days 32 – 60)***
  - 3/1/16 – 3/31/16 – RHC **"Low"** rate ***(days 61 – 91)***

Episode 2

Dates of Service 6/1/16 – 7/31/16 – **(61 total days)**

- 6/1/16 – 6/30/16 – RHC **"High"** rate ***(days 1 – 30)***
- 7/1/16 – 7/30/16 – RHC **"High"** rate ***(days 31 – 60)***
  - 7/31/16 - 7/31/16 – RHC **"Low"** rate ***(day 61 – 61)***

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Hospice Payment Changes – Effective January 1, 2016

Routine Home Care (RHC) Per Diem Rates

Claim Example 6:

There is a Gap Between the Hospice Lock-In Segment of 60 Days or more (Different Providers):

The system will calculate the days between the end date of Hospice lock-in 1 and the effective date of Hospice lock-in 2. When the number of days between these two dates is greater than 60 days, each episode is considered its own episode, (***even when the lock-in segments are for different providers)***.

Episode 1

Dates of Service 1/1/16 – 3/1/16 - **(61 total days)**

- 1/1/16 – 1/31/16 – RHC **"High"** rate ***(days 1 – 31)***
- 2/1/16 - 2/29/16 – RHC **"High"** rate ***(days 32 – 60)***
  - 3/1/16 – 3/1/16 – RHC **"Low"** rate ***(day 61 – 61)***

Episode 2

Dates of Service 6/1/16 – 7/31/16 – **(60 total days)**

- 6/1/16 – 6/30/16 – RHC **"High"** rate ***(days 1 – 30)***
- 7/1/16 – 7/30/16 – RHC **"High"** rate ***(days 31 – 60)***
  - 7/31/16 – 7/31/16 – RHC **"Low"** rate ***(day 61 – 61)***

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Hospice Payment Changes – Effective January 1, 2016

Routine Home Care (RHC) Per Diem Rates

Claim Example 7:

Hospice Election Where Dates of Service are not Submitted in Chronological Order:

The **"Low"** rate will be applied to dates of service that are more than 60 days from the start of the Hospice election, *regardless of the order the dates are submitted*.

Dates of Service 1/1/16 – 3/31/16 – **(91 total days)**

- Claim 1 - 1/1/16 – 1/31/16 – RHC **"High"** rate ***(days 1 – 31)***
  - Claim 2 - 3/1/16 – 3/31/16 – RHC **"Low"** rate ***(days 61– 91)***
- Claim 3 - 2/1/16 – 2/29/16 – RHC **"High"** rate ***(days 32 – 60)***

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Hospice Payment Changes – Effective January 1, 2016

Routine Home Care (RHC) Per Diem Rates

Claim Example 8:

Hospice Election Where Dates of Service are not Submitted Within an Election:

The system will calculate the days at the "**High"** rate within the episode from the start of the lock-in segment for the first 60 days for dates of service on/or after 1/1/16 and the "**Low"** rate will apply to dates that are 61 days and beyond from the beginning date of each episode**, this will occur even when days are not submitted**.

Election period 1/1/16 – 4/30/16 - **(121 total days)**

- Claim 1 - 1/1/16 – 1/31/16 – RHC **"High"** rate ***(days 1 – 31)***
- Claim 2 - ***2/5/16 – 2/29/16*** – RHC **"High"** rate ***(days 36 – 60)***
  - Claim 3 - 3/1/16 – 3/31/16 – RHC **"Low"** rate ***(days 61 – 91)***
  - Claim 4 - 4/4/16 – 4/30/16 – RHC **"Low"** rate ***(days 95 – 121)***

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Hospice Payment Changes – Effective January 1, 2016

- Service Intensity Add-On (SIA)

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Hospice Payment Changes – Effective January 1, 2016

Service Intensity Add-On (SIA):

Hospice services with dates of services on or after January 1, 2016, are eligible for an end of life (EOL) Service Intensity Add-On (SIA) payment in addition to the per diem rate for the RHC level of care if the following criteria are met:

- The service day billed is an RHC level of care day.
- The service day occurs during the last seven days of life.
- The service is provided by a registered nurse (RN) or social worker that day for at least 15 minutes (one unit), up to 4 hours total (16 units).
- The service cannot be provided by a social worker via telephone.

Note: Hospice agencies can provide more than the maximum allowed number of units reimbursed for SIA services; however, Medicaid will only reimburse up to the maximum of 16 units per day for services provided by an RN and/or social worker combined.

The SIA payment will be paid at the continuous home care (CHC) hourly rate divided by four, multiplied by the number of units. This reimbursement will be based on the CHC rate for the appropriate geographic region.

Hospice Payment Changes – Effective January 1, 2016

Service Intensity Add-On (SIA):

Hospice claims that qualify for the EOL SIA payment ***must be billed with occurrence code 55 and the date of death*** and the applicable following Revenue Center Code (RCC) and Healthcare Common Procedure Coding System (HCPCS) code(s):

RCC	HCPCS	Description
551	G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting
561	G0155	Services of clinical social worker in home health or hospice settings, each 15 minutes

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Hospice Payment Changes – Effective January 1, 2016

Service Intensity Add-On (SIA):

Hospice claim with header/detail dates of services: 1/1/16 – 1/8/16. *Detail dates of service 1/2/16 – 1/8/16 have SIA services provided by a RN and/or social worker with occurrence code 55 and date of death 1/8/16:*

Detail	RCC	HCPCS	DOS	Units
1	651		1/1/16	1
2	651		1/2/16	1
3	551	G0299	1/2/16	8
4	651		1/3/16	1
5	551	G0299	1/3/16	8
6	651		1/4/16	1
7	551	G0299	1/4/16	8
8	651		1/5/16	1
9	551	G0299	1/5/16	8
10	651		1/6/16	1
11	551	G0299	1/6/16	8
12	651		1/7/16	1
13	551	G0299	1/7/16	8
14	561	G0155	1/7/16	8
15	651		1/8/16	1
16	551	G0299	1/8/16	8
17	561	G0155	1/8/16	8

Hospice Payment Changes – Effective January 1, 2016

Service Intensity Add-On (SIA):

CHC Hourly Rate:

RCC Code	RCC description	Region	Rate Type	Max Fee	Effective Date	End Date
652	HOSPICE/CTNS HOME	1	DEF	48.28	10/1/2015	12/31/2299
652	HOSPICE/CTNS HOME	2	DEF	42.41	10/1/2015	12/31/2299
652	HOSPICE/CTNS HOME	3	DEF	45.35	10/1/2015	12/31/2299
652	HOSPICE/CTNS HOME	4	DEF	44.29	10/1/2015	12/31/2299
652	HOSPICE/CTNS HOME	5	DEF	42.89	10/1/2015	12/31/2299
652	HOSPICE/CTNS HOME	6	DEF	43.42	10/1/2015	12/31/2299

SIA Rate per Unit (CHC Hourly Rate Divided by Four):

RCC Code	RCC description	Region	Rate Type	Max Fee	Effective Date	End Date
551	SKILLED NURS/VISIT	1	DEF	12.07	1/1/2016	12/31/2299
551	SKILLED NURS/VISIT	2	DEF	10.6	1/1/2016	12/31/2299
551	SKILLED NURS/VISIT	3	DEF	11.34	1/1/2016	12/31/2299
551	SKILLED NURS/VISIT	4	DEF	11.07	1/1/2016	12/31/2299
551	SKILLED NURS/VISIT	5	DEF	10.72	1/1/2016	12/31/2299
551	SKILLED NURS/VISIT	6	DEF	10.86	1/1/2016	12/31/2299
561	MED SOC SERVS/VISIT	1	DEF	12.07	1/1/2016	12/31/2299
561	MED SOC SERVS/VISIT	2	DEF	10.6	1/1/2016	12/31/2299
561	MED SOC SERVS/VISIT	3	DEF	11.34	1/1/2016	12/31/2299
561	MED SOC SERVS/VISIT	4	DEF	11.07	1/1/2016	12/31/2299
561	MED SOC SERVS/VISIT	5	DEF	10.72	1/1/2016	12/31/2299
561	MED SOC SERVS/VISIT	6	DEF	10.86	1/1/2016	12/31/2299

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Client Eligibility – Determining the Hospice Benefit

Client Eligibility – Determining the Hospice Benefit

- The Department of Social Services (DSS) recommends that providers verify a client's eligibility on the date of service prior to performing the service as eligibility can change at any time.

- To determine if a client is eligible for the Hospice benefit, providers may use any of the available methods of checking client eligibility:

  - Provider Secure Web site at www.ctdssmap.com
  - Provider Electronic Solutions Software
  - HIPAA ASC X12N 270/271 Health Care Eligibility Inquiry and Response
  - Automated Voice Response System (AVRS)

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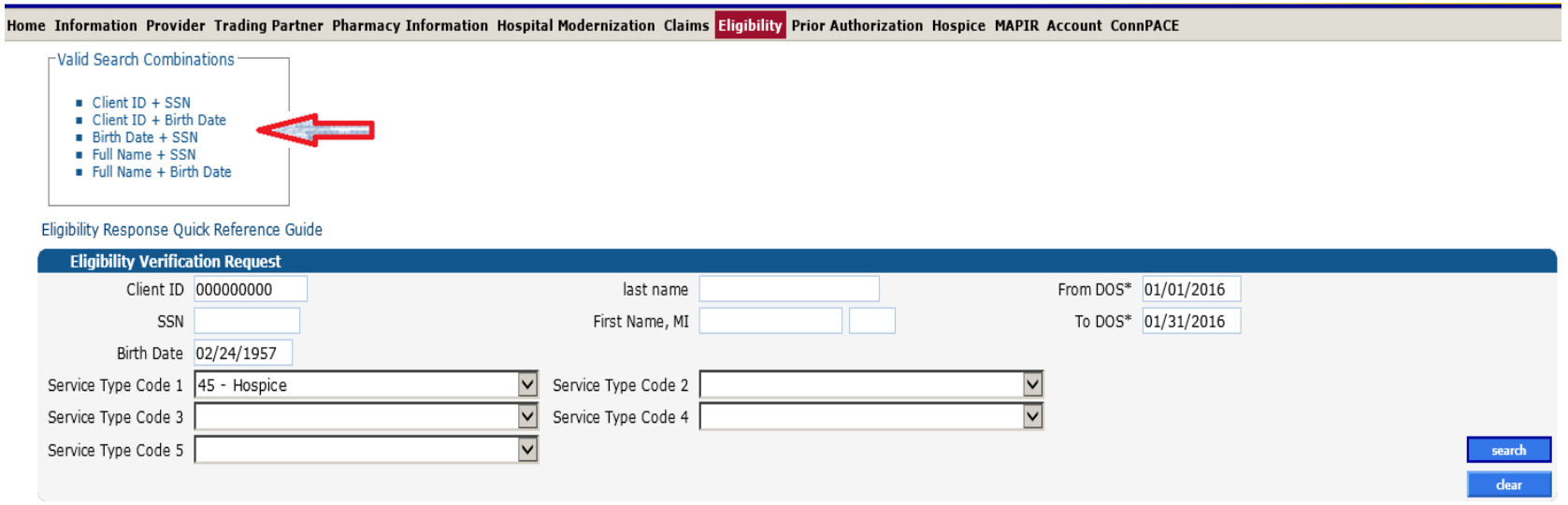
Client Eligibility – Determining the Hospice Benefit

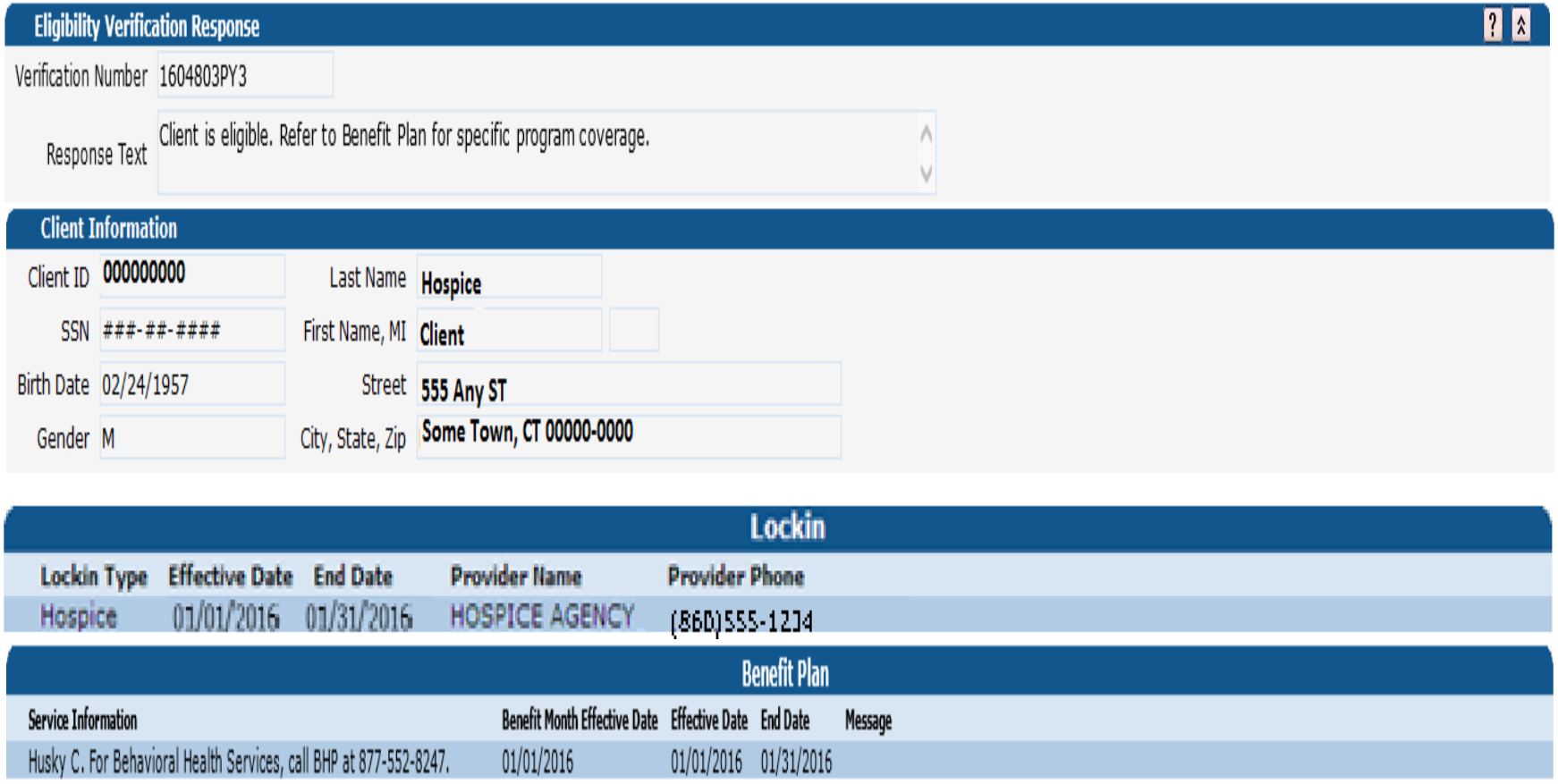
- To verify a Connecticut Medical Assistance Program (CMAP) client's eligibility through the secure site – click on the *Eligibility tab* on the main menu.
- Enter at least one of the *valid client data search combination* as noted below, then click search.



Note: If entering a client's full name as part of your search criteria, the client's name must be entered as it appears in their CMAP profile.

Client Eligibility – Determining the Hospice Benefit

- The Verification Number validates the eligibility information received during the inquiry.
- Clients with HUSKY A, B, C and D coverage are eligible for Hospice Services.



Eligibility Verification Response

Verification Number: 1604803PY3

Response Text: Client is eligible. Refer to Benefit Plan for specific program coverage.

Client Information

Client ID	000000000	Last Name	Hospice
SSN	###-##-####	First Name, MI	Client
Birth Date	02/24/1957	Street	555 Any ST
Gender	M	City, State, Zip	Some Town, CT 00000-0000

Lockin

Lockin Type	Effective Date	End Date	Provider Name	Provider Phone
Hospice	01/01/2016	01/31/2016	HOSPICE AGENCY	(860)555-1234

Benefit Plan

Service Information	Benefit Month Effective Date	Effective Date	End Date	Message
Husky C. For Behavioral Health Services, call BHP at 877-552-8247.	01/01/2016	01/01/2016	01/31/2016	

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Client Eligibility – Determining the Hospice Benefit

- A client is eligible to receive the Hospice benefit when:
  - The client is certified by a physician as being terminally ill.
  - Initial certification is 90 days.
  - Recertification is for a second 90 day period followed by unlimited 60 day periods.

- The client will be locked into service by a single Hospice agency for services relating to their terminal illness for the duration of the certification period.
  - A client may change Hospice agencies once during this period under **Medicare**, **no limit** for **Medicaid.**
  - A client may choose to revoke election and/or re-elect Hospice services at any time.

- Clients that are eligible for both Medicare A and Medicaid receive Hospice services through Medicare.
  - When a dually eligible client decides to elect, revoke, or change Hospice providers, they must make such elections, revocations, and changes in both the Medicare and Medicaid programs, *except dually eligible clients receiving Hospice/IP Respite, RCC 655, these changes are only required to be entered in the Medicaid program*.

On-line Hospice Transactions

- Locking in the Hospice Benefit

On-line Hospice Transactions

Locking in the Hospice Benefit

- All clients **(dually eligible and HUSKY only)** who elect the Hospice benefit ***must*** be locked into the care of the Hospice provider during the course of their election in order for the Hospice provider to be paid for the service billed.

- The Hospice Provider must enter an *Election Transaction* via their secure Web Account within seven (7) business days of the effective date of the Hospice election.

- When a client is pending HUSKY eligibility, the Hospice Provider ***must*** enter an *Election Transaction* via their secure Web Account *within seven (7) business days* of the client's eligibility being added to DSS' client eligibility file.

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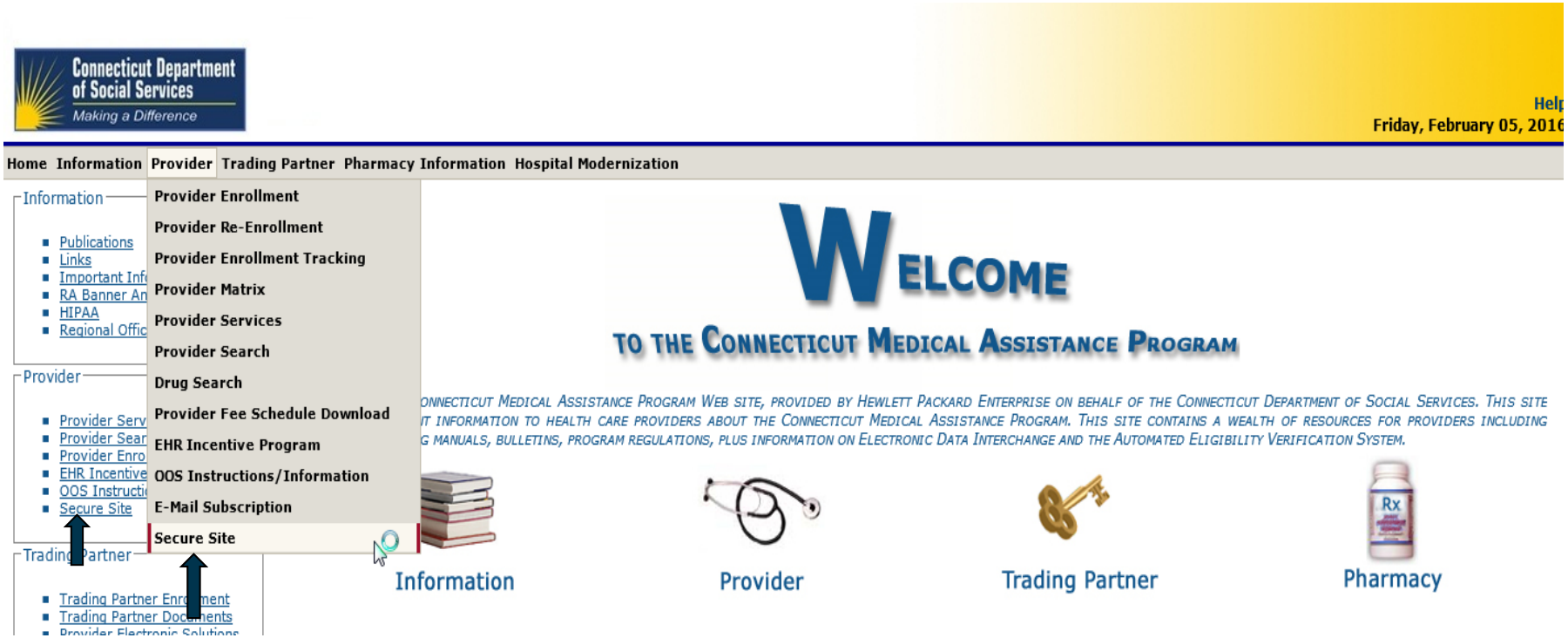
On-line Hospice Transactions

Locking in the Hospice Benefit

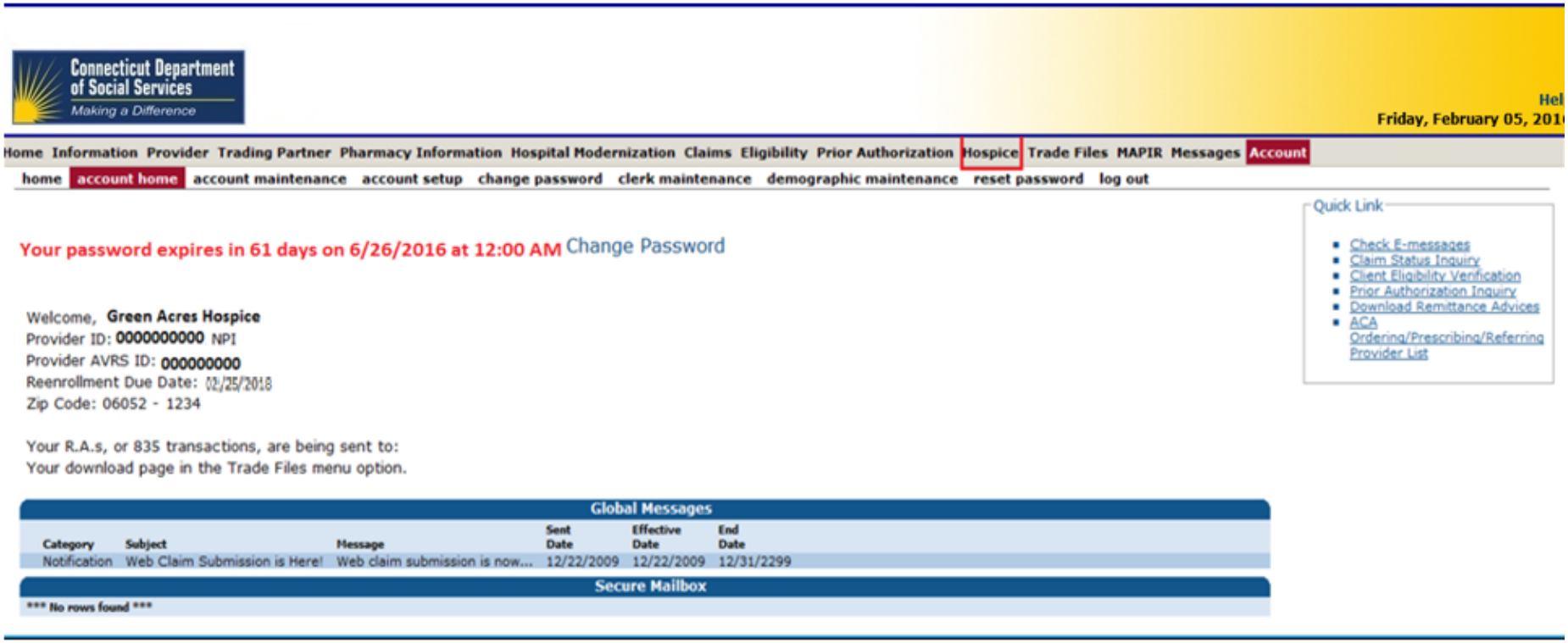
To enter a ***Hospice Election Transaction***, providers must log into their secure Web account from the www.ctdssmap.com Home page and click **"Secure Site"** on the left hand side or from the **"Provider"** drop down.



On-line Hospice Transactions

Locking in the Hospice Benefit

From the provider's secure Web account Home Page, click *"Hospice"*



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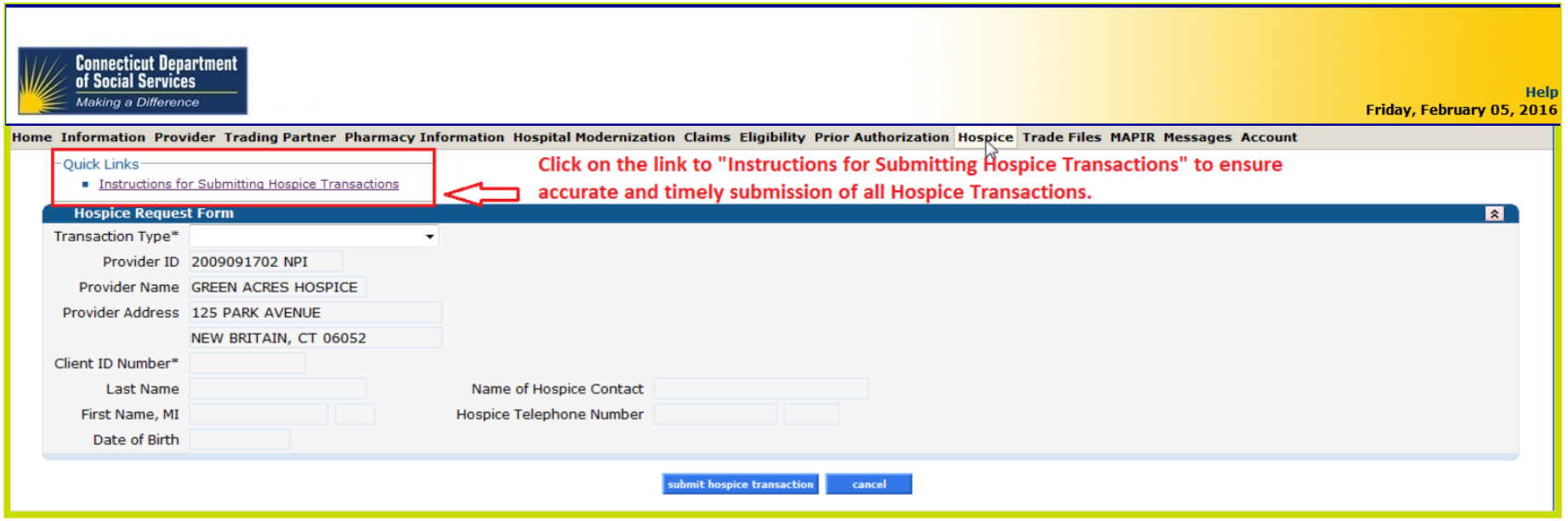
On-line Hospice Transactions

Locking in the Hospice Benefit

The ***"Instructions for Submitting Hospice Transactions"*** have been revised effective ***March 15, 2016***. These instructions will provide you with step by step guidance for submitting all Hospice Transactions, including ***important filing requirements*** and reflect the messages that appear when transactions are submitted.

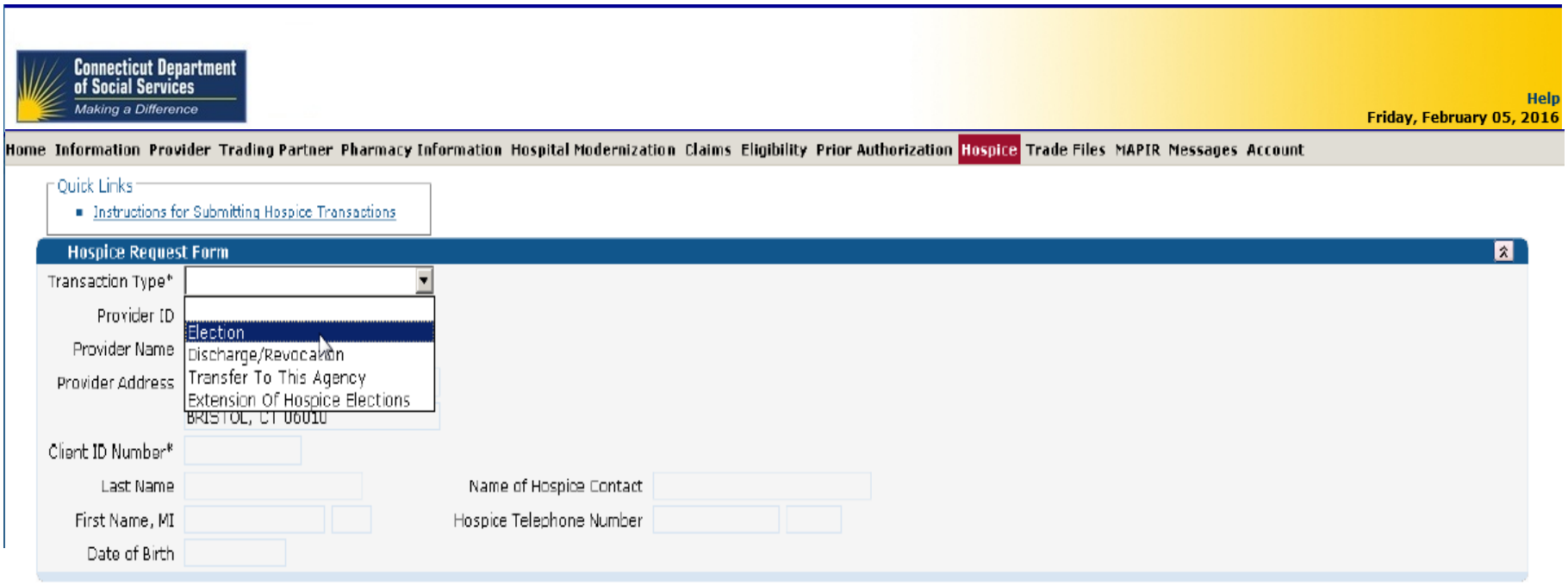


Note: If you are logged in under another secure Web account, such as your Home Health Agency or Assisted Living Services Agency secure Web account, the following message will be displayed:

On-line Hospice Transactions

Locking in the Hospice Benefit

To submit a ***"Hospice Election"*,** click on ***"election"*** from the dropdown, complete the transaction fields that have an asterisk and click ***"Submit Hospice Transaction".***



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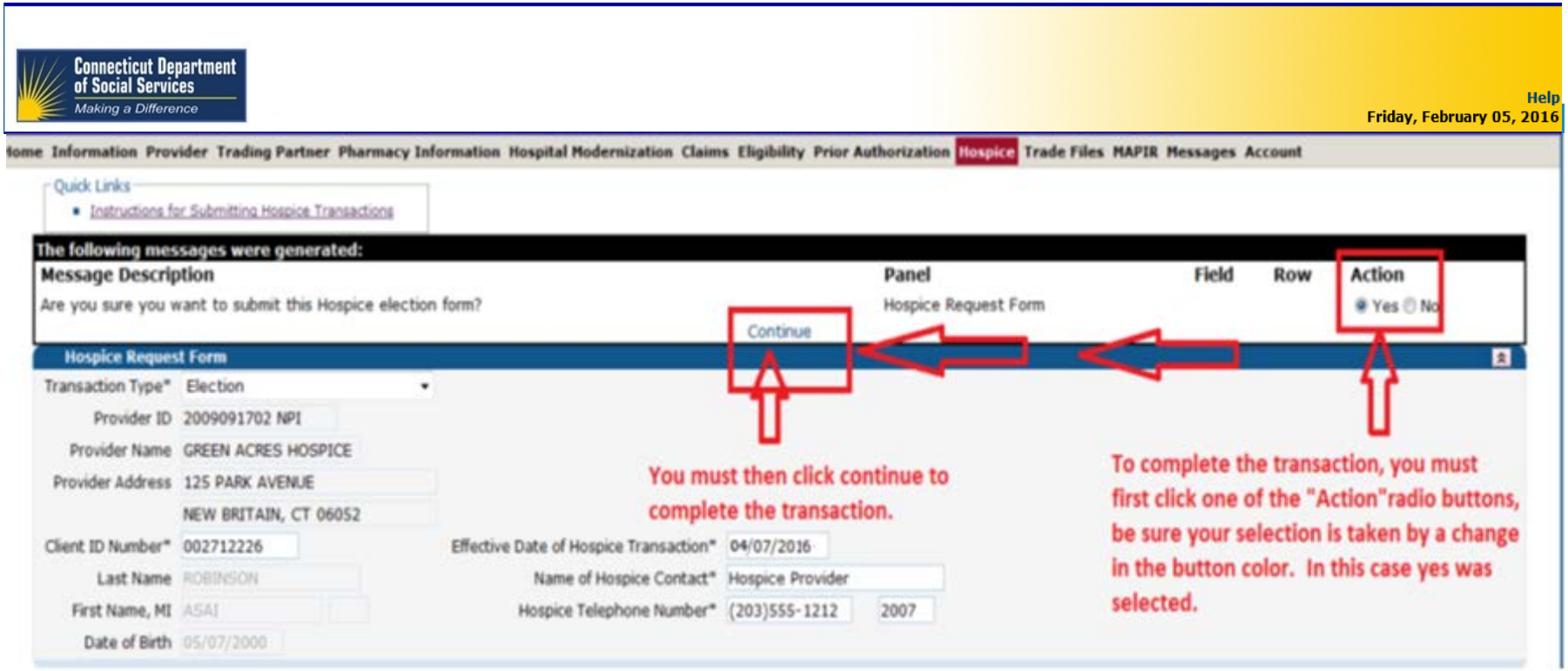
On-line Hospice Transactions

Locking in the Hospice Benefit

Once you confirm that you want to submit the election click ***"Continue".***

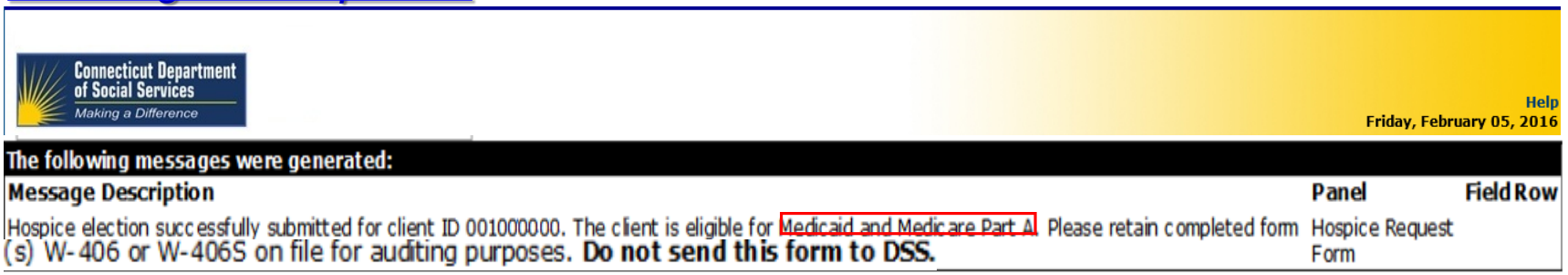


On-line Hospice Transactions

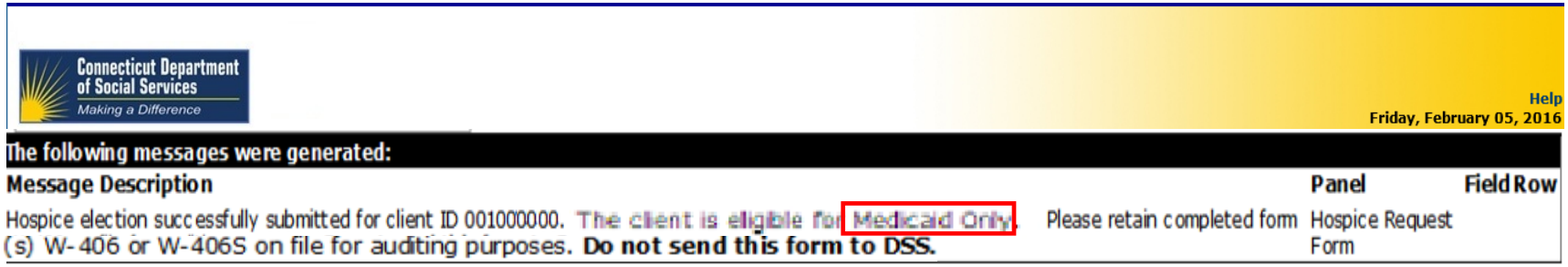
Locking in the Hospice Benefit

Once you click ***"Continue"*****,** you will receive a ***confirmation message*** that your transaction was ***successfully submitted***.

Dual Eligible Response:



Medicaid Only Response:



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On-line Hospice Transactions

- Important Points to Remember in Order to Effectively Manage Your Lock-In

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Hospice Election Transaction

Important Points to Remember in Order to Effectively Manage Your Lock-In:

✓Election:

- Hospice Election transactions **must** be submitted by the Hospice Agency within seven (7) days when:
  - A client initially elects the Hospice benefit
  - Re-elects the benefit after revocation
  - Re-elects the benefit after discharging from the care of another Hospice Agency or your own Agency
- Submission of the "Election Transaction" does not immediately place the lock-in on the client's eligibility file, this **may take up to fourteen (14) business days to be updated**.
- Providers **must** make their own corrections prior to updates reflecting on the client's eligibility; corrections submitted once the eligibility file has been updated **will not** be allowed.
- **Failure to submit the "Election Transaction" timely, could result in lost Hospice lock-in days**; if this occurs, providers will have to use the first day the on-line transaction tool will allow.
- Providers are encouraged to confirm accurate entry of the Hospice election by checking eligibility and Hospice agency provider ID.
- Hospice Election form(s) W-406 or W-406S **should not** be sent to DSS, they should be retained by the provider for audit purposes.
- It is the Hospice provider's responsibility to maintain the lock in as applicable to the client's treatment and request as defined in the Hospice Regulations, by submitting all on-line transactions in a **timely matter**. Such as: Discharge/Revocation, Transfers and Extensions.
-

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Hospice Discharge Transaction

Important Points to Remember in Order to Effectively Maintain Your Lock-In:

✓Discharge:

- A ***discharge should be entered timely*** to update the lock-in as soon as possible to avoid delay in entering additional transactions or delaying treatment by other providers in the care of a client. Discharges may be updated until the discharge transaction appears on the eligibility file.
- A ***discharge should not be entered*** if a client is being directly transferred to another Hospice Agency. An automatic discharge will be entered upon receipt of the transfer by the receiving Hospice Agency.
- The discharge form(s) W-404, W-404S or revocation form(s) W-405, W-405S should not be sent to DSS unless the reason for discharge is:
  - Just cause (discharge code 5) – This reason for discharge requires DSS approval. Discharge forms for this reason must be faxed to 860-424-5799.
- Submission of the discharge transaction does not automatically update the lock-in on the client's eligibility file. Entry of the transaction may take up to fourteen (14) business days.
- Each revocation must be entered as a discharge.
- A new election cannot be entered until the discharge transaction has been entered and the client's eligibility file updated.

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Hospice Transfer Transaction

Important Points to Remember in Order to Effectively Maintain Your Lock-In:

✓Transfer:

- A transfer transaction is entered by the Hospice Agency directly receiving a client from another Hospice Agency.
- A transfer transaction may be submitted up to three (3) days prior to the transfer date or three (3) days after the transfer date.
- Submission of the transfer transaction does not automatically update the lock-in on the client's eligibility file. Entry of the transaction may take up to fourteen (14) business days.
- Hospice transfer transactions may be updated until the transfer transaction appears on the eligibility file.
- A discharge from the transferring Hospice will not occur until the transfer transaction is received by the receiving Hospice.
- The Hospice Transfer form(s), W-403 or W-403S, should not be submitted to DSS.

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Hospice Extension Transaction

Important Points to Remember in Order to Effectively Maintain Your Lock-In:

✓Extension:

- An on-line extension transaction is entered by a Hospice Agency to extend the lock-in of a client that will exceed the initial twelve (12) month election period or subsequent twelve (12) month extension period.

- A Hospice extension may be submitted up to thirty (30) days prior to the end date of the most current Hospice lock-in segment.

- A Hospice extension cannot be submitted more than three (3) business days after the end date of the current Hospice segment.

- Submission of the extension transaction does not automatically update the lock-in on the client's eligibility file. Entry of the transaction may take up to fourteen (14) business days.

- Hospice Election form(s) W-406 or W-406S **should not** be sent to DSS for extensions, they should be retained by the provider for audit purposes.

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Claim Submission Guidelines

Claim Submission Guidelines

Covered Services

- DSS reimburses for Hospice services at one of four ***Levels of Care***, (routine, continuous, respite or general inpatient).
  - ***RCC 651 – Hospice/RTN Home***
  - ***RCC 652 - Hospice/CTNS Home***
  - ***RCC 655 – Hospice/IP Respite***
  - ***RCC 656 – Hospice/IP Non-Respite***

- When a dually eligible client, (Medicare A and HUSKY) decides to elect, revoke, discharge, extend or transfer the Hospice benefit, these changes **must** be made in both the Medicare and Medicaid programs. **Exception:** Providers are only required to enter this information in the Medicaid program for dually eligible clients receiving ***level of care*** Hospice/IP Respite, RCC 655 **only**.

- DSS reimburses for Hospice physician services, ***RCC 657*** billed by the Hospice agency for both HUSKY only and crossover claims when the following criteria are met:
  - These claims must be billed with at least one procedure code per date of service by the physician employed by or contracted by the Hospice agency
  - Service must be related to the terminal illness

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Claim Submission Guidelines

Covered Services cont.

- If the client is on Hospice in a Nursing Home or ICF/IID, the “pass through” payment for the Nursing Home is made to the Hospice agency under, ***RCC 658*** to cover room/board at 95% of the Nursing Home’s rate on file. The Hospice agency then reimburses the Nursing Home for the room/board.

- Hospice services with dates of service on or after January 1, 2016, are eligible for a SIA payment in addition to the per diem rate for the RHC level of care. When the criteria is met, SIA services must be billed with ***RCC 551*** and ***HCPCS G0299*** *provided by an RN* and/or **RCC 561** and ***HCPCS G0155*** provided by a social worker with ***occurrence code 55 and date of death***.

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Claim Submission Guidelines

Hospice Reimbursement for Client in **Community:**

Location of Service	Private Home		
	Hospice per Diem	Room and Board RCC 658	End of Life (EOL) Service Intensity Add-On (SIA)
Routine home RCC 651	Yes	No	Yes
Continuous home RCC 652	Yes	No	No
Respite RCC 655	Yes	No	No
General Inpatient RCC 656	Yes	No	No

Claim Submission Guidelines

Hospice Reimbursement for Client in **Nursing Home or ICF/IID:**

Location of Service	Hospice per Diem	Room and Board RCC 658	End of Life (EOL) Service Intensity Add-On (SIA)
Routine home RCC 651	Yes	Yes	Yes
Continuous home RCC 652	No	No	No
Respite RCC 655	No	No	No
General Inpatient RCC 656	Yes	No	No
Nursing Home/ICF/IID bed hold 183, 185		Paid to nursing facility or ICF/IID	No

Claim Submission Guidelines

Other Services Billed by Hospice Agency:

Other Billable Codes	Description	Additional Comments
RCC 657 + HCPC	Physician/APRN services	May be billed in conjunction with any hospice RCC
RCC 658	Room and board in NF or ICF/IID	Payable to hospice when client has been authorized for admission to that facility
RCC 659 + HCPC S9381	Add-on code for escort service in accordance with §17b-262-845(b) of the Regulations of Connecticut State Agencies	Approved by DSS on a case by case basis for extraordinary costs associated with escort services
RCC 551 + HCPC G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting	Hospice services are eligible for an EOL SIA payment in addition to the RHC level of care when specific criteria are met. Reference Section 8.1.
RCC 561 + HCPC G0155	Services of clinical social worker in home health or hospice settings, each 15 minutes	Hospice services are eligible for an EOL SIA payment in addition to the RHC level of care when specific criteria are met. Reference Section 8.1.

Non-Covered Hospice Services

Non-Covered Hospice Services

- Reference section 17b-262-842 of the regulation
- These services are *not covered* when the client elects the Hospice benefit
  - ✓ **Treatment to cure the illness**
    - **Except for children under the age of 21 (HUSKY A, C, and D)**
    - **Except for children under age 19 (HUSKY B)**
  - ✓ **Hospice services by more than one Hospice provider**
  - ✓ **Drugs that are anti emetics and narcotic analgesics billed by pharmacy providers**

Prior Authorization Requirements

Prior Authorization Requirements

Hospice Services Requiring Prior Authorization:

- **General inpatient care in a Hospital or Nursing Home which extends beyond the *fifth* day of care for HUSKY only clients:**
  - CHN PA request for Hospice Services

- **Hospice care extending for more than 12 months for HUSKY only clients:**
  - Complete on-line extension and
  - CHN PA request for Hospice Services
  - Retain the revised W-406 or W-406S in the clients records, do not send to DSS.

- **Hospice Care extending for more than 12 months for Dually eligible clients:**
  - Complete on-line extension
  - Retain the revised W-406 or W-406S in the clients records, do not send to DSS.

Refer to chapter 9 on the www.ctdssmap.com Web site for prior authorization information.

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Patient Liability

Patient Liability

- Patient Liability represents the amount a client in a Nursing Home is responsible to contribute toward their care each month.
- Patient liability amounts are calculated and determined by DSS based on the client's income (pension, SS, etc.) and healthcare expenses.
- If a claim is submitted where the patient liability exceeds the Medicaid allowed amount an A/R (accounts receivable) is created for the difference.
- If a claim is recouped an A/R is created to take back the patient liability.
- If the claim is resubmitted, the system will pay the claim and include the patient liability in the claim payment.

Patient Liability

- Patient liability is deducted from the first claim processed for the month in which patient liability is due.
- For example:
  - Client resides in a Nursing Home.
  - From 1/1/16 – 1/5/16 the client is in the hospital.
  - On 1/6/16 the client returns to the Nursing Home and elects the Hospice benefit.
  - Nursing Home submits a claim for client's bed reserve 1/1/16-1/5/16.
  - The Hospice submits a claim for Nursing Home room and board for 1/6/16 - 1/31/16.
  - Patient liability is deducted from the first claim that processes; at the header of the claim, not the detail.
- Hospice agency and Nursing Home providers need to make arrangements to reconcile patient liability.

Patient Liability

- Mass adjustments due to patient liability changes within clients' profiles are processed the first cycle of the following month in which the change occurred; adjustments will appear on the remittance advice (RA) with an ICN region code 53.

- Changes do not require claim adjustments to be performed by providers.

- Claims will be automatically adjusted by Hewlett Packard Enterprise and the necessary A/Rs, payouts and reimbursements will be generated.

Explanation of Benefit (EOB) Code Descriptions, Cause & Resolution

EOB Code Descriptions, Cause and Resolution

EOB Code 0702 – Hospice room and board not covered without Nursing Home authorization

- ***Cause/Resolution***
  - Once the Nursing Home authorization has been added to the client's eligibility file, the claim can be resubmitted.

EOB Code 0710 – Revenue not covered for client enrolled in Medicare Hospice

- ***Cause/Resolution***
  - ***Only RCC 655 or 658 is valid when billing a Hospice claim for a client with a Medicare Hospice lock-in***. Correct the RCC and resubmit the claim, otherwise, the claim is not payable.

EOB Code 1024 – Provider is not authorized to bill for this client

- ***Cause/Resolution***
  - The claim is not payable until EMS is updated with a Hospice lock-in for the client to be serviced by the billing provider. ***To determine if EMS has been updated, perform a client eligibility verification transaction. Once EMS has been updated, resubmit the claim.***

EOB Code Descriptions, Cause and Resolution

EOB Code 0711 – Claim denied. Client does not have Hospice lock-in

- ***Cause/Resolution***
  - Perform a client eligibility verification transaction to determine if the client has been locked-in to the billing Hospice agency. If the lock-in is in place, resubmit the claim to Hewlett Packard Enterprise.
  - If the lock-in is ***not authorized*** for the date(s) of service:
    - And services provided is RCC 658, the Nursing Home may bill these charges as a routine room and board claim.
    - And services provided is either RCC 651 or 652, the Hospice agency may bill comparable Home Health services under their Home Health agency provider number.
    - And services provided are RCC 656, either the Hospital or Nursing Home must bill charges as a routine Hospital or Nursing Home stay.

Note: If the lock-in is not in place within fourteen (14) business days of a valid submission of the on-line election transaction, please contact the Provider Assistance Center. Once election is confirmed, the request will be escalated to DSS for expedited entry.

EOB Code Descriptions, Cause and Resolution

EOB Code 0722 – Occurrence code 55 **Required**

- ***Cause/Resolution***
  - Claims that contain either the Skilled Nurs/Visit – 551/G0299 and/or Med Soc Servs/Visit – 561/G0155 must have occurred within the last seven days of life to receive SIA payment. ***Resubmit the claim with occurrence code 55.***

EOB Code 0723 – Occurrence code 55 **Missing** Date

- ***Cause/Resolution***
  - Claims that contain either the Skilled Nurs/Visit – 551/G0299 and/or Med Soc Servs/Visit – 561/G0155 must have occurred within the last seven days of life to receive SIA payment. If the client does not have a date of death on the EMS file or the date of death on the claim is ***missing***, the detail will deny. ***Resubmit the claim with the date of death.***

EOB code 0724 – Occurrence code 55 **Invalid** Date

- ***Cause/Resolution***
  - Claims that contain either the Skilled Nurs/Visit – 551/G0299 and/or Med Soc Servs/Visit – 561/G0155 must have occurred within the last seven days of life to receive SIA payment. If the client does not have a date of death on the EMS file or the date of death on the claim is ***invalid***, the detail will deny. ***Resubmit the claim with a valid date of death.***

EOB Code Descriptions, Cause and Resolution

EOB code 0725 – Date of Death not **Within 7 Days**

- *Cause/Resolution*
  - Claims that contain either the Skilled Nurs/Visit – 551/G0299 and/or Med Soc Servs/Visit – 561/G0155 must have occurred within the last seven days of life to receive SIA payment. If the client has a date of death on the EMS file, we will confirm that the SIA details occurred within seven days of the date of death. If the client does not have a date of death on the EMS file and the date of death on the claim is ***more than seven days from the date of service of the SIA***, the detail will deny. **If the SIA services did occur within the last seven days of life, resubmit the claim with correct dates of service**.

EOB code 6290 – Hospice RN-SW Services are **Limited to 16 Units Per Day**

- *Cause/Resolution*
  - A combination of up to four (4) hours (16 units) are allowed for the combination of Skilled Nurs/Visit – 551/G0299 and/or Med Soc Servs/Visit – 561/G0155 per date of service within the last seven days of life. If ***more than 16 units are billed for the RN and/or social worker***, those units *will not* be included in the SIA payment. **No additional action is needed**.

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EOB Code Descriptions, Cause and Resolution

EOB code 5220 – RHC RCC Must be Billed with RN-SW SVC For the Same Client/Provider/Date of Serv

- *Cause/Resolution*
  - Claims that contain either the Skilled Nurs/Visit – 551/G0299 and/or Med Soc Servs/Visit – 561/G0155 must be billed with RHC on the **same claim, same client, same provider and date of service**. The SIA detail will deny, when claims with either the RN G0299/551 and/or social worker service G0155/561 are billed without RHC. **Resubmit the claim adding the RHC detail**.

EOB code 5040 – No Paid Routine Home Care Service

- *Cause/Resolution*
  - Claims that contain either the Skilled Nurs/Visit – 551/G0299 and/or Med Soc Servs/Visit – 561/G0155 must have a ***paid*** detail with RHC ***on the same claim***. If there isn't a ***paid*** detail for RCC 651 on the **same claim**, the SIA detail will deny. **Resubmit the claim adding the RHC detail and/or adjust a previously paid claim that contains a paid RHC detail to add the SIA detail**.

Important: *Claims in history with a paid RHC detail must be adjusted to add the SIA detail*, the resubmission of a claim adding the SIA detail will result in a denial with the following EOB codes:

5001 – Exact Duplicate
5402 – Only 1 Hospice Level of Care Allowed Per Date

Hospice Reminders

Hospice Reminders

- Exceptions to Untimely Submission of the Notice of Election (NOE):

- Fire, floods, earthquakes, or other unusual events that inflict extensive damage to the Hospice's ability to operate.
- An event that produces a data filing problem due to a Department systems issue that is beyond the control of the Hospice.
- Retroactive client eligibility.
- Other circumstances determined by the Department to be beyond the Hospice's control.

NOTE: The Hospice provider must call the Provider Assistance Center at 1-800-842-8440 if one of the above qualifying circumstances prevents you from submitting your NOE within the timely filing requirements.

Reference Provider Bulletin: PB14 - 80 for additional information

Hospice Reminders

Based on ICD-9CM coding guidelines, the following diagnosis codes **should not be used** as the **primary diagnosis** when submitting Hospice Services for dates of service through 9/30/15:

799.3 (Debility, unspecified)

780.79 (Other malaise and fatigue),

783.7 (adult failure to thrive)

Additional dementia diagnosis codes:

294.10 (Dementia in Condition classified elsewhere without behavioral disturbance)

294.11 (Dementia in Condition classified elsewhere with behavioral disturbance)

Based on ICD-10CM coding guidelines, the following diagnosis codes **should not be used** as the **primary diagnosis** when submitting Hospice Services for dates of service on or after 10/1/15:

R53.81 (Other malaise)

R62.7 (adult failure to thrive)

Additional dementia diagnosis codes:

F02.80 (Dementia in diseases classified elsewhere without behavioral disturbance)

F02.81 (Dementia in diseases classified elsewhere with behavioral disturbance)

NOTE: Claims submitted with any of the above-mentioned diagnosis codes as the primary diagnosis will be denied

Reference Provider Bulletin: PB14 - 80 for additional information and/or the Hospice Chapter 8 "Claim Submission Instructions"

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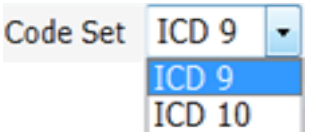
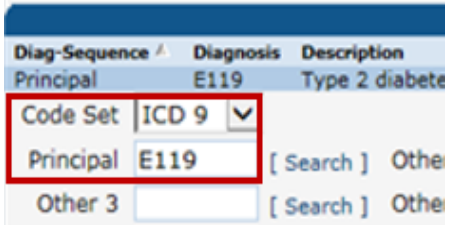
ICD-10 Information

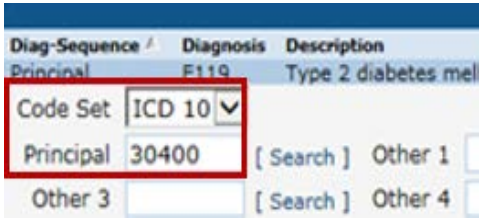
ICD-10 Information

- As of **October 1, 2015**, the ICD-9 code sets used to report medical diagnoses and inpatient procedures have been replaced by ICD-10 code sets.
- Diagnosis panels on the www.ctdssmap.com Web site has a drop down list to select either the ICD-9 or ICD-10 Code Set.



- Edits on the Web portal will prevent a claim from being submitted when there is a mismatch between the Code Set and the Diagnosis code.





ICD-Information

ICD-10 Implementation Information – Related Explanation of Benefit (EOB) Codes

0492 ICD9 diagnosis code qualifiers after ICD10 implementation date

Cause

A claim was submitted with one of the following ICD-9 diagnosis code qualifiers for a date of service after the ICD-10 implementation date of 10/1/2015.

- BK – Primary Diagnosis
- BJ – Admit Diagnosis (Institutional)
- BN – Ecode Diagnosis (Institutional)
- BF – Other Diagnosis
- PR – Visit Diagnosis (Institutional)

Resolution

Change the diagnosis code qualifier to one of the following ICD-10 diagnosis code qualifiers and resubmit the claim.

- ABK – Primary Diagnosis
- ABJ – Admit Diagnosis (Institutional)
- ABN – Ecode Diagnosis (Institutional)
- ABF – Other Diagnosis
- APR – Visit Diagnosis (Institutional)

ICD-10 Information

ICD-10 Implementation Information – Related Explanation of Benefit (EOB) Codes

0485 Diagnosis codes must be all same code set

Cause
A claim was submitted with diagnosis codes from both the ICD-9 and ICD-10 code sets.

Resolution
Diagnosis codes from only one code set can be submitted on a claim. Submit the diagnosis codes from the appropriate code set (ICD-9 or ICD-10) based on the date(s) of service on the claim.

- ICD-9 codes are valid for dates of service through 9/30/2015
- ICD-10 codes are valid for dates of service 10/1/2015 forward

Please refer to Provider Bulletin 2015-61 for the span date logic for the ICD-10 implementation for the various claim types.

ICD-10 Information

ICD-10 Implementation Information – Related Explanation of Benefit (EOB) Codes

4027 Diagnosis code not covered for date of service

Cause
A claim is submitted where a header diagnosis code is present, but the claim date of service is outside of the effective and end date for the diagnosis code per DSS policy.

Resolution
If the claim was submitted with an ICD-9 diagnosis code(s) for a date of service after 10/1/2015, resubmit the claim with the appropriate ICD-10 diagnosis code(s).

If the claim was submitted with an ICD-10 diagnosis code(s) for a date of service prior to 10/1/2015, resubmit the claim with the appropriate ICD-9 diagnosis code(s).

If the diagnosis code on the claim is not a valid diagnosis code and has been terminated by CMS, resubmit the claim with a valid diagnosis code.

Please refer to Provider Bulletin 2015-61 for the span date logic for the ICD-10 implementation for the various claim types.

ICD-10 Information

ICD-10 Implementation Information – Related Explanation of Benefit (EOB) Codes

4039 Diagnosis cannot be used as principal diagnosis

Cause

A non-pharmacy claim is submitted with a principal diagnosis code that cannot be used as the principal diagnosis code according to coding guidelines.

- On a professional or dental claim, if a diagnosis pointer is filled in at the detail, the primary diagnosis is the one designated by the first occurrence of the pointer
- On a professional or dental claim, if there is no diagnosis pointer filled in at the detail, the primary is considered the first header diagnosis code

Resolution

Resubmit the claim with a principal diagnosis code that is acceptable as a principal diagnosis according to coding guidelines.

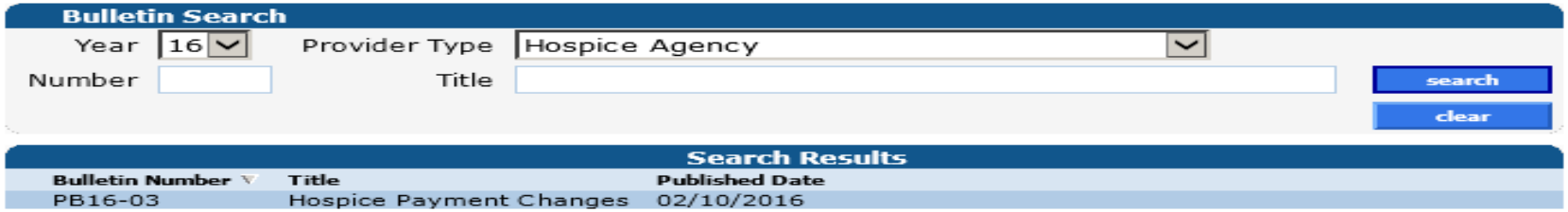
Note: Currently set to Post & Pay

Program Resources/Contacts/Wrap Up & Questions

Program Resources

Connecticut Medical Assistance Program Web site – www.ctdssmap.com

Information > Publications **> Bulletins**



Information > Publications **> Provider Manuals**

Provider Manuals

Chapter	Title
1	Introduction
2	Provider Participation Policy
3	Provider Enrollment and Re-enrollment
4	Client Eligibility
5	Claim Submission Information Additional Chapter 5 Information • Carrier Listing Sorted by Name • Carrier Listing Sorted by Code
6	Electronic Data Interchange Options
7	Specific Policy Regulation Hospice View Chapter 7
8	Provider Specific Claims Submission Instructions Hospice View Chapter 8
9	Prior Authorization
10	Web/AVRS
11	Other Insurance and Medicare Billing Guides Select a claim type View Chapter 11
12	Claim Resolution Guide

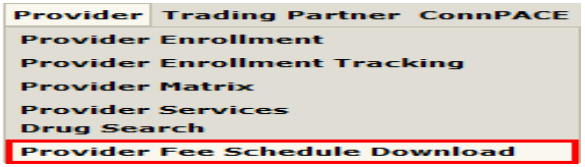
Program Resources

- Rates have been increased effective 10/1/15 and changes to support the implementation of SIA and the two-tiered RHC reimbursement effective 1/1/16 are also reflected on the fee schedule.
- From the Home Page select Provider > Provider Fee Schedule Download > “I accept” > Hospice.
- To access the CSV file press the control key while clicking the CSV link, then select “Open”.
- To determine the rate for each county and associated town based on the regional rates listed on the Fee Schedule, providers should refer to the *Hospice Town/Metropolitan Statistical Area Regions Codes Crosswalk* located on the www.ctdssmap.com Web site.
- Select Publications > scroll to “Hospice Forms” and click on the Town/Metropolitan Statistical Area Regions Codes Crosswalk.

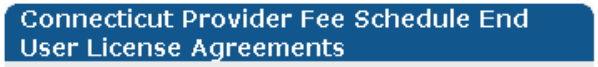
Program Resources

CMAP Fee Schedules are available for download from the Web site:

Select Provider Fee Schedule Download from the Provider drop-down menu



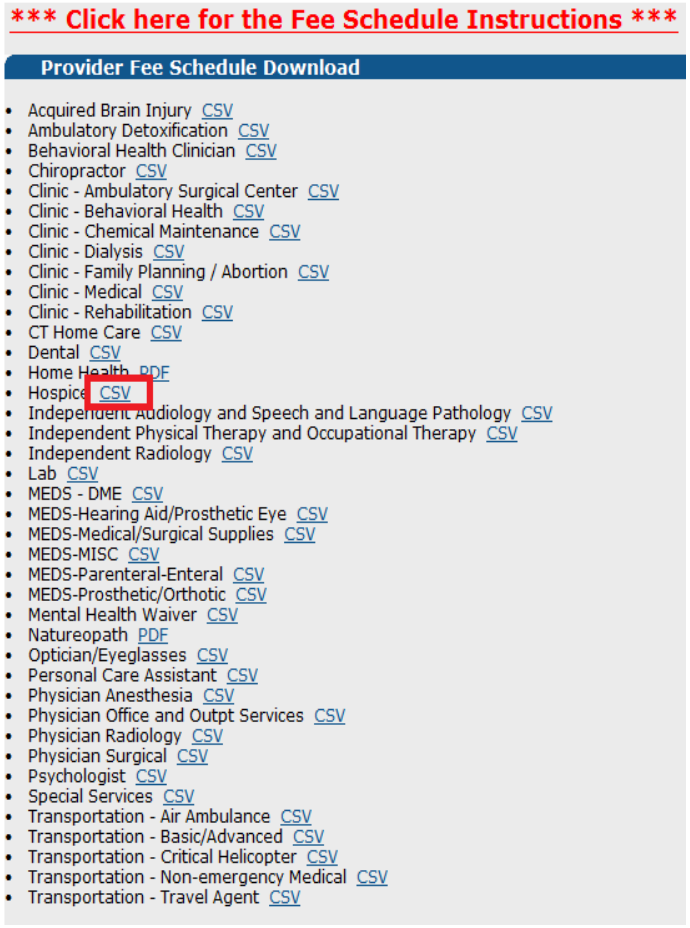
You must read and accept the **End User License Agreement**



click I Accept

Provider Fee Schedules are listed by provider type and specialty.

Hold down the **control key** and **click** the **Hospice CSV link** to download the fee schedule.



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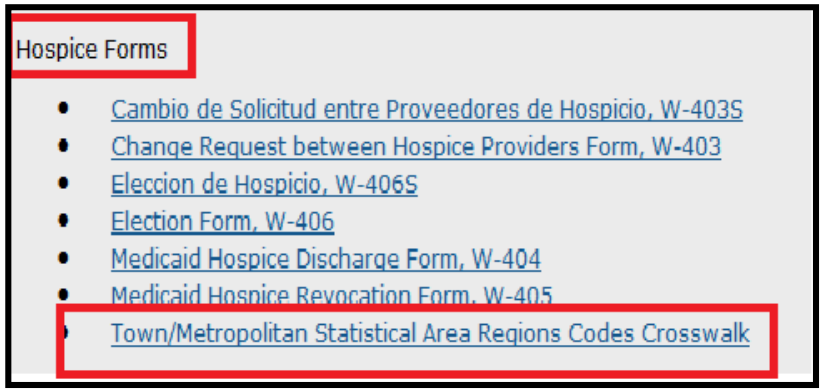
Program Resources

The **fee schedule provides the rate by region.** The Hospice provider must **refer to the crosswalk located at Publications>Forms>Hospice Forms** to determine the regional rate associated to the client's county and town of residence on file at the time of claim submission.



Town Code	Town Description	Regional Area or Metropolitan Statistical Area	Effective Date	End Date
1	Andover	02	01/01/2009	12/31/2299
2	Ansonia	03	01/01/2009	12/31/2299
3	Ashford	05	01/01/2009	09/30/2015
3	Ashford	06	10/01/2015	12/31/2299
4	Avon	02	01/01/2009	12/31/2299
5	Barkhamsted	05	01/01/2009	12/31/2299
6	Beacon Falls	03	01/01/2009	12/31/2299
7	Berlin	02	01/01/2009	12/31/2299
8	Bethany	03	01/01/2009	12/31/2299
9	Bethel	01	01/01/2009	12/31/2299
10	Bethlehem	05	01/01/2009	12/31/2299
11	Bloomfield	02	01/01/2009	12/31/2299
12	Bolton	02	01/01/2009	12/31/2299
13	Bozrah	04	01/01/2009	12/31/2299
14	Branford	03	01/01/2009	12/31/2299
15	Bridgeport	01	01/01/2009	12/31/2299
16	Bridgewater	05	01/01/2009	12/31/2299
17	Bristol	02	01/01/2009	12/31/2299
18	Brookfield	01	01/01/2009	12/31/2299
19	Brooklyn	05	01/01/2009	09/30/2015
19	Brooklyn	06	10/01/2015	12/31/2299
20	Burlington	02	01/01/2009	12/31/2299
21	Canaan	05	01/01/2009	12/31/2299
22	Canterbury	05	01/01/2009	09/30/2015
22	Canterbury	06	10/01/2015	12/31/2299
23	Canton	02	01/01/2009	12/31/2299
24	Chaplin	05	01/01/2009	09/30/2015
24	Chaplin	06	10/01/2015	12/31/2299
25	Cheshire	03	01/01/2009	12/31/2299
26	Chester	02	01/01/2009	12/31/2299
27	Clinton	02	01/01/2009	12/31/2299
28	Colchester	04	01/01/2009	12/31/2299

Note: Refer to Provider Bulletin: PB 2015-77 for the reconfiguring of the Hospice regions.

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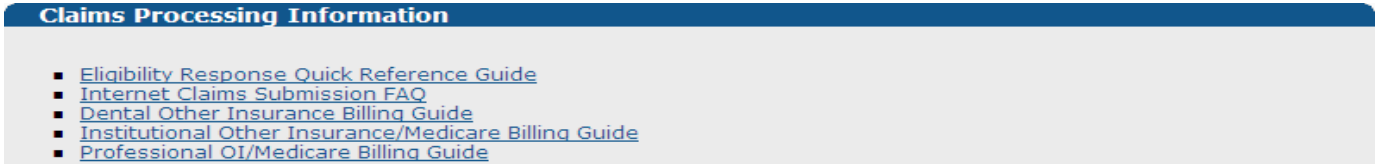
Program Resources

Home **> Important Messages**

Information > Publications **> Provider Newsletters**

- Quarterly publications to providers on a wide range of topics

Information > Publications **> Claims Processing Information**



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Contacts

- ***Hewlett Packard Enterprise Provider Assistance Center (PAC)***
  - 1-800-842-8440 – Monday through Friday, 8:00 AM – 5:00 PM (EST), excluding holidays.
  - ctdssmap-provideremail@hpe.com

- ***Hewlett Packard Enterprise Electronic Data interChange (EDI) Help Desk***
  - 1-800-688-0503 – Monday through Friday, 8:00 a.m. to 5:00 p.m. (EST), excluding holidays.

- ***CHNCT Provider Relations*** *(prior authorizations)*
  - 1-800-440-5071 – Monday through Friday, 9:00 a.m. to 7:00 p.m. (EST).

- ***www.huskyhealth.com***

- ***www.ctdssmap.com***

Wrap Up & Questions

- Questions & Answers

Thank you for attending

today's workshop!

Please complete the workshop evaluation, your comments are appreciated!

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