



Handbook for Hospice Agencies

Chapter K-200 Policy and Procedures For Hospice Services

Illinois Department of Healthcare and Family Services

Issued November 2016

Chapter K-200

Hospice Services

Table of Contents

Foreword

Definitions

K-200 Basic Provisions

K-201 Provider Participation

- 201.1 Participation Requirements
- 201.2 Participation Approval
- 201.3 Participation Denial
- 201.4 Provider File Maintenance

K-202 Record Requirements

K-211 Determination of Need for Hospice Services

- 211.1 Physician Certification
- 211.2 Notice of Election
- 211.3 Requirements for Election
- 211.4 Benefit Periods
- 211.5 Change in Hospice Provider
- 211.6 Revocation of Hospice Care
- 211.7 Notification of Termination

K-212 Concurrent Palliative and Curative Care for Children Receiving the Hospice Benefit

K-230 Covered Services

K-232 Core Services

- 232.1 Physician Services
- 232.2 Nursing Services
- 232.3 Counseling Services
- 232.4 Medical Social Services

K-234 Furnishing of Other Services

- 234.1 Short Term Inpatient Care
- 234.2 Medical Equipment, Supplies, Drugs and Biologicals
- 234.3 Home Health Aide and Homemaker Services
- 234.4 Therapy Services

K-240 Non-Covered Services

K-250 Hospice Reimbursement

- 250.1 Routine Home Care
- 250.2 Continuous Home Care
- 250.3 Inpatient Respite Care
- 250.4 General Inpatient Care
- 250.5 Physician Services
- 250.6 Nursing Home Room and Board Charges

K-260 Payment Process

- 260.1 Charges
- 260.2 Claim Preparation and Submittal
- 260.3 Electronic Claim Submittal
- 260.4 Payment
- 260.5 Payment Adjustments

Appendices

- K-1 Explanation of Information on Provider Information Sheet
- K-1a Facsimile of Provider Information Sheet

- K-2 Hospice Claim Required Fields

- K-3 Billing Scenarios

- K-4 Internet Quick Reference Guide

Foreword

Purpose

This handbook, along with recent [provider notices](#), will act as an effective guide to participation in the Department's Medical Programs. It contains information that applies to fee-for-service Medicaid providers. It also provides information on the Department's requirements for enrollment and provider participation.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions in and supplements to the handbook are released as necessary based on operational need and State or federal laws requiring policy and procedural changes. Updated handbooks are posted on the [Provider Handbooks](#) page of the website.

Providers are held responsible for compliance with all policy and procedures contained herein. Providers should register to receive [e-mail notification](#); when new provider information has been posted by the Department.

Providers should always verify a participant's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the participant's coverage. It is imperative that providers check HFS electronic eligibility systems regularly to determine eligibility. The [Recipient Eligibility Verification \(REV\)](#) System, the Automated Voice Response System (AVRS) at 1-800-842-1461, and the [Medical Electronic Data Interchange \(MEDI\)](#) systems are available.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Hospital and Provider Services at 1-877-782-5565.

Definitions

Department of Healthcare and Family Services (HFS) or “Department” – The Department of Healthcare and Family Services (HFS) or “Department” is the agency that administers Illinois’ Medical Assistance (Medicaid) Program, as well as other public healthcare programs.

Document Control Number (DCN) – As identified on the HFS 194-M-2 paper Remittance advice, a twelve-digit number assigned by the department to identify each claim that is submitted by a provider. The format is YDDDLLSSSSSS.

Y Last digit of year claim was received
DDD Julian date claim was received
LL Document Control Line Number
SSSSSS Sequential Number

HCPCS – Healthcare Common Procedure Coding System

Identification Card or Notice – The card issued by the Department to each person or family who is eligible under Medical Assistance, All Kids, FamilyCare, Veterans Care, Health Benefits for Workers with Disabilities (HBWD) and Qualified Medicare Beneficiaries (QMB) who are not eligible for Medical Assistance, but are eligible for Department consideration of Medicare coinsurance and deductibles.

Inpatient Services – Those services provided to a patient whose condition warrants formal admission and treatment in a hospital, and that are reimbursed based on the per diem or per discharge all-inclusive rate.

Institutional Claim format – Claims prepared in the 837I or Direct Data Entry (DDE) electronic formats or UB-04 paper claim format.

National Provider Identifier (NPI) – The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for healthcare providers, payees, and health plans. For healthcare providers and payees, this identifier is referred to as the National Provider Identifier (NPI).

Participant – A term used to identify an individual receiving coverage under one of the Department’s medical programs. It is interchangeable with the term “recipient”.

Provider Enrollment Services (PES) – The section of the Department of Healthcare and Family Services that is responsible for maintaining provider enrollment records.

Recipient Identification Number (RIN) – The nine-digit identification number unique to the individual receiving coverage under one of the Department’s Medical Programs. It is vital that this number be correctly entered on billings for services rendered.

Remittance Advice – A document issued by the Department which reports the status of claims (invoices) and adjustments processed. This may also be referred to as a voucher.

Chapter K-200

Hospice Services

K-200 Basic Provisions

For consideration for payment by the Department for hospice services, such services must be provided by a provider enrolled for participation in the Department's Medical Programs via the web-based system known as Illinois Medicaid Program Advanced Cloud Technology ([IMPACT](#)). Services provided must be in full compliance with applicable federal and state laws, the general provisions contained in the [Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures](#), and the policy and procedures contained in this handbook, as well as the applicable provisions contained in 42 CFR Part 418.1 through 418.405. Exclusions and limitations are identified in specific topics contained herein.

The billing instructions contained within this handbook are specific to the Department's paper forms. Providers billing the facility services described in this handbook use the UB-04 claim form for billing paper claims. The instructions apply to patients enrolled in traditional fee-for-service and **do not apply to patients** enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs). Further information can be found at the [HFS Care Coordination website](#).

Providers wishing to submit X12 electronic transactions must refer to [Chapter 300](#), Handbook for Electronic Processing. Chapter 300 identifies information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the [Illinois Department of Healthcare and Family Services](#)

K-201 Provider Participation

K-201.1 Participation Requirements

A proprietary or not-for-profit hospice holding the following qualifications is eligible to be considered for enrollment to participate in the Department's Medical Programs:

- A valid license issued by the Illinois Department of Public Health (or meeting the requirements of the State in which the hospice provider is located) and
- Certification by the Social Security Administration for participation in the Medicare Program (Title XVIII).

A hospice program shall comply with the [Health Care Worker Background Check Act](#) and the [Health Care Worker Background Check Code](#).

To comply with the Federal Regulations at [42 CFR Part 455 Subpart E - Provider Screening and Enrollment](#), Illinois has implemented a new electronic provider enrollment system. The web-based system is known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT).

Under the IMPACT system, category of service(s) (COS) is replaced with Specialties and Subspecialties. When enrolling in IMPACT, a [Provider Type Specialty](#) must be selected. A provider type subspecialty may or may not be required.

Refer to [IMPACT Provider Types, Specialties and Subspecialties](#) for additional information.

K-201.2 Enrollment Approval

When enrollment is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data on the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix K-1.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department files. If any of the information is incorrect, refer to Topic K-201.4.

K-201.3 Participation Denial

When enrollment is denied, the provider will receive written notification of the reason for denial.

Within ten (10) calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten (10) calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination.

Department rules concerning the basis for denial of enrollment are in [89 Ill. Adm. Code 140.14](#). Department rules concerning the administrative hearing process are in [89 Ill. Adm. Code 104 Subpart C](#).

K-201.4 Provider File Maintenance

The information carried in the Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims. Any inaccuracies found must be corrected and the Department notified immediately via [IMPACT](#).

Failure of a provider to properly notify the Department of corrections or changes may cause an interruption in participation and payments.

Department Responsibility

When there is a change in a provider's enrollment status or the provider submits a change the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the payee address is different from the provider address.

K-202 Record Requirements

The Department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. Refer to [Chapter 100](#) for record requirements applicable to all providers.

In the absence of proper and complete medical records, no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

The minimal record requirements satisfying Department standards for hospice services are as follows:

- Identification of the participant: name, address, case identification number, recipient identification number and age
- Complete and current diagnosis
- Name of ordering practitioner
- Statement of election of hospice benefits
- Statement by physician regarding terminal illness including diagnosis and prognosis
- Multidisciplinary team plan of care
- Contractual agreements between the hospice provider and long term care facilities
- Contractual agreements between the hospice provider and acute care hospitals

K-211 Determination of Need for Hospice Services

K-211.1 Physician Certification

The physician certification must identify the diagnosis of a terminal illness that prompted the patient to elect hospice care. It must include a statement that the individual's medical prognosis is that the patient's life expectancy is six (6) months or less if the terminal illness runs its normal course.

If the hospice cannot obtain the written certification within 2 calendar days, after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment.

The certification must also include the date and signature(s) of the physician(s).

Recertification may be completed no more than 30 calendar days prior to the start of the subsequent benefit period.

For the initial ninety (90) -day periods, (see Topic K-211.4, Benefit Periods), the hospice must obtain written certification statements from the medical director of the hospice or the physician member of the hospice interdisciplinary group and the participant's attending physician. For subsequent periods, the only requirement is certification by the medical director of the hospice or the physician member of the hospice interdisciplinary group. A copy of the physician certification must be maintained in the hospice patient record and is subject to post-payment audit.

K-211.2 Notice of Election

An individual must file an election statement with the hospice. The election statement must include the following items:

1. Identification of the hospice that will provide care.
2. The individual's or legal representative's acknowledgement that he or she has been given a full understanding of hospice care as an alternative to traditional covered Medicaid services and has made an informed decision to elect hospice care.
3. Waiver of all rights to Medicaid payments for the following services for the duration of the election of hospice care:
 - Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice); and
 - Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition, or services that are equivalent to hospice care, except for:
 - Services provided by the designated hospice;
 - Services provided by another hospice under arrangements made by the designated hospice;

- Services provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services;
 - Room and board by a nursing facility if the individual is a resident.
 - Services provided outside the hospice benefit for patients 21 years of age and older, as identified in 89 Ill. Admin. Code section 140.469(h).
4. The effective date of the election.
 5. The signature of the individual or legal representative. In the event that the patient is not physically or mentally able to sign the Notice of Election, his or her legal representative may do so on his or her behalf.

Section 2302 of the Affordable Care Act, titled "Concurrent Care for Children," amended sections 1905(o)(1) and 2110(a)(23) of the Social Security Act to remove the prohibition of receiving curative treatment upon election of the hospice benefit for a Medicaid or Children's Health Insurance Program (CHIP) eligible child. Accordingly, election statements for children through age 20 must differ in that they must inform pediatric patients that they are entitled to all Medicaid benefits concurrently with hospice care.

The hospice must notify the Department after an eligible participant elects hospice care by completing the [HFS 1592 - Notification to HFS of Illinois Medicaid Hospice Benefit Election - Initial Election Period](#).

Do **not** use the institutional claim format for notification of election to the Department. This may result in delaying the payment process or rejection of a claim for service.

Hospices are strongly encouraged to notify the Department promptly, as delay in notification can impact the hospice payment as well as other providers' payment.

Incoming HFS 1592 participant election information will be entered with an ending date that is 180 days from the initial election date. The 180-day period encompasses the initial two 90-day benefit periods.

Hospice providers will be required to submit the [HFS 1593 - Notification to HFS of Illinois Medicaid Hospice Benefit - Continuing Benefit Period and Recertification of Terminal Illness](#) for each 60-day extension period of election. These extensions should be submitted no earlier than 15 days prior to the ending date of the current period, in order to prevent the election from expiring. If the hospice election expires, hospice payments will end and any nursing home room and board payments from the Department will be made to the nursing home, not to the hospice provider.

After a hospice patient dies or is discharged, the hospice must complete the [HFS 1594 – Notification to HFS of Patient Discharge from Hospice Care](#).

Allow two (2) weeks after submitting one of the hospice forms before submitting a claim for service. Claims submitted prior to the Department's update of multiple data segments will cause the claim to reject. The hospice must then rebill before payment can be adjudicated.

It is extremely important that the hospice agency notifies the Department of election information in a timely manner so as not to disrupt payment to the hospice or its associated nursing homes.

If a patient's eligibility for medical assistance is cancelled, the database will automatically enter a hospice end date. If the patient re-applies for medical assistance and is approved, and the patient is still under hospice care, a new HFS 1593 notification will need to be submitted to the Department to update the hospice election period on the Department's file.

The HFS forms for notification of election/discharge may be mailed or faxed to the Department. The mailing address is:

Illinois Department of Healthcare and Family Services
Bureau of Hospital and Provider Services
P. O. Box 19128
Springfield, Illinois 62794-9128
Attn: UB Billing Unit

The telefax number is 217-524-4283, Attn: UB Billing Unit

K-211.3 Requirements for Election

Hospice care is available only if the following conditions are met:

- The patient's physician and/or the hospice medical director certify that the patient is terminally ill (for hospice purposes terminal illness is defined as a life expectancy of six (6) months or less if the terminal illness runs its normal course); and
- The patient or legal representative, in the event the patient is physically or mentally unable to sign, signs an election statement indicating an informed choice of hospice benefits for the terminal illness; and
- The patient receives care from a Medicare certified hospice that is enrolled with the Department to provide hospice services; and
- The services are provided in accordance with a plan of care established by the patient's attending physician, the medical director or physician designee and the interdisciplinary group. The plan must include an assessment of the individual's needs and identification of the services including the management

of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs. Detailed plan of care and interdisciplinary group requirements are identified in 42 CFR Part 418.

K-211.4 Benefit Periods

Benefit periods consist of two ninety (90) day benefit periods, followed by an unlimited number of sixty (60) day benefit periods.

The benefit periods may be used consecutively or at intervals. Regardless of whether they are used consecutively or at intervals, the patient must be certified as terminally ill at the beginning of each benefit period. If a patient is eligible for Medicare Part A, the Medicare benefit period(s) and the Medicaid benefit period(s) run concurrently.

K-211.5 Change in Hospice Provider

A patient electing hospice care may change hospice providers once during each benefit period. If a patient transfers from one hospice to another, both providers must notify the Department in writing. The transferring hospice must submit an HFS 1594 notification of termination (see Topic K-211.7) and the receiving hospice must submit an HFS 1592 notice of election (see Topic K-211.2). In cases where one hospice discharges a patient and another hospice admits the person on the same date, the Department does not reimburse the transferring hospice for the discharge day. The second hospice will be paid starting with their date of admission. This policy also applies when a hospice undergoes a change of ownership or name change.

K-211.6 Revocation of Hospice Care

A patient has the right to cancel hospice care at any time and return to standard Medicaid coverage. If a patient cancels hospice coverage during any benefit period, any time remaining in that period is forfeited. If a patient has used the two ninety (90) day periods prior to cancellation and again elects hospice care at any time in the future, they can be certified for an unlimited number of sixty (60) day periods. The patient must be certified as terminally ill by hospice standards at the beginning of each period.

An individual may not designate an effective date earlier than the date that the revocation is made.

K-211.7 Notification of Termination

The Department must be notified via the [HFS 1594 - Notification to HFS of Illinois Medicaid Hospice Benefit Election](#) when a patient terminates hospice care.

A hospice may “discharge for cause” only in limited circumstances. These situations are identified in 42 CFR Part 418.26.

K-212 Concurrent Palliative and Curative Care for Children Receiving the Hospice Benefit

Section 2302 of the Affordable Care Act, titled “Concurrent Care for Children,” amends sections 1905(o)(1) and 2110(a)(23) of the Social Security Act to remove the prohibition of receiving curative treatment upon election of the hospice benefit for a Medicaid or Children’s Health Insurance Program (CHIP) eligible child.

Eligible children through age 20 may elect to receive the hospice benefit, but also continue to be eligible to receive covered curative treatment.

This policy does not change the criteria for electing the hospice benefit, nor change the process for hospitals to contact the hospice regarding payment of hospital admissions as denoted in Topic K-234.1.

K-230 Covered Services

The Department covers four types of hospice care: routine home care, continuous home care, general inpatient care and respite care. In addition, the Department covers physician services, a service intensity add-on payment, and nursing home room and board charges related to the hospice patient. Refer to Topic K-250 for further information on these categories of care.

To be covered, hospice services must meet the following requirements:

- The services must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions.
- The individual must elect hospice care in accordance with Topic K-211 and a plan of care must be established as set forth in Topic K-211.3 before services are provided.
- The services must be consistent with the plan of care.
- A certification that the individual is terminally ill must be completed as set forth in Topic K-211.1.

K-232 Core Services

Physician services, nursing care, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees. Supplemental services may be contracted during periods of peak patient loads and to obtain physician specialty services. These contractual services are the responsibility of the hospice provider and are included in the all-inclusive rate.

K-232.1 Physician Services

A doctor of medicine or doctor of osteopathy must perform the function of the hospice medical director and/or the physician member of the interdisciplinary group. Services include administrative and general supervisory activities performed by physicians who are employees of, or working under arrangements made with, the hospice.

K-232.2 Nursing Services

Nursing care is to be provided by or under the supervision of a registered nurse.

K-232.3 Counseling Services

Counseling services may be provided to the terminally ill patient and the family members or other persons caring for the patient at home. Counseling includes bereavement counseling, provided after the patient's death, as well as dietary, spiritual, and any other counseling services for the individual and family provided while the individual is enrolled in the hospice program.

K-232.4 Medical Social Services

Medical social services must be provided by a qualified social worker, under the direction of a physician.

K-234 Furnishing of Other Services

K-234.1 Short Term Inpatient Care

Inpatient care must be available for pain control, symptom management, and respite purposes, and must be provided in a participating facility.

Under 42 CFR Part 418, services for pain control and symptom management can be provided in:

- A hospital meeting the requirements of Part 418.100 (a) and (e)
- A skilled nursing facility meeting the requirements of Part 418.100 (a) and (e)
- A hospice that can provide inpatient care directly, in compliance with all standards under Part 418.100

Contracting for hospital general inpatient services and reimbursing the hospital for these services is the responsibility of the hospice provider if the hospitalization is for palliative care related to the terminal illness of the patient. When a hospice patient is placed in a hospital, the hospital must send the bill to the hospice.

- In the case of an adult age 21 and over, if the hospice determines that the service was not related to the terminal illness, the hospice must return the bill to the hospital with a written statement explaining the bill is being denied. The hospital must attach the denial letter to its UB-04 claim form when it is submitted to the Department.
- Children through age 20 are allowed to receive curative as well as palliative care concurrently. If the hospice determines that the child's service was not related to the terminal condition, or was related but curative in nature, the hospice must return the bill to the hospital with a written statement explaining the bill is being denied. The hospital must attach the denial letter to its UB-04 claim form when it is submitted to the Department.

The Department cannot pay the hospital's claim without the denial letter from the hospice.

Under 42 CFR Part 418, services for respite care can be provided in:

- A Medicare-certified hospital meeting the requirements of Part 418.100 (b) and (e) regarding 24-hour nursing services and patient areas.
- A Medicare-certified skilled nursing facility meeting the requirements of Part 418.100 (b) and (e)
- A Medicare-certified hospice that can provide inpatient care directly, in compliance with all standards under Part 418.100.
- A Medicare or Medicaid-certified nursing facility that meets the standards specified in 42 CFR Part 418.110(e).

K-234.2 Medical Equipment, Supplies, Drugs and Biologicals

Drugs and biologicals that are used primarily for the relief of pain and symptom control related to the patient's terminal illness are included in the daily rate. Durable medical equipment, appliances and other self-help and personal comfort items related to the palliation or management of the patient's terminal illness are to be provided as needed. Equipment is provided by the hospice for use in the patient's home while the patient is under hospice care. Medical supplies include those that are part of the written plan of care.

K-234.3 Home Health Aide, Hospice Aide and Homemaker Services

Home health aides or hospice aides may provide personal care services, and perform household services such as changing the bed, light cleaning and laundering essential to the comfort and cleanliness of the patient to maintain a safe and sanitary environment in areas of the home used by the patient. These services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the patient to carry out the activities of daily living outlined in the plan of care.

K-234.4 Therapy Services

Physical therapy, occupational therapy and speech-language pathology services may be provided for the purpose of symptom control or to enable the patient to maintain activities of daily living and basic functional skills.

K-240 Non-Covered Services

Certain services are not covered in the scope of the Medical Assistance Program and payment cannot be made for their provision to participants. Refer to [89 Illinois Administrative Code Section 140.6](#) for a list of non-covered services.

Per [89 Ill. Admin Code Section 140.469\(h\)](#), for adults 21 years of age and over, the following services are not covered for **non-hospice providers** serving patients enrolled in the Department's hospice program:

- Dental Services
- Optometric Services and Eyewear
- Nursing Services Provided by Registered Nurses and Licensed Practical Nurses
- Occupational, Physical, and Speech Therapy Services
- Audiology Services
- General Clinic Services
- General Hospital Outpatient Services (Ambulatory Procedures Listing Services)
- Hospital Psychiatric Clinic Type A and Type B Services
- Hospital Outpatient Physical Rehabilitation Services
- Mental Health Rehabilitation Option Services
- Alcohol and Substance Abuse Rehabilitation Services
- Medical Equipment and Supplies
- Social Work and Psychological Services
- Home Health Services
- Homemaker Services
- Palliative Drugs

Physician and nurse practitioner services will be reimbursed only if the provider identifies the service as not related to the terminal illness by using the “GW” modifier with the procedure code billed.

K-250 Hospice Reimbursement – All Inclusive Rate

The Centers for Medicare and Medicaid Services (CMS) establishes payment amounts for the following specific categories of covered hospice care: routine home care, continuous home care, service intensity add-on, inpatient respite care and general inpatient care. The Department establishes payment amounts for physician services and nursing home room and board.

Medicaid hospice payment rates are calculated based on the annual hospice rates established under Medicare. These rates are authorized by Section 1814(i)(1)(C)(ii) of the Social Security Act, which also provides for an annual increase in payment rates for hospice care services. Hospice physician services are not increased under this provision.

CMS determines base rates. Actual payment amounts for routine home care, continuous home care and service intensity add-on are based upon the geographic location (Core-Based Statistical Area) where the service is furnished. Hospice providers must use the appropriate Value Code and CBSA on their claims to identify the location where the routine home care or continuous home care services were provided. Each CBSA is assigned a wage index that reflects local geographical differences in wage levels. Payment is determined when the wage index is added to the payment calculation for each service. The listing of CBSAs and corresponding wage indices is announced annually in the *Federal Register*. The Department posts the CBSAs pertinent to Illinois, with current [reimbursement information](#), on the website.

Rates for general inpatient care and inpatient respite care are based upon the CBSA **where the inpatient facility is located**. Hospice providers must use the appropriate Value Code and CBSA on their claims to identify the location of the inpatient facility.

Payment is made for only one of the following categories of hospice care: routine home care, continuous home care, general inpatient care or inpatient respite care on a particular day. A service intensity add-on payment may be billed with routine home care in the last seven days of life if certain criteria are met as defined in Topic K-250.6.

K-250.1 Routine Home Care – Revenue Code 0651

Routine Home Care is applicable for each day the patient (1) remains in his residence, (2) is under the care of the hospice and (3) is not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day. The place of residence may be either a private home or a long-term care facility.

Effective with dates of service on and after January 1, 2016, the Department will reimburse routine home care on a two-tier system. Days 1 through 60 will be paid based upon a higher rate, while days 61 and beyond will be paid at a lower rate.

For patients who have hospice elections on file on and after November 2, 2015 (within 60 days preceding January 1, 2016), the Department will look back to those elections to calculate the initial 60 days of hospice RHC. Of the initial 60 days, only services provided on and after January 1, 2016 will be paid at the higher rate.

The eligibility for these rates follows the **patient** eligibility and not the hospice provider billed on the claims. For a hospice patient who has been discharged and readmitted to hospice within 60 days of that discharge, the prior hospice days will continue to follow the patient in the determination of the appropriate rate. 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 and the patient will requalify for the higher rate.

K-250.2 Continuous Home Care – Revenue Code 0652

Continuous Home Care requires a minimum of eight (8) hours of care during a 24-hour day that begins and ends at midnight. The care does not need to be consecutive but must total at least eight (8) hours; i.e., four (4) hours in the morning and four (4) hours in the evening.

Continuous home care is reimbursed by the quarter-hour. The quarter-hour rate will be reimbursed for every quarter-hour or part of a quarter-hour of continuous home care provided up to 24 hours a day. If the hospice bills less than a total of 32 quarter-hour units (eight hours) in a day, the claim will not be rejected, but will be paid at the routine home care rate.

Continuous home care is provided during a period in which a patient requires continuous care that is primarily nursing care to achieve palliation or management of acute medical symptoms. A registered nurse, a licensed practical nurse, a home health aide or a homemaker may provide care; however, a registered nurse or a licensed practical nurse must provide care for more than half of the period of continuous care. **Continuous home care is covered only when it is provided to maintain a patient at home during a medical crisis.** Hospices must keep appropriate documentation to support this level of care as medically necessary. Suspected abuse of this benefit may warrant Department referral for audit.

K-250.3 Inpatient Respite Care – Revenue Code 0655

Inpatient respite care is applicable for each day in which the patient is in an approved inpatient facility (see Topic K-234.1) and is receiving respite care. Respite care is short-term inpatient care provided to the patient when, in the opinion of the attending physician, it is necessary to relieve the family members or other persons caring for the patient at home. This must be documented in the patient's medical record.

Respite care may be provided only on an occasional basis and may not be reimbursed for more than five (5) consecutive days at a time including the date of admission but not counting the date of discharge. Charges for the sixth (6th) and any subsequent days are to be made at the routine home care rate. On the day of discharge from an inpatient unit, the appropriate home care rate is to be billed unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient respite rate is to be billed for the discharge date.

K-250.4 General Inpatient Care – Revenue Code 0656

General inpatient care is applicable for each day the patient receives inpatient care for a condition related to the patient's terminal illness. See Topic K-234.1 for the facilities where these services may be provided.

On the day of discharge from an inpatient unit, the appropriate home care rate is to be billed unless the patient dies as an inpatient. When the patient is discharged deceased, the general inpatient rate is to be billed for the discharge date.

K-250.5 Physician Services – Revenue Code 0657

Physician services provided by a physician who is an employee of the hospice, or by arrangement with the hospice provider, will be reimbursed based on the State maximum reimbursement, or the physician's usual and customary fee, whichever is less, unless the patient care services are furnished on a volunteer basis.

This reimbursement is in addition to the hospice per diem rate, and excludes those services performed by the physician serving as medical director and/or the physician member of the hospice interdisciplinary group.

The costs of services of the medical director and/or the physician member of the interdisciplinary group are included in the reimbursement rates for routine home care, continuous home care and inpatient respite care.

K-250.6 Service Intensity Add-on Payment – Revenue Codes 055X and 056X

Effective with service From Dates on and after January 1, 2016, an SIA payment may be billed for visits by a social worker or registered nurse (personnel defined in

[42 CFR Part 418.114](#)), when provided during routine home care during the last seven days of life. The SIA payment is in addition to the RHC payment. The SIA hourly rate is derived from the hospice Continuous Home Care hourly rate and is payable in 15-minute increments (one unit = 15 minutes).

The eligible SIA payment revenue lines may only encompass **at a maximum** the last seven days of life. The maximum number of hours allowed per day is four hours (16 units) for either the social worker services or registered nurse services or a combination of the two services. If more than 16 units per day are billed for **either** 055X or 056X, the claim will reject. If the combination of 055X & 056X exceeds 16 units per day, the additional units will be ignored, as long as neither 055X nor 056X exceed the maximum individually. If the number of SIA days billed is less than seven, the provider may only bill the maximum units allowed per day. To receive the SIA, the claim must contain routine home care Revenue Code 0651.

Billing for Registered Nurse Services – Services provided by a registered nurse must be billed with HCPCS code G0299 and Revenue Code 055X.

Billing for Social Work Services – Services provided by a social worker must be billed with HCPCS code G0155 and Revenue Code 056X. This service may not be provided by a social worker via telephone.

If SIA days cross calendar months, the Department must have the initial month's claim in payable status before the hospice bills the last claim identifying patient death. The Department will run a monthly report on participants where the following conditions are met:

- The Department received a claim identifying patient death.
- The patient had SIA days in the month of death.
- The patient mathematically could have received SIA days in the previous month.

The Department will make payment adjustments for those earlier claims to reimburse the hospice for the SIA days billed on the initial claim. The Adjustment Reason Code appearing on the Remittance Advice for these claims will be 3566 – Service Intensity Add-on Adjustment.

Any SIA date must be tied to a date for RHC in order to be reimbursed. Revenue code 0651 (RHC) associated with an SIA day, plus revenue codes 055X (registered nurse service) and/or 056X (social work service), **must be billed by individual service date**. If there are no SIA days associated with specific RHC days, RHC revenue code 0651 may be billed for multiple service units (FL 46).

K-250.7 Nursing Home Room and Board Charges – Revenue Code 0658

Section 1905 (o)(3) of the Social Security Act mandates that the Department provide payment to the hospice agency for nursing home room and board charges for long

term care (LTC) facility residents receiving hospice care. The LTC facility cannot bill hospice patients' nursing home room and board charges directly to the Department. The hospice is responsible for paying the facility.

Contracts between hospice providers and long term care facilities should specify the responsibilities of the hospice provider for reimbursing the facility in a timely manner for the room and board charges. Disputes regarding payment of the room and board charges must be resolved between the long term care facility and the hospice provider.

For long term care patients, including residents of a Supportive Living Facility (SLF), who are eligible for Medicare Part A, the hospice must bill Medicare for the hospice care and physician services. However, the hospice must still send in a notification of election to the Department identifying the patient's actual hospice election date, so that information may be put in Department files. The Department does not cover the room and board of patients residing in a SLF.

Room and board services include the performance of personal care services, assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies. Also included are medical supplies and over-the-counter medications.

The Department reimburses the hospice provider a rate equal to ninety-five percent (95%) of the facility's Department calculated per diem rate for basic care minus any patient income. This patient income is known as patient credit, and is determined by the patient's DHS local office (Family Community Resource Center, or FCRC).

If a patient resides in more than one LTC facility in a billing period, the hospice must split its claim and submit bills according to dates the patient is in each facility. If the patient is discharged and readmitted to the same facility, separate claims must also be submitted. This will ensure correct reimbursements for the nursing home room and board payment.

No reimbursement will be authorized for a bed hold fee for a LTC hospice patient.

K-260 Payment Process

K-260.1 Charges

Charges billed to the Department must be the provider's usual and customary charge billed to the general public for the same service or item. Providers may only bill the Department after the service has been provided.

To be paid for services, all claims, including claims that are corrected and resubmitted, must be received within 180 days of the date of service.

Charges for hospice services must be submitted to the Department on a UB-04 paper claim form or in the X12 837 Institutional claim format.

Covered services must be billed to the Department using ICD-10 diagnosis codes.

Charges for services and items provided to participants enrolled in a Managed Care Managed Care Organization (MCO) or Managed Care Community Network (MCCN) must be billed to that entity according to the contractual agreement with the MCO or MCCN. Information regarding MCOs and MCCNs can be found on the [HFS Care Coordination web page](#).

K-260.2 Claim Preparation and Submittal

Refer to Chapter 100 for general policy and procedures regarding claim submittal. Appendix K-2 contains specific billing instructions for hospice providers.

Hospice claims may be billed for services spanning up to one (1) calendar month. Claims are to be submitted after third party resources have been billed. As the Department is the payer of last resort, providers are to bill any known third party first. If at the end of thirty (30) days from the date of the TPL billing, no response has been received, or if a response has been received advising of the amount of the TPL payment, the provider may bill the Department in accordance with instructions in Appendix K-2. The Department's TPL status codes are identified in Appendix K-2.

For electronic claims submittal, refer to Topic K-260.3 below. Claims requiring an attachment may not be electronically submitted.

K-260.3 Electronic Claim Submittal

Refer to [Chapter 100](#) for general policy and procedures regarding claim submittal.

Any services that do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in [Chapter 300](#), 5010 Companion Guide.

Providers billing electronically should take special note of the requirement that Form HFS 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three (3) years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form HFS 194-M-C can be found on the last page of each Remittance Advice that reports the disposition of any electronic claims. Refer to Chapter 100 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, providers should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor if the Department determines that the service rejections are being caused by the submission of incorrect or invalid data.

K-260.4 Payment

All claims adjudicated by the Department will be identified on the HFS 194-M-2, Remittance Advice. The Remittance Advice is sent to the hospice's payee address on file with the Department. Refer to Chapter 100 for payment procedures utilized by the Department and explanations of Remittance Advice detail provided to providers.

K-260.5 Payment Adjustments

Policy and procedures regarding payment adjustments are provided in Chapter 100. Adjustments may be initiated only for a service for which payment has been made by the Department and reported on the Remittance Advice. It cannot be used to correct a rejected service or a suspended claim. Hospices are to use the [HFS 2249](#) adjustment form for services previously paid. Completed adjustment forms should be mailed to the following address at the Department for processing:

Illinois Department of Healthcare and Family Services
MMIS Adjustments
P.O. Box 19101
Springfield, Illinois 62794-9101