Handbook for Hospice Agencies

Chapter K-200 Policy and Procedures For Hospice Services

Illinois Department of Healthcare and Family Services

CHAPTER K-200

Hospice Services

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FOREWORD

PURPOSE

This handbook has been prepared for the information and guidance of hospice providers who provide items or services to participants in the Department's Medical Programs. It also provides information on the Department's requirements for provider participation and enrollment.

This handbook can be viewed on the Department's Web site at:

http://www.hfs.illinois.gov/handbooks/chapter200.html

This handbook provides information regarding specific policies and procedures relating to hospice services.

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 will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the Department's Medical Programs. The updates will be posted to the Department's Web site at:

http://www.hfs.illinois.gov/releases/

Providers will be held responsible for compliance with all policy and procedures contained herein.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Comprehensive Health Services at 877-782-5565.

CHAPTER K-200

HOSPICE SERVICES

K-200 BASIC PROVISIONS

For consideration for payment by the Department for hospice services, a provider enrolled for participation in the Department's Medical Programs must provide such services. Services provided must be in full compliance with both the general provisions contained in the Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures at http://www.hfs.illinois.gov/handbooks/chapter100.html 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 wishing to submit X12 electronic transactions must refer to Chapter 300, Handbook for Electronic Processing at http://www.hfs.illinois.gov/handbooks/chapter300.html

Chapter 300 identifies information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other healthcare 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).

The hospice provider must be enrolled for the specific category of service for which the charges are to be made:

Category 60 – Routine Home Care
Category 61 – General Inpatient Care
Category 62 – Continuous Care
Category 63 – Respite Care

Procedure: The provider must complete and submit:

- Form HFS 2243 (Provider Enrollment/Application)
- Form HFS 1413 (Agreement for Participation)
- W9 (Request for Taxpayer Identification Number)

These forms may be obtained from the Provider Participation Unit. E-mail requests for enrollment forms should be addressed to:

hfs.ppu@illinois.gov

Providers may also call the unit at 217-782-0538 or mail a request to:

Illinois Department of Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114
http://www.hfs.illinois.gov/enrollment/

The forms must be completed (printed in ink or typewritten), signed and dated in ink by the provider, and returned to the above address. The provider should retain a copy of the forms. The date on the application will be the effective date of enrollment unless the provider requests a specific enrollment date and it is approved by the Department.

Participation approval is not transferable - When there is a change in ownership, location, name, or a change in the Federal Employer's Identification Number, a new application for participation must be completed. Claims submitted by the new owner using the prior owner's assigned provider number may result in recoupment of payments and other sanctions.

K-201.2 PARTICIPATION APPROVAL

When participation 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 participation 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 participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out 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 are to be corrected and the Department notified immediately.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid the Department is to be notified. When possible, notification should be made in advance of a change.

Procedure: The provider is to line out the incorrect or changed data, enter the correct data, sign and date the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

Illinois Department of Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

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, Topic 110 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

Refer to Chapter 100, Topic 110.2 for information pertaining to the required retention period of medical records.

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

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 (either directly or under arrangement) 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; or room and board by a nursing facility if the individual is a resident.
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.

The hospice must notify the Department after an eligible participant elects hospice care.

The hospice may forward a copy of the patient's official Notice of Election to hospice care, or list the patient on letterhead or plain paper. The following information must be included:

- The name, address, provider number, and telephone number of the hospice agency.
- The patient's name as it appears on the patient's medical card.
- The patient's recipient identification number, date of birth, and date of election to hospice care.

Do **not** use the institutional claim format for notification of election. 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.

Allow two (2) weeks after submitting an election statement 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.

The hospice notice of election will remain open on the Department's database as long as the patient is eligible, or until the hospice notifies the Department of an end date. If the patient's eligibility 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 notice of election will need to be submitted to the Department to update the hospice election period on the Department's file.

Notices of election may be mailed or faxed to the Department. The mailing address is:

Illinois Department of Healthcare and Family Services
Bureau of Comprehensive Health 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 a notification of termination (see Topic K-211.7) and the receiving hospice must submit a 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 when a patient terminates hospice care. The following information must be included:

- The hospice provider's name, address, telephone number, and provider number;
- The patient's name as it appears on the medical card, the Recipient Identification Number, and the patient's date of birth;
- Date of termination;
- The reason for termination: death, revocation, transfer to another hospice, decertification, non-recertification, or "discharge for cause" by the hospice.

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

Notices of termination may be mailed or faxed to the Department. The mailing address is:

Illinois Department of Healthcare and Family Services
Bureau of Comprehensive Health 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-230 COVERED SERVICES

The Department covers the four types of hospice care: routine home care, continuous home care, general inpatient care, and respite care. In addition, the Department covers physician services 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:

- They 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 related to the terminal illness of the patient.

When a hospice patient is placed in a hospital, the hospital must send a bill to the hospice. If the hospitalization was not related to the terminal illness, the hospice will return the bill to the hospital with a written statement explaining the bill is being denied because the hospitalization was not related to the terminal illness of the patient. The hospital will then submit an inpatient claim to the Department with the denial letter attached. 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 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

Although the CFR also identifies an intermediate care facility as an approved facility for respite purposes, Illinois Department of Public Health hospice rules under 77 Illinois Administrative Code Part 280, Hospice Programs, do not. Therefore, respite services are not billable if provided in an ICF.

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 AND HOMEMAKER SERVICES

Qualified home health aides must furnish home Health Aide (HHA) services. Home health aides may provide personal care services, perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed, light cleaning and laundering essential to the comfort and cleanliness of the patient. HHA 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 the Handbook for Providers of Medical Services, Chapter 100, General Policy and Procedures Topic 104 for a list of non-covered services.

Services not covered under the scope of the Hospice Program include services received for the treatment of an illness or injury not related to the individual's terminal condition. These services will be billed by the providers rendering these services, and be reimbursed separately under the Department's Medical Programs.

K-250 HOSPICE REIMBURSEMENT - ALL INCLUSIVE RATE

The Centers for Medicare and Medicaid Services (CMS) establishes payment amounts for four specific categories of covered hospice care: routine home care, continuous home care, 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 and continuous home care 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 published annually in the *Federal Register.* The Department posts the CBSAs pertinent to Illinois, with current rate information, on the Web site at <http://www.hfs.illinois.gov/reimbursement/>.

For dates of service through December 31, 2007, rates for general inpatient care and inpatient respite care are based upon the CBSA where the hospice provider is located. These rates are standard regardless of the CBSA where the service is rendered, and are identified for each provider on the Provider Information Sheet. The Provider Information Sheet is generated by the Department and mailed to each provider when rates are updated.

For dates of service beginning January 1, 2008, 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 categories of hospice care (routine home care, continuous home care, general inpatient care, or inpatient respite care) on a particular day.

K-250.1 ROUTINE HOME CARE - REVENUE CODE 0651

Routine Home Care is applicable for each day the patient remains in his residence, is under the care of the hospice and 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.

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.

For dates of service prior to January 1, 2007, continuous home care is reimbursed at an hourly rate for every hour or part of an hour of continuous home care provided by the hospice, up to 24 hours a day. For dates of service on and after January 1, 2007, 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. For dates of service on and after January 1, 2007, 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.

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 (6^{th}) 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 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 eligible for Medicare Part A, the hospice must bill Medicare for the four (4) levels of 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.

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.

Charges for services and items provided to participants enrolled in a Managed Care Organization (MCO) must be billed to the MCO according to the contractual agreement with the MCO.

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

K-260.2 CLAIM PREPARATION AND SUBMITTAL

Refer to Chapter 100, Topic 112, 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

Any services that do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claim submittal can be found in Chapter 100, Topic 112.3.

> 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, Topic 130.5 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-1, Remittance Advice. The Remittance Advice is sent to the hospice's payee address on file with the Department. Refer to Chapter 100, Topics 130 and 132, for payment procedures utilized by the Department and General Appendix 7 for explanations of Remittance Advice detail provided to providers.

K-260.5 PAYMENT ADJUSTMENTS

General policy and procedures regarding payment adjustments are provided in Chapter 100, Topic 132. Chapter 100, General Appendix 6 provides specific information concerning the use of the adjustment form as it pertains to UB claims.

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