

**Redding**  
 San Jose Oakland  
 Vacaville Eureka  
 Paradise Chico  
 Citrus Heights  
 Thousand Oaks  
 San Francisco  
 Salinas  
 Sunnyvale Seaside  
 Ventura  
 Carmel  
 Hayward  
 Santa Clarita  
 Humboldt  
 Fort Bragg Mendocino Marin  
**Sacramento**  
 San Luis Obispo Bishop  
 Santa Ana Fairfield  
 Ione Walnut Creek  
 Tahoe City Bieber Eagleville  
 Folsom  
 Elk Grove  
 Adin  
**Escondido**  
 Oxnard  
 Solvang  
 Santa Barbara  
**Visalia**  
 Huntington Beach  
 Victorville Weed  
 Barstow Baker  
 Salinas  
 Simi Valley  
 San Andreas  
**Ontario**  
 Mojave  
**Pasadena**  
 Indio  
 Lancaster  
 Fresno Alhambra  
 Torrance Hemet  
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**Concord**  
**Long Beach**  
 Vista San Clemente Julian  
 Chula Vista Alpine  
 San Marcos  
 San Diego

**Medi-Cal**

**Provider**

**Training**

**2024**

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Home Health & Hospice  
Care Program



The Outreach and Education services is made up of Provider Field Representatives located throughout California and includes the Small Provider Billing Assistance and Training Program staff, who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment. See the below additional tools and free services available to your provider community.

### Medi-Cal Learning Portal (MLP)

Explore the Medi-Cal Learning Portal (MLP) that offers Medi-Cal providers and billers self-paced online training about billing basics, related policies and procedures; new initiatives and any significant changes to the Medi-Cal program.

#### How can you get started using the MLP?

- First time users must complete a one-time registration at [www.learn.medi-cal.ca.gov](http://www.learn.medi-cal.ca.gov)
- After logging in, you will be able to RSVP for training events or view eLearning courses
- Refer to the Medi-Cal Learning Portal (MLP) Job Aid or the Medi-Cal Learning Portal (MLP) User Guide for detailed instructions

#### How can you benefit from using the MLP?

- Significantly reduce billing errors by learning billing best practices
- Quizzes that test your knowledge
- Practice your skills using interactive activities

## **Free Services for Providers**

### Provider Seminars and Webinars

Provider Training Seminars and Webinars offer basic and advanced billing courses for all provider types. Seminars also offer a free billing assistance called the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Provider Field Representative. The dates and locations for the annual provider training seminars and webinars can be found on the events calendar in the MLP tool and in the News area on [www.medi-cal.ca.gov](http://www.medi-cal.ca.gov).

### Provider Field Representatives

Receive one-on-one assistance from Provider Field Representatives who live and work in cities throughout California. Provider Field Representatives are available to visit providers at their office to assist with billing needs and/or provide custom billing training to office staff.

### Small Provider Billing Assistance and Training Program

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

All of the aforementioned services are available to providers at no cost!



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# Home Health Agencies & Home and Community-Based Services

## Introduction

### Purpose

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

### Objectives

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

### Acronyms

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

# Home Health Program Description

An HHA is a public agency that is primarily engaged in providing skilled services as outpatient services prescribed by a physician and provided at the recipient's home. Services are conducted in accordance with a written treatment plan and are reviewed by a physician every 60 days. The treatment plan must indicate a need for one or more of the following services:

- Part-time or intermittent skilled nursing service by licensed nursing personnel
- In-home medical care services as defined in the *Welfare and Institutions Code* (W&I Code) Section 14132(t)
- Physical, occupational or speech therapy
- Medical social services
- Home health aide services
- Medical supplies other than drugs and biologicals
- Other home health services
- The use of medical appliances, provided for under an approved treatment plan

**Note:** Durable Medical Equipment (DME), such as an infusion pump, is reimbursable only when billed by a valid DME provider. DME cannot be billed by an HHA provider.

# Policies

## Coverage Requirements

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

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

## Electronic Visit Verification (EVV)

The EVV system verifies that all Medi-Cal funded Personal Care Services (PCS) and Home Health Community Services (HHCS) that require an in-home visit are captured using six identified data elements. EVV is a telephone and computer-based solution that electronically verifies all in-home service visits occur. The six data elements that must be captured are listed below:

1. Type of service performed
2. Individual receiving service
3. Date of service
4. Location of service delivery
5. Individual providing service
6. Time service began and ended

Visit the [Electronic Visit Verification](#) page on the DHCS website for up-to-date guidance and information related to the implementation of EVV in California.



# Home Health Agencies Billing Codes

For additional billing information, refer to *Home Health Agencies (HHA) Billing Codes and Reimbursement Rates* (home hlth cd) section in Part 2 of the Medi-Cal provider manual.

**Table of Home Health Agencies Billing Codes**

<b>Current CPT/HCPCS Level II Code Description</b>	<b>Revenue Code Description</b>	<b>Current CPT/HCPCS Level II Code Description</b>
A9999 (Miscellaneous DME supply or accessory, not otherwise specified)	0270 (medical/surgical supplies)	As authorized/TAR required
G0088 (Professional services, initial visit, for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological in the individual's home, each 15 minutes)	Not applicable	As authorized/TAR required
G0089 (Professional services, initial visit, for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological in the individual's home, each 15 minutes)	Not applicable	As authorized/TAR required
G0151 (services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes)	0421 (physical therapy/visits)	As authorized, or as necessary to complete initial or six month case evaluation (HCPCS code G0162 and revenue code 0583)
G0152 (services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes)	0431 (occupational therapy/visit)	Same as previous

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Page updated: February 2023

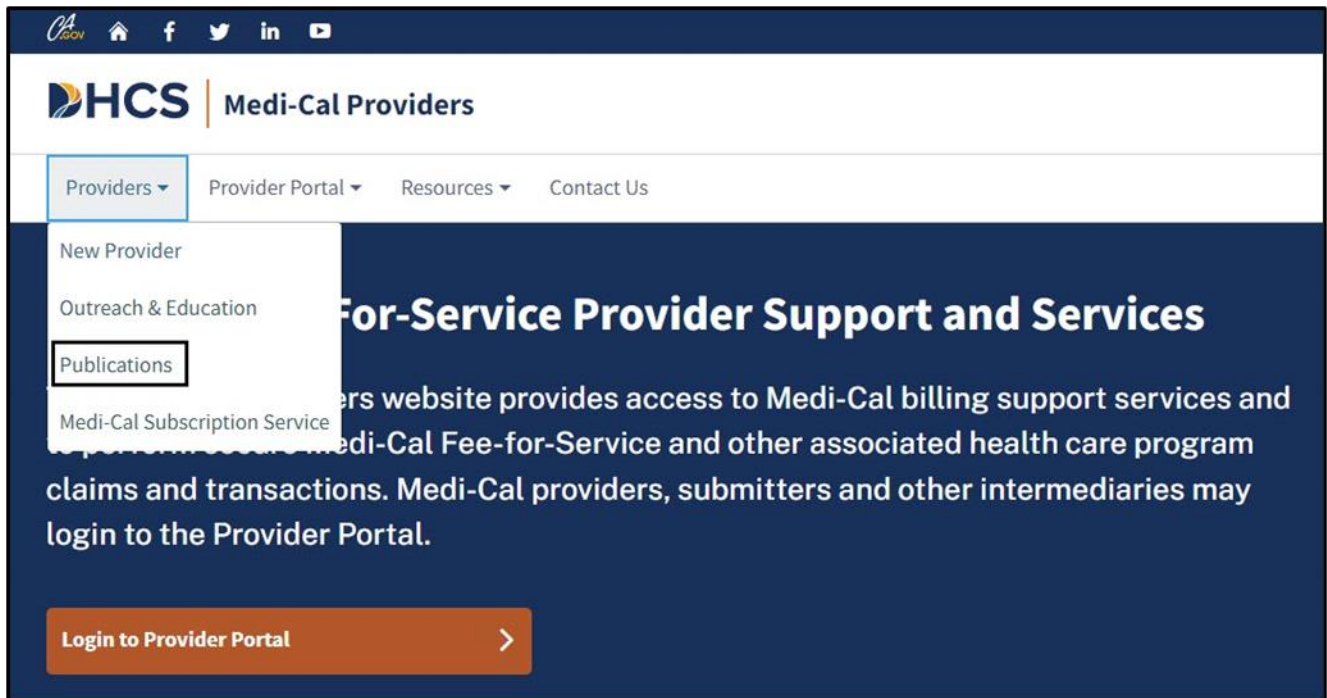
**Table of Home Health Agencies Billing Codes (continued)**

<b>Current CPT/HCPCS Level II Code Description</b>	<b>Revenue Code Description</b>	<b>Current CPT/HCPCS Level II Code Description</b>
G0153 (services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes)	0441 (speech pathology/visit)	Same as previous
G0155 (services of clinical social worker in home health or hospice settings, each 15 minutes)	0561 (medical social services/visit)	Same as previous
G0156 (services of home health/hospice aide in home health or hospice setting, each 15 minutes)	0571 (aide/home health/visit)	As authorized/TAR required
G0162 (skilled services by a registered nurse [RN] in delivery of management/evaluation of plan of care, each 15 minutes)	0583 (visit/home health/assessment)	Four in six months (1 hour)/TAR not required
G0162 (same as previous)	0589 (visit/home health/other)	Four in six months (1 hour)/TAR not required
G0299 (direct skilled nursing services of RN in home health or hospice setting, each 15 minutes)	0551 (skilled nursing/visit)	As authorized, or as necessary to complete initial or six-month case evaluation (HCPCS code G0162 and Revenue Code 0583)
G0300 (direct skilled nursing services of a Licensed Practical Nurse (LPN) in home health or hospice setting, each 15 minutes)	0551 (skilled nursing/visit)	Same as previous
99501 (home visit for postnatal assessment and follow-up care)	0580 (visit/home health)	Once in six months/TAR not required
99502 (home visit for newborn care and assessment)	0580 (visit/home health)	Once in six months/TAR not required
99600 (unlisted home visit service or procedure)	0589 (visit/home health/other)	As authorized/TAR required

# Accessing the Medi-Cal Provider Homepage

The Medi-Cal Provider website home page can be accessed by opening an internet browser, typing [mcweb.apps.prd.cammis.medi-cal.ca.gov](http://mcweb.apps.prd.cammis.medi-cal.ca.gov) in the address bar and press **Enter**.

To access provider communities and their associated reference materials, navigate to Publications from the Providers drop-down menu.

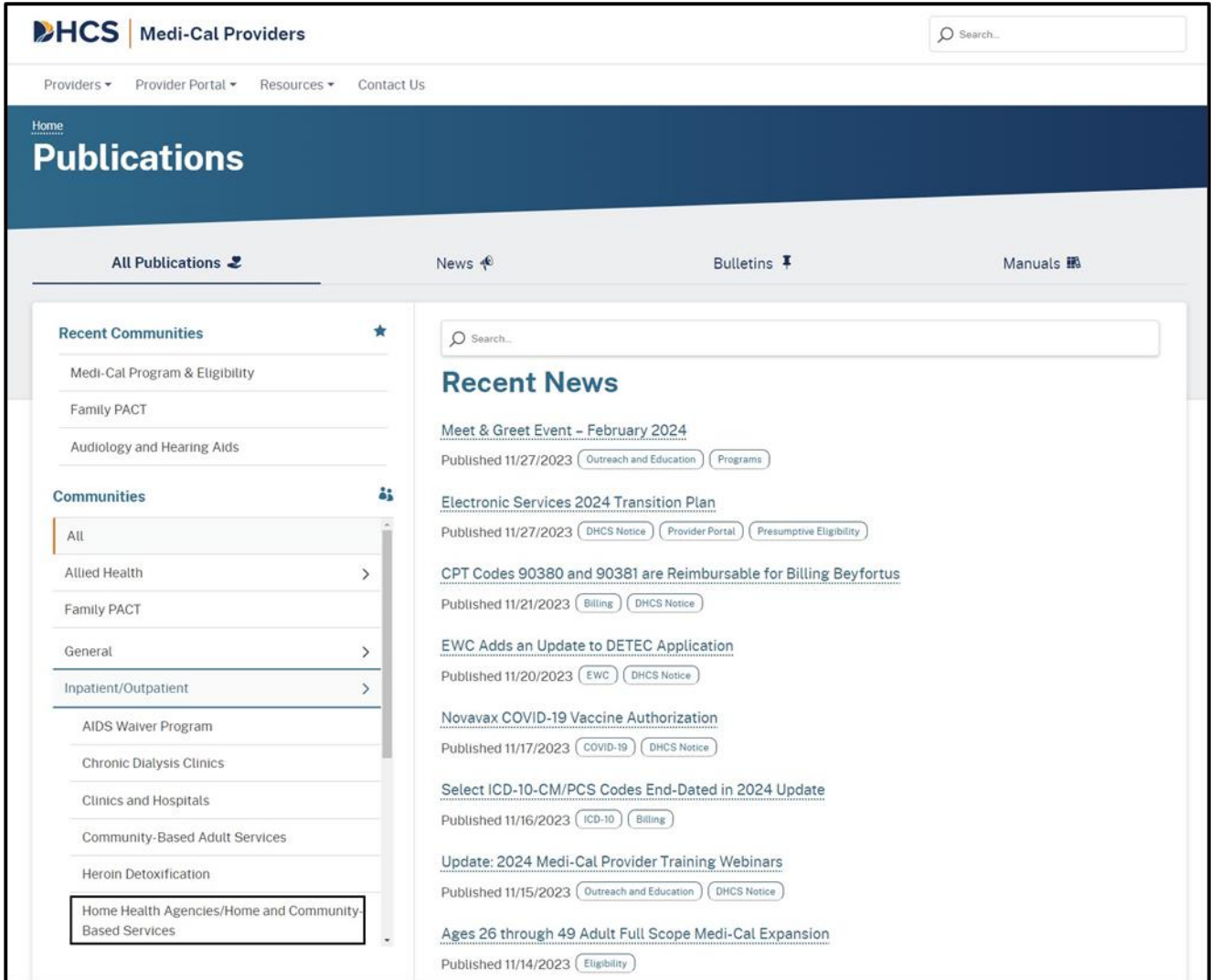


**Figure 1.1:** The Providers drop-down menu on the Medi-Cal Provider homepage.

# A Home Health Agencies & Home and Community-Based Services

Page updated: January 2024

Services offered within Medi-Cal are shown on the Publications page. Navigate to the Inpatient/Outpatient Community and select **Home Health Agencies/Home and Community-Based Services**.



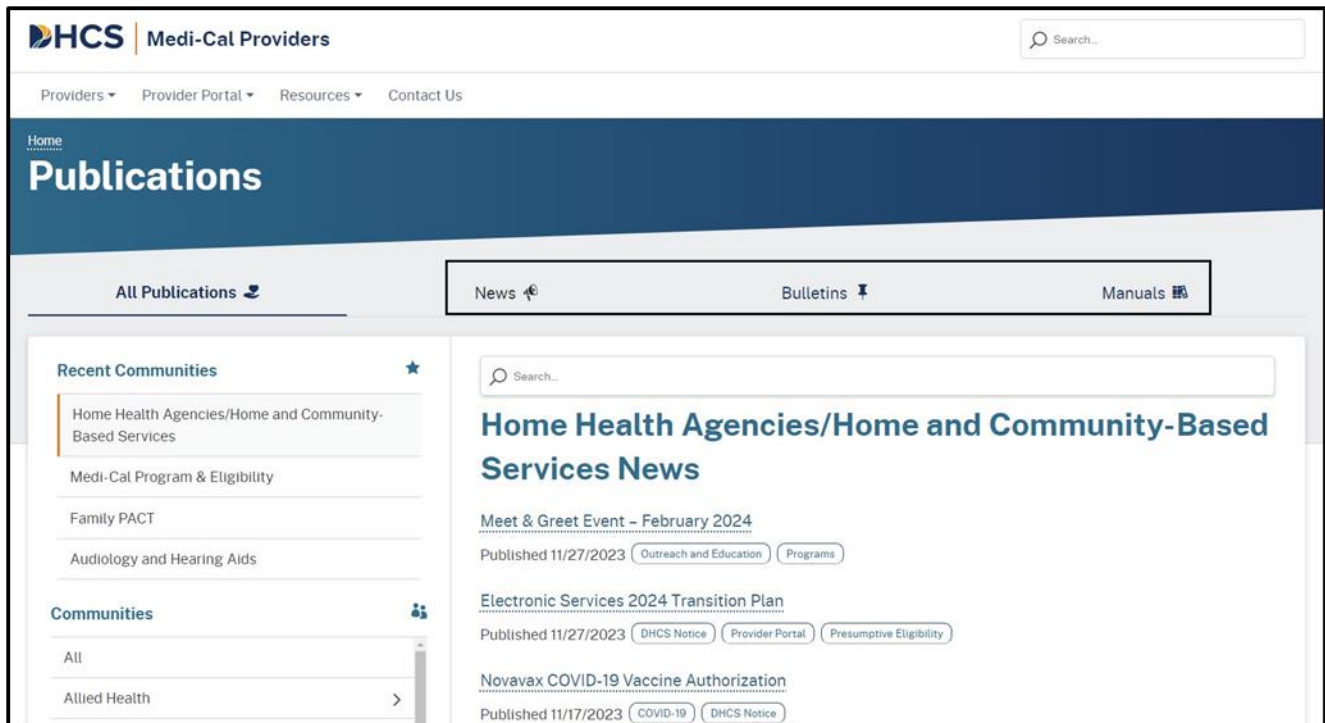
**Figure 1.2:** All provider communicates may be accessed individually from the Medi-Cal Provider Publications homepage.

## A Home Health Agencies & Home and Community-Based Services

Page updated: January 2024

Once you have clicked on your desired provider community, the community-specific page will appear. Every provider community page contains:

- News
- Bulletins
- Provider Manuals



The screenshot displays the HCS Medi-Cal Providers website interface. At the top, the HCS logo and 'Medi-Cal Providers' text are visible, along with a search bar. Below the header, navigation links for 'Providers', 'Provider Portal', 'Resources', and 'Contact Us' are present. The main content area features a dark blue banner with the word 'Home' and the title 'Publications'. A navigation bar below the banner includes 'All Publications' (with a dropdown arrow), 'News' (with a left arrow), 'Bulletins' (with a right arrow), and 'Manuals' (with a document icon). On the left side, there are two sections: 'Recent Communities' with a star icon, listing 'Home Health Agencies/Home and Community-Based Services', 'Medi-Cal Program & Eligibility', 'Family PACT', and 'Audiology and Hearing Aids'; and 'Communities' with a group icon, listing 'All' and 'Allied Health' (with a right arrow). The main content area on the right has a search bar and a heading 'Home Health Agencies/Home and Community-Based Services News'. Below the heading, three news items are listed: 'Meet & Greet Event – February 2024' (published 11/27/2023, tags: Outreach and Education, Programs), 'Electronic Services 2024 Transition Plan' (published 11/27/2023, tags: DHCS Notice, Provider Portal, Presumptive Eligibility), and 'Novavax COVID-19 Vaccine Authorization' (published 11/17/2023, tags: COVID-19, DHCS Notice).

**Figure 1.3:** Publications Navigation Bar serves as a starting point for providers to access published materials for all communities.

# Home Health Agencies Billing

## Physician Treatment Plan

Authorization requests for services beyond the case evaluation require prior approval and must include a written treatment plan that will be approved and signed by a physician within 30 working days of the treatment plan.

Since the ordering physician has 30 working days to sign a written treatment plan, an authorization request may be submitted to the TAR Processing Center with an unsigned written treatment plan. The unsigned written treatment plan must have a physician's verbal order for services, taken and recorded by a health care professional at the time services are ordered. A healthcare professional may be a registered nurse, qualified therapist, social worker or any other health professional responsible for furnishing or supervising care.

The treatment plan must include:

- The principal diagnosis and significant associated diagnoses
- Prognosis
- Date of onset of the illness
- Specific types of services to be rendered by each discipline
- Therapeutic goals to be achieved by each discipline and anticipated time for achievement of goals
- The extent to which HHA care has been previously provided and benefits or improvements demonstrated by such care
- A description of the home situation, to include whether assistance is available from household members, homemakers, attendants or others

A re-authorization request must include a statement describing the recipient's progress toward achieving the therapeutic goals.

**Note:** Upon request, the written treatment plan must be available to Department of Health Care Services (DHCS) staff by providing HHA documenting evidence of the ordering physician's signature within 30 working days of the treatment plan date.

## Face-to-Face Encounter

For all services delivered by a home health agency, a face-to-face encounter with a physician, nurse practitioner, clinical nurse specialist physician assistant or certified nurse midwife that is related to the primary reason the recipient requires the home health services is required. Face-to-face encounters may be done via telehealth.

The following conditions must be met in order for the face-to-face encounter to be satisfied:

- The provider performing the face-to-face encounter must communicate the clinical findings of that face-to-face encounter to the ordering physician.
- The clinical findings from the face-to-face encounter must be incorporated into a written or electronic document included in the recipient's medical record.
- The physician prescribing the home health agency services must document that the face-to-face encounter, which is related to the primary reason the recipient requires services by a home health agency, has occurred within 90 days prior to or within 30 days after the start of services.
- The physician writing the prescription for home health agency services must document who conducted the face-to-face encounter and the date of the encounter.

# Knowledge Review 1

HHA services are provided as outpatient services.

True  False

Treatment plans must be reviewed every:

- a. 15 days
- b. 30 days
- c. 60 days
- d. As appropriate

Most HHA claims require the use of revenue codes when submitting claims for adjudication.

True  False

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

True  False

See Appendix for [Answer Key](#).



## Same Day Services

### Skilled Care Services

When performing any of the skilled care services (HCPCS codes G0151 through G0153, G0299, G0300 and G0155) listed below on the same date of service as the initial or six-month case evaluation (revenue code 0583 and HCPCS code G0162), both services must be billed on the same claim and are reimbursable without authorization. If the skilled care service is billed separately, authorization is required.

Service	HCPCS Code	Revenue Code
Physical therapy	G1051	0421
Occupational therapy	G0152	0431
Speech therapy	G0153	0441
Skilled nursing	G0299 or G0300	0551
Medical social services	G0155	0561

**Note:** Only one skilled care service may be billed in conjunction with the initial evaluation.

### Mother and Baby

Services performed for a mother and baby on the same day require a separate *UB-04* claim form and a separate TAR for each recipient.

- HHA providers who render services to a mother and her newborn(s) during the neonatal period (month of delivery and subsequent month) may be reimbursed without authorization for only one initial skilled nursing visit utilizing revenue code 0551 and HCPCS code G0299 or G0300.
- A case evaluation and initial treatment plan is reimbursable for the mother without authorization using revenue code 0583 and HCPCS code G0162.
- A case evaluation and initial treatment plan for the newborn using the mother's Medi-Cal ID number may be reimbursed without authorization when it is performed on a different date than the mother's case evaluation and initial treatment plan using revenue code 0583 and HCPCS code G0162.
- If more than one visit is necessary or if services are rendered to mother and infant on the same date of service for the month of birth and the following month and the infant is using the mother's ID, authorization is required.

## Home Health Psychiatric Nursing Services

HHA services are excluded from coverage by the Mental Health Program (MHP) as set forth in the *California Code of Regulations (CCR)*. However, home health psychiatric nursing is a skilled nursing service that may be provided by an HHA to a Medi-Cal recipient with a psychiatric illness or condition.

**Note:** HHA psychiatric nursing service visits require the submission of a TAR for approval. The TAR must be accompanied by a written plan of care approved by a physician every 62 days.

Refer to the *Home Health Agencies (HHA)* (home hlth) section in the Part 2 manual for authorization requirements.

The following are examples of psychiatric services that may be provided by a home health nurse:

- Make an initial evaluation using observation and assessment skills
- Evaluate, review and teach the use of medications, emphasizing compliance
- Administer IM or I.V. medication, if necessary
- Manage situational (or other) crises; perform suicidal assessments, as necessary
- Provide psychotherapeutic assessments as ordered by the physician, which may include supportive counseling, behavior modification (for obsessive-compulsive behaviors such as hand washing) and cognitive retraining (positive thinking process)
- Provide psychological education such as teaching/training with disease process, symptom and safety management, coping skills and problem solving

## Home Health Aide Services

Home health aide services (revenue code 0571 and HCPCS code G0156) are both Medicare and Medi-Cal benefits. These services may include personal care and household services that must be billed as part of a physician-approved treatment plan and must be supervised by a registered nurse therapist.

Personal care services include:

- Ambulation
- Bathing
- Catheter site care
- Feeding assistance
- Grooming
- Medical assistance
- Prescribed exercise assistance
- Range of motion exercises
- Skin care
- Transfers out of bed

Certain household services may also be included in the visit if they are incidental to medically necessary services and do not substantially increase the home health aide's service time.

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

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

## Diabetes Prevention Program (DPP) Benefit

Medi-Cal providers who meet the Centers for Disease Control and Prevention (CDC) standards to offer DPP services and wish to render diabetes prevention services in addition to their other Medi-Cal services must submit a *Medi-Cal Supplemental Changes Form* (DHCS 6209) to DHCS. Upon approval, providers will be designated as DPP providers. Only enrolled DPP providers may be reimbursed for DPP services rendered by peer coaches who have been trained to deliver the required curriculum and have the skills, knowledge and qualities specified in the National Diabetes Prevention Program guidelines.

For more information about provider requirements, refer to the *Diabetes Prevention Program* (diabetes) section of the Part 2 manual.

Diabetes prevention services can be offered through the following delivery methods:

- In person: Participants are physically present in a classroom or classroom-like setting and peer coaches provide training.
- Distant learning: Peer coaches deliver sessions via remote classroom where the coach is present in one location and participants are calling or video-conferencing from another location.

**Note:** Providers may refer to the Frequently Asked Questions (FAQs) for DPP services on the DHCS website for additional information.

Providers are required to meet all state and federal translation and interpretation standards. Providers include the following:

- Medi-Cal provider-designated agents
- Public and private agencies and/or individuals engaged in planning, providing or securing Medi-Cal services for recipients seeking diabetes prevention services

**Note:** Information about interpretation and translation services is located in the *Provider Regulations* section of the Part 1 manual.

## DPP Billing Codes

### Core Sessions (months one through six):

A core session is approximately one hour and adheres to the CDC curriculum for core sessions.

HCPCS Code	Description	Notes
G9873	First Medi-Cal DPP core session was attended by a DPP recipient	Payment is without regard to weight loss
G9874	Four total Medi-Cal DPP core sessions were attended by a DPP recipient	Payment is without regard to weight loss
G9875	Nine total DPP core sessions were attended by a DPP recipient	Payment is without regard to weight loss

**Note:** For the complete list of billable codes for core and ongoing maintenance sessions delivered in months 7 thru 24, refer to the *Diabetes Prevention Program* (diabetes) section of the Part 2 manual.

## Medical Supplies

Medical supplies given to Medi-Cal recipients by HHA personnel may be covered as separately reimbursable items subject to authorization. Supplies are separately reimbursable if:

- They are not used as part of a treatment visit (that is, they are left with the recipient for later use)
- They are provided in accordance with the recipient's written treatment plan

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Page updated: September 2020

Under Medi-Cal, the medical supply used in connection with the treatment visit (for example, bandages used to change dressings) is included in the reimbursement for the nursing visit. The reimbursement is intended to include the cost of incidental supplies. Medical supplies can be considered separately reimbursable only when they are left with the recipient.

Medical supplies are:

- Subject to authorization regardless of their cost
- Billed with revenue code 0270 and HCPCS code A9999
  - Billed “By Report”
  - An invoice, an itemized list and a TAR should be attached to the claim
- Treatment plan must state these supplies are consistent with the treatment proposed

### **Homebound Recipient**

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

### **Other HHA Services**

Other services provided by HHA personnel that do not apply to any of the previous categories may be separately reimbursable and subject to authorization.

**Example:** Respiratory therapist services should be billed with CPT code 99600 and revenue code 0589.

- Must be billed “By Report”
- An invoice, an itemized list and a TAR should be attached to the claim

# Home Health Agencies Billing Scenarios

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

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

## Skilled Nursing Services: “From-Through Billing”

See samples below. A physician has prescribed in-home medical care for a recipient who requires intermittent injections. The recipient has a written plan of care that is reviewed by the physician every 60 days. The agency that renders the services submits claims monthly. The skilled nursing visits are billed in the “from-through” format and require authorization.

**Note:** HHA claims do not require condition, occurrence or value code information (Boxes 18 thru 28, 31 thru 37 and 39 thru 41).

### Claim line 1:

- Enter the description of the service rendered (skilled nursing visits) in the Description field (Box 43).
- Enter the “from” date of service (December 1, 2022) in six-digit format as 120122 in the Service Date field (Box 45).

### Claim line 2:

- Enter code “0551” in the Revenue Code field (Box 42) to indicate that this is a home health skilled nursing visit.
- Enter the specific days the services were rendered (12/1, 5, 8, 13, 20, 26 and 30) in the Description field (Box 43).
- Enter the procedure code (G0299) in the HCPCS/Rate field (Box 44).
- Enter the “through” date of service (December 1, 2022) in six-digit format as 120122 in the Service Date field (Box 45).
- Enter a “28” in the Service Units field (Box 46).
- Enter the usual and customary charges in the Total Charges field (Box 47).

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Page updated: February 2023

### **Claim line 3:**

- Enter code “0589” to indicate that this is a home health visit in the *Revenue Code* field (Box 42).
- Enter the description of the service rendered (administered drugs) in the *Description* field (Box 43).
- Enter the procedure code (99600) in the *HCPCS/Rate* field (Box 44).
- Enter the service date 120122 in the *Service Date* field (Box 45).
- Enter a “1” in the *Service Units* field (Box 46).
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

### **Claim line 4:**

- Enter code “0270” in the *Revenue Code* field (Box 42) to indicate that this home health visit involved providing medical supplies.
- Enter the description of the service rendered (medical supplies) in the *Description* field (Box 43).
- Enter the procedure code (A9999) in the *HCPCS/Rate* field (Box 44).
- Enter the service date 120122 in the *Service Date* field (Box 45).
- Enter a “1” in the *Service Units* field (Box 46).
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

### **Claim line 23:**

- Enter code “001” to designate that this is the total charge line in the *Revenue Code* field (Box 42).
- Enter the total of all charges in the *Total Charges* field (Box 47).



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**Remaining Claim Fields**

<b>Box #</b>	<b>Field name</b>	<b>Instructions</b>
4	Type of Bill	Enter the two-digit facility type code "33" (home health – outpatient) and one-character claim frequency code "1" as "331."
50	Payer Name	Enter "O/P Medi-Cal" to indicate the type of claim and payer.
56	NPI	Enter the HHA's NPI.
63	Treatment Authorization Codes	Enter the 11-digit TAR number.
66	ICD Indicator (DX)	Because this claim is submitted with a diagnosis code, an ICD indicator of "0" is required in the white space below. An indicator is required only when an ICD-10-CM code is entered on the claim.
67	Unlabeled (Primary Diagnosis Code)	Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.
77	Operating	Enter the rendering provider's NPI.
80	Remarks	HCPCS code A9999 must be billed "By Report," which requires an invoice, itemized list of supplies and a TAR to be attached to the claim. Indicate that the claim has attachments.  Refer to <i>the Home Health Agencies (HHA)</i> (home hlth) section of the Part 2 provider manual for additional code A9999 billing instructions.

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Page updated: February 2023

<b>1 UPTOWN MEDICAL CENTER</b>										<b>2</b>										<b>3a PAT. CNTRL. #</b>		<b>4 TYPE OF BILL</b>																								
<b>140 SECOND STREET</b>																				<b>b. MED. REC. #</b>		<b>331</b>																								
<b>ANYTOWN CA 958235555</b>																				<b>5 FED. TAX NO.</b>		<b>6 STATEMENT COVERS PERIOD FROM</b>		<b>7 THROUGH</b>																						
<b>8 PATIENT NAME</b>															<b>9 PATIENT ADDRESS</b>															<b>a</b>																
<b>b DOE, JOHN</b>															<b>b</b>															<b>c</b>					<b>d</b>											
<b>10 BIRTHDATE</b>					<b>11 SEX</b>		<b>12 DATE</b>		<b>ADMISSION</b>		<b>14 TYPE</b>		<b>15 SRC</b>		<b>16 DHR</b>		<b>17 STAT</b>		<b>18</b>		<b>19</b>		<b>20</b>		<b>21</b>		<b>CONDITION CODES</b>		<b>22</b>		<b>23</b>		<b>24</b>		<b>25</b>		<b>26</b>		<b>27</b>		<b>28</b>		<b>29 ACDT STATE</b>		<b>30</b>	
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<b>38</b>															<b>39 VALUE CODES CODE AMOUNT</b>					<b>40 VALUE CODES CODE AMOUNT</b>					<b>41 VALUE CODES CODE AMOUNT</b>																					
															<b>a</b>					<b>b</b>					<b>c</b>					<b>d</b>																
<b>42 REV. CD.</b>			<b>43 DESCRIPTION</b>												<b>44 HCPCS / RATE / HIPPS CODE</b>						<b>45 SERV. DATE</b>			<b>46 SERV. UNITS</b>			<b>47 TOTAL CHARGES</b>			<b>48 NON-COVERED CHARGES</b>			<b>49</b>													
<b>1</b>			<b>SKILLED NURSING VISITS</b>												<b>G0299</b>						<b>120122</b>			<b>28</b>			<b>770 00</b>																			
<b>2</b>			<b>12/1, 5, 8, 13, 20, 26, 30</b>												<b>99600</b>						<b>120122</b>			<b>1</b>			<b>100 00</b>																			
<b>3</b>			<b>ADMINISTERED DRUGS</b>												<b>A9999</b>						<b>120122</b>			<b>1</b>			<b>25 00</b>																			
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<b>23 001</b>			<b>PAGE OF</b>												<b>CREATION DATE</b>						<b>TOTALS</b>			<b>895 00</b>																						

**Sample:** Partial Skilled Nursing Services. Please adapt to your billing situation.

# A Home Health Agencies & Home and Community-Based Services

Page updated: February 2023

50 PAYER NAME <b>O/P MEDI-CAL</b>		51 HEALTH PLAN ID		52 FIEL INFO	53 AS9 BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE <b>895 00</b>	56 NPI <b>0123456789</b>	
58 INSURED'S NAME		59 P/FEL	60 INSURED'S UNIQUE ID <b>90000000A95001</b>			61 GROUP NAME		62 INSURANCE GROUP NO.	
63 TREATMENT AUTHORIZATION CODES <b>01234567890</b>				64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME		
66 DX <b>D1D1D1D</b>		A		B		C		68	
69 ADMIT DX <b>0</b>		70 PATIENT REASON DX a		b		71 PPS CODE c		72 ECI a b c	
74 PRINCIPAL PROCEDURE CODE DATE		3. OTHER PROCEDURE CODE DATE		d. OTHER PROCEDURE CODE DATE		75		76 ATTENDING NPI LAST FIRST QUAL	
c. OTHER PROCEDURE CODE DATE		d. OTHER PROCEDURE CODE DATE		e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI LAST FIRST QUAL		79 OTHER NPI LAST FIRST QUAL	
80 REMARKS <b>SEE ATTACHMENTS</b>		81 CC a		b		c		79 OTHER NPI LAST FIRST QUAL	
		d						THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF	

UB-04 CMS-1450 © 2005 NUBC OMB APPROVAL PENDING NUBC National Uniform Billing Committee LIC9213257

**Sample: Partial Skilled Nursing Services. Please adapt to your billing situation.**

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

See samples below. A physician has prescribed in-home medical care for a patient who had a stroke. The patient has a written plan of care that is reviewed by the physician every 60 days. This claim is submitted for initial case evaluation plus treatment plan services. No TAR is required for a skilled nursing visit rendered on the same day as the initial evaluation (HCPCS Level II code G0162). These services are billed on the same claim form.

**Note:** HHA claims do not require condition, occurrence or value code information (Boxes 18 thru 28, 31 thru 37 and 39 thru 41).

### Claim line 1:

- Enter code “0583” in the *Revenue Code* field (Box 42) to indicate that this is a visit/home health assessment.
- Enter the description of the service rendered (Initial case evaluation) in the *Description* field (Box 43).
- Enter the procedure code (G0162) in the *HCPCS/Rate* field (Box 44).
- Enter the date of service (December 1, 2022) in six-digit format as 12012022 in the *Service Date* field (Box 45).
- Enter a “1” in the *Service Units* field (Box 46). Quantities must be billed in whole units.
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

A Home Health Agencies & Home and Community-Based Services

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**Claim line 2:**

- Enter code “0551” in the *Revenue Code* field (Box 42) to indicate that this is a home health skilled nursing visit.
- Enter the description of the service rendered (skilled nursing visit) in the *Description* field (Box 43).
- Enter the procedure code (G0299) in the *HCPCS/Rate* field (Box 44).
- Enter the date of service (December 1, 2022) in six-digit format as 120122 in the *Service Date* field (Box 45).
- Enter a “1” in the *Service Units* field (Box 46). Quantities must be billed in whole units.
- Enter the usual and customary charges in the *Total Charges* field (Box 47).

**Claim line 23:**

- Enter code “001” in the *Revenue Code* field (Box 42) to designate that this is the total charge line.
- Enter the total of all charges in the *Total Charges* field (Box 47).

**Remaining Claim Fields**

Box #	Field name	Instructions
4	Type of Bill	Enter the two-digit facility type code “33” (home health – outpatient) and one-character claim frequency code “1” as “331.”
50	Payer Name	Enter “O/P MEDI-CAL” to indicate the type of claim and payer.
56	NPI	Enter the HHA’s NPI.
66	ICD Indicator (DX)	Because this claim is submitted with a diagnosis code, an ICD indicator of “0” is required in the white space below. An indicator is required only when an ICD-10-CM code is entered on the claim.
67	Unlabeled (Primary Diagnosis Code)	Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.
77	Operating	Enter the rendering provider’s NPI.

A Home Health Agencies & Home and Community-Based Services

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1	UPTOWN MEDICAL CENTER												2		3a PAT. CNTRL. #		4 TYPE OF BILL										
	140 SECOND STREET														b. MED. REC. #		331										
	ANYTOWN CA 958235555														5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		7 THROUGH								
8	PATIENT NAME												a	9	PATIENT ADDRESS												a
b	DOE, JOHN												b	c	d	e											
10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30							
	08241980	M																									
31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49									
	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE	OCCURRENCE DATE								
38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57								
	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT	VALUE CODES AMOUNT								
42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61								
	REV. CD.	DESCRIPTION	HCPCS / RATE / HIPPS CODE	SERV. DATE	SERV. UNITS	TOTAL CHARGES	NON-COVERED CHARGES																				
1	0583	INITIAL CASE EVALUATION	G0162	120122	1	60 00																					
2	0551	SKILLED NURSING VISIT	G0299	120122	1	42 00																					
3																											
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Sample: Partial Initial Case Evaluation Billed on Same Day as Skilled Nursing Visit. Please adapt to your billing situation.

**A** Home Health Agencies & Home and Community-Based Services

Page updated: February 2023

60 PAYER NAME <b>O/P MEDI-CAL</b>		51 HEALTH PLAN ID		56 FILL INFO	57 AS9 BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE <b>102 00</b>	58 NPI <b>0123456789</b>
63 TREATMENT AUTHORIZATION CODES <b>01234567890</b>		64 DOCUMENT CONTROL NUMBER			65 EMPLOYER NAME			62 INSURANCE GROUP NO.
66 DX <b>D1D1D1D</b>		69 ADMIT DX		70 PATIENT REASON DX	71 PPS CODE		72 ECA	68
74 PRINCIPAL PROCEDURE CODE		a. OTHER PROCEDURE CODE		b. OTHER PROCEDURE CODE		75		73
60 REMARKS		81CC a		b		c		76 ATTENDING NPI
		b		c		77 OPERATING NPI <b>1234567890</b>		QUAL
		c		d		78 OTHER NPI		QUAL
		d				79 OTHER NPI		QUAL

UB-04 CMS-1450 © 2005 NUBC OMB APPROVAL PENDING NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

**Sample:** Partial Initial Case Evaluation Billed on Same Day as Skilled Nursing Visit. Please adapt to your billing situation.

# Home and Community-Based Services

## Program Description

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

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

## Background

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

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

## HCBS Provider Participants

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

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



## Home and Community-Based Eligibility

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

### Regular Medi-Cal Eligibility Rules

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

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

### Special Waiver Eligibility Rules

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

### Authorization of HCBS Services

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

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

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

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

## **HCBCS Waivers and IHO and NF/AH Waivers Defined**

HCBS waiver services provide in-home care to recipients who otherwise require prolonged institutionalization in one of the following facility types:

- Acute care hospital
- Adult or pediatric subacute nursing facility
- Nursing Facility Level A (NF-A) or Nursing Facility Level B (NF-B)
- Intermediate Care Facility for Developmentally Disabled

## **In-Home Operations (IHO) and Nursing Facility/Acute Hospital (NF/AH) Waivers**

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

## Special Billing Instruction Reminders

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

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

## Knowledge Review 2

1. Home and Community-Based Services (HCBS) provide in-home care to recipients who require services for a short duration period.  
True       False
2. Who administers the HCBS waiver services to Medi-Cal eligible frail seniors and persons with disabilities? \_\_\_\_\_
3. Two goals of the Medi-Cal Waiver Program are:
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
4. All HCBS services require prior authorization.  
True       False

See Appendix for [Answer Key](#).

# Resource Information

## References

The following reference materials provide Medi-Cal program and eligibility information.

### **Provider Manual References**

#### **Part 1**

*Aid Codes Master Chart* (aid codes)

*OBRA and IRCA* (obra)

*Remittance Advice Details and Medi-Cal Financial Summary* (remit)

- *Remittance Advice Details (RAD) Codes, Messages and Electronic Correlations*

#### **Part 2**

*Diabetes Prevention Program* (diabetes)

*Home and Community-Based Services (HCBS)* (home)

*Home and Community-Based Services (HCBS) Billing Codes and Reimbursement Rates*  
(home cd)

*Home Health Agencies (HHA)* (home hlth)

*Home Health Agencies (HHA) Billing Codes and Reimbursement Rates* (home hlth cd)

*Home Health Agencies (HHA) Billing Examples* (home hlth ex)

*Palliative Care* (palli care)

*UB-04 Completion: Outpatient Services* (ub comp op)

#### **Other References**

Department of Health Care Services (DHCS) *Criteria for Home Health Agency Services*



# Hospice Care

## Introduction

### Purpose

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

### Objectives

Provide an overview of the Medi-Cal hospice care program coverage

Discuss hospice care program eligibility

Examine the policy and billing requirements

Introduce and review billing examples

### Acronyms

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

## Program Coverage

Hospice care is a form of medical multidisciplinary care that addresses the unique requirements of terminally ill individuals.

Hospice is used to alleviate pain and suffering, and treat symptoms rather than to cure the illness. Medical and nursing services are designed to maximize the patient's comfort, alertness and independence so the patient can reside in the home as long as possible.

Providers must enroll as a Medi-Cal hospice provider. All claims are submitted using the *UB-04* claim form.

Hospice providers may include the following:

- Hospitals
- Skilled nursing facilities
- Intermediate care facilities
- Home health agencies
- Any licensed health provider who has been certified by Medicare to provide hospice care and is enrolled as a Medi-Cal hospice care provider.

**Note:** All services must be rendered in accordance with Medicare requirements. Hospice is a covered optional benefit under Medi-Cal with two 90-day periods, beginning on the date of hospice election, followed by unlimited 60-day periods.

## Hospice Care Eligibility

Any Medi-Cal recipient certified by a physician as having a life expectancy of six months or less may elect to receive hospice care in lieu of normal Medi-Cal coverage for services related to the terminal condition. Election of hospice care occurs when the patient (or representative) voluntarily files an election statement with the hospice provider. This statement acknowledges that the patient understands that the hospice care relating to the illness is intended to alleviate pain and suffering rather than to cure the illness and that certain Medi-Cal benefits are waived by this election.

In accordance with Section 2302 of the Patient Protection and Affordable Care Act (ACA), any Medi-Cal eligible recipient younger than 21 years of age and certified by a physician as having a life expectancy of six months or less may elect to concurrently receive hospice care in addition to curative treatment of the hospice-related diagnosis.

Non-hospice providers will be able to bill Medi-Cal for medically necessary, curative treatments that are provided within their scope of practice and that are considered a benefit under the Medi-Cal program. All services are subject to current hospice frequency and utilization review guidelines.



## B Hospice Care

Page updated: September 2020

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

### Hospice Eligibility, Billing and Payment Requirements

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

Attn: Hospice Clerk  
Department of Health Care Services  
Medi-Cal Eligibility Division, MS 4607  
1501 Capitol Avenue, Room 4063  
P.O. Box 997417-7417  
Sacramento, CA 95899-7417

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

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

### Service Restrictions

The response from the eligibility verification system for recipients who elect to receive hospice care in lieu of curative treatment and services will state “Primary diagnosis/limited to hospice.” The recipient is not eligible to receive services related to the terminal diagnosis from providers other than a hospice provider or the attending physician.

When the response is returned from the eligibility verification system, the other provider should identify the name of the recipient’s hospice provider and inform the provider that the hospice patient is seeking other medical assistance related to the terminal diagnosis.

The special message “Primary diagnosis/limited to hospice” does not specify that Medi-Cal recipients are prohibited from receiving other services that are unrelated to the primary diagnosis, such as physician examinations, drugs or other medical care.

## B Hospice Care

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### Patient Certification/Recertification Requirements

The attending physician and the medical director or physician member of the hospice interdisciplinary team must certify in writing at the beginning of the first 90-day period that the patient is terminally ill. For all subsequent recertification periods, only a hospice physician may certify that the patient is terminally ill. Only a physician (primary or hospice medical director) can certify that the patient is terminally ill with a life expectancy of six months or less.

At the start of the first 90-day period of care, the hospice provider must maintain an initial certification that the patient is terminally ill in the patient's medical records. At the start of each subsequent period of care, the hospice provider must maintain a recertification in the patient's medical records.

A hospice physician or NP is required to have a face-to-face encounter with every hospice patient to determine the continued eligibility of that patient. The face-to-face encounter requirement is satisfied when the following criteria are met:

An encounter must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to every subsequent benefit period.

The hospice physician or NP who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter.

A hospice physician or a hospice NP is a practitioner who can perform the encounter.

The hospice must retain the certification statements and have them available for audit purposes.

Timeframes for exceptional circumstances for new hospice admissions are in the third or later benefit period. In cases where a hospice newly admits a patient in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period.

**Example:** If the patient is an emergency weekend admission, it may be impossible for a hospice physician or NP to see the patient until the following Monday. Or, if CMS data systems are unavailable, the hospice may be unaware that the patient is in the third benefit period.

In such documented cases, a face-to-face encounter that occurs within two days after admission is considered timely. Additionally, for such documented exceptional cases, if the patient dies within two days of admission without a face-to-face encounter, a face-to-face encounter can be deemed as complete.

## B Hospice Care

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**Example:** When a Medi-Cal hospice patient transfers from one hospice to another, it is sometimes difficult to determine what benefit period a patient is currently in. In such cases, the receiving hospice may not know if a face-to-face recertification is necessary. The receiving hospice provider is required to document in the patient's medical records all efforts to obtain the previous hospice benefit period, either from the transferring hospice provider or from other sources.

If the receiving hospice cannot determine the correct benefit period, the face-to-face recertification clock starts from the time the receiving hospice provider completed the intake process. This information must be maintained in the patient's medical records for auditing purposes.

## B Hospice Care

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### Knowledge Review 1

1. A patient has an end-stage liver disease and her attending physician told her she has six months to live. The patient elects hospice in lieu of curative treatment. She completes the election package and her attending doctor and the hospice medical director or the physician member of the hospice interdisciplinary team certifies she is terminally ill. The woman elects hospice on September 1, 2017, and begins receiving hospice care.
  - A. What is the date of the initial certification? \_\_\_\_\_
  - B. What would be the date of the first recertification? \_\_\_\_\_
  - C. What would be the date of the next recertification? \_\_\_\_\_

See the appendix for the [Answer Key](#).

**Notes:**

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## B Hospice Care

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### Hospice Revocation

A patient (or representative) may revoke the election or hospice care at any time in writing. However, a hospice cannot “revoke” a patient’s election. To revoke the election of hospice care, the patient, as well as the hospice provider, must inform DHCS in writing and must include the following:

A signed statement that the individual revokes the election of hospice care for the remainder of that election period, and;

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

**Note:** Verbal revocation of benefits is not acceptable. The individual forfeits hospice coverage for any remaining days in that election period.

Upon revoking of hospice care for a particular election period, the patient is no longer covered under the Medi-Cal hospice benefit and he or she resumes Medi-Cal coverage of the benefits waived when hospice care was elected.

An individual may, at any time, elect to receive hospice coverage for any other election periods that he or she is eligible to receive.

Subsequently, if the patient re-elects hospice care, the hospice provider must submit a new patient hospice election to DHCS. The hospice provider retains the initial certification of terminal illness from the hospice physician in the terminally ill patient’s medical records.

The hospice care period starts again with the two 90-day periods followed by the unlimited 60-day periods.

### Classification of Care

Each day of hospice care is classified into one of four levels of care:

- Routine home care
- Continuous home care
- Inpatient respite care
- General inpatient care (no respite)/hospice general care

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

## Policies

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

Revenue codes identify specific accommodations, ancillary services, unique billing calculations or arrangements. These codes permit facilities to bill for facility usage and services rendered. Many of these services do not have corresponding procedure codes. HIPAA requires that payers (including Medi-Cal) accept revenue codes and utilize them in claim adjudication. Hospice claims submitted without revenue codes will be denied. Frequency limitations also apply to hospice revenue codes.

### Hospice Routine Home Care Updates

Federal Rule 42 CFR Part 418, CMS-1629-F RIN 0938-AS39 Medicare Program: *FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements* established an updated reimbursement rate of differential payments for routine home care services.

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

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

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

0552 (routine home care [SIA rate])

0650 (routine home care [high rate])

0659 (routine home care [low rate])

## B Hospice Care

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

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

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

### Notes:

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## B Hospice Care

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Service Description	Revenue Code	Description	When to Bill	Service Description
Hospice care services	0552	Routine home care (service intensity add-on [SIA] rate)	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	15 minute increments, up to 4 hours per day, maximum of seven days
Hospice care services	0650	Routine home care (high rate) (per diem)	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	One unit per claim line, per day
Hospice care services	0659	Routine home care (low rate) (per diem)	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	One unit per claim line, per day
Hospice care services	0652	Continuous home care	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	Minimum of eight hours (units) Maximum of 24 hours (units) per claim line, per day
Hospice general care	0655	Inpatient respite care	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	One unit per claim line, per day and limit of five days for each episode (stay) <b>Note:</b> Services billed beyond five days for each episode will be paid at the routine home care rate (revenue code 0651) for additional days



## B Hospice Care

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Service Description	Revenue Code	Description	When to Bill	Service Description
Hospice general care	0656 <b>Note:</b> Revenue code 0656 must be billed in conjunction with HCPCS code T2045. A TAR is required.	General inpatient care (no respite/hospice general care)	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	One unit per claim line, per day
Hospice general care	0657	Physician's services	For Medi-Cal recipients who are entitled to Medicare, but not eligible for Part A coverage on the date of service	One unit per claim line, per day
Hospice room and board	0658 <b>Note:</b> Hospice providers rendering services in an RCFE may not be reimbursed for room and board revenue code 0658.	Room and board codes	Always	N/A

Medi-Cal hospice providers are required, upon request, to make available to DHCS complete and accurate medical and fiscal records, signed and dated by appropriate staff. This is to fully substantiate all claims for hospice services submitted to the California Medicaid Management Information System (California MMIS) Fiscal Intermediary and to permit access to all record and facilities for the purpose of claim auditing, program monitoring and utilization review.

**Note:** Records must be held three years from the last service date.

**Notes:**

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# Hospice Billing

## Special Physician Services

- Address pain and symptom management
- Require revenue code 0657 when services are related to the terminal condition
- Are provided by a physician employed by or under arrangement made by the hospice
- May be billed only for physician services to manage symptoms that cannot be remedied by the recipient's attending physician because of one of the following:
  - Immediate need
  - Attending physician does not have the required special skills
- Bill revenue code 0657 on a separate line for each date of service
- If a recipient is receiving care for more than one day in a month, use the "from-through" billing method to bill per-diem service and room and board codes.
- If billing for a single day, bill that day on one line with a single date of service.
- Do not bill per-diem codes on a single line with a quantity greater than one (1), or the claim will be denied.

Medi-Cal requires that hospices document all coexisting or additional diagnoses related to the recipient's terminal illness on hospice claims. Hospice providers should not report coexisting or additional diagnoses unrelated to the terminal illness.

## Same or Overlapping Dates of Service

Only one level of hospice care is allowed for any hospice recipient for the same date of service. Claims for more than one type of hospice service billed for the same recipient on the same or overlapping date(s) of service will be denied.

**Exception:** In cases where one hospice discharges a recipient and another hospice admits the same recipient on the same day, each hospice may bill for reimbursement and each will be reimbursed at the appropriate level of care for its respective day of discharge or admission.

## B Hospice Care

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### Room and Board Billing

When billing for room and board codes, the following information is required in the *Remarks* field (Box 80) or as an attachment to the *UB-04* claim:

The recipient resides in a certified NF or Intermediate Care Facility (ICF)

The name and address of the NF or ICF

A Minimum Data Set (MDS) on file at the NF verifies that the recipient meets the NF or ICF level of care

**Note:** A TAR is not required for hospice care room and board provided in a NF or ICF.

### Share of Cost

Long Term Care Share of Cost (SOC) should be cleared by a hospice provider on the *UB-04* claim form by completing the *Value Codes and Amounts* fields (Boxes 39 and 41). The value code is "23" and the value amount is what has been paid or obligated by the patient for SOC.

#### Notes:

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## B Hospice Care

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### Hospice Billing Examples

The examples in this module are to assist providers in billing hospice care services on the *UB-04* claim form. The following examples are samples only. Please adapt to your billing situation.

#### **“From-Through” Billing of General Inpatient Hospice Care**

Scenario: The recipient has elected Medi-Cal hospice coverage and is admitted to the hospital on three separate occasions (three days each visit) for monitoring and adjustment of pain medications. Authorization is required for general inpatient care days.

##### **Claim Line 1:**

Enter the description of the service rendered (inpatient care) in the *Description* field (Box 43).

Enter the beginning service (June 1, 2018) in six-digit format as “060118” in the *Service Date* field (Box 45).

##### **Claim Line 2:**

Enter code “0656” to indicate that this is a general inpatient care (no respite)/hospice general care service in the *Revenue Code* field (Box 42).

Enter the specific days the services were rendered (6/1, 3, 4, 16, 17, 18, 25, 26 and 27) in the *Description* field (Box 43).

Enter the procedure code (HCPCS code T2045) in the HCPCS/Rate field (Box 44). (Enter the required TAR number).

Enter the “through” date of service (June 27, 2018) in six-digit format as “062718” in the *Service Date* field (Box 45).

Enter a “9” to indicate the number of days the recipient received inpatient care in the *Service Units* field (Box 46).

Enter the usual and customary charges in the *Total Charges* field (Box 47).

##### **Claim Line 23:**

Enter code 001 to designate that this is the total charge line in the *Revenue Code* field (Box 42).

Enter the total of all charges in the *Total Charges* field (Box 47).

## B Hospice Care

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### Remaining Claim Fields

Box #	Field name	Instructions
4	Type of Bill	Enter the two-digit facility type code "81" (special facility – hospice [non-hospital based] and one-character claim frequency code "1" as "811"
50	Payer Name	Enter "O/P Medi-Cal" to indicate the type of claim and payer.
56	NPI	Place the hospice provider number.
63	Treatment Authorization Codes	Enter the 11-digit TAR number.
66	ICD Indicator (DX)	Because this claim is submitted with a diagnosis code, an ICD indicator of "0" is required in the white space below. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.
67	Unlabeled (Primary Diagnosis Code)	Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.
77	Operating	Enter the NPI of the facility in which the recipient resides.

### Notes:

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# B Hospice Care

Page updated: September 2020

1 <b>UPTOWN MEDICAL CENTER</b> <b>140 SECOND STREET</b> <b>ANYTOWN, CA 958235555</b>		2		3a PAT. CNTRL. #		4 TYPE OF BILL <b>811</b>	
b PATIENT NAME <b>DOE, JOHN</b>		9 PATIENT ADDRESS		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
10 BIRTHDATE <b>04251951</b>	11 SEX <b>M</b>	12 DATE	13 ADMISSION HPI	14 TYPE	15 SRC	16 DHR	17 STAT <b>YO</b>
31 OCCURRENCE DATE	32 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	35 OCCURRENCE DATE	36 OCCURRENCE DATE	37 OCCURRENCE DATE	38
42 REV. CD.		43 DESCRIPTION <b>INPATIENT CARE</b>		44 HCPCS / RATE / HPPS CODE <b>T2045</b>		45 SERV. DATE <b>060118</b>	
46 SERV. UNITS <b>9</b>		47 TOTAL CHARGES <b>45000</b>		48 NON-COVERED CHARGES		49	
50 PAYER NAME <b>O/P MEDI-CAL</b>		51 HEALTH PLAN ID		52 REL. INFO		53 ASG. BEN.	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE <b>45000</b>		56 NPI <b>0123456789</b>		57 OTHER PRV ID	
58 INSURED'S NAME		59 PREL.		60 INSURED'S UNIQUE ID <b>90000000A95001</b>		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES <b>01234567890</b>		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66 ICD-9-CM <b>D1D1D1D</b>		67 ICD-9-CM <b>0</b>		68 ICD-9-CM <b>A B C D E F G H</b>		69 ICD-9-CM <b>I J K L M N O P Q</b>	
69 ADMIT. DX		70 PATIENT REASON DX		71 FPS CODE		72 ECI	
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING NPI <b>2345678901</b>		77 OPERATING NPI	
78 OTHER NPI		79 OTHER NPI		80 REMARKS		81 CC	
81 CC		82 CC		83 CC		84 CC	

Figure 1: "From-Through" Billing of General Inpatient Hospice Care

## B Hospice Care

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### Room and Board

Scenario. A hospice provider is billing for room and board for a recipient who has no Medicare health coverage and has Alzheimer's disease. The recipient has elected Medi-Cal hospice coverage for monitoring and adjustment of pain medications.

#### Claim Line 1:

Enter the description of the service rendered (Room and Board) in the *Description* field (Box 43).

Enter the beginning service (June 1, 2018) in six-digit format as "060118" in the *Service Date* field (Box 45).

#### Claim Line 2:

Enter revenue code "0658" (room and board) in the *Revenue Code* field (Box 42).

Enter the specific days the services were rendered (6/1, 2, 3, 4 and 5) in the *Description* field (Box 43).

Enter the "through" date of service (June 5, 2018) in six-digit format as "060518" in the *Service Date* field (Box 45).

Enter a "5" to indicate the number of days the recipient received room and board services in the *Service Units* field (Box 46).

Enter the usual and customary charges in the *Total Charges* field (Box 47).

#### Claim Line 23:

Enter code "001" to designate that this is the total charge line in the *Revenue Code* field (Box 42).

Enter the total of all charges minus the SOC in the *Total Charges* field (Box 47).

## B Hospice Care

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### Remaining Claim Fields

Box #	Field name	Instructions
4	Type of Bill	Enter the two-digit facility type code "26" (Nursing Facility Level B) and one-character claim frequency code "1" as "261."
39	Code Value Codes Amount	Enter aid code "23" in the Code column and "10000" for a \$100 SOC in the Value Codes Amount column.
50	Payer Name	Enter "O/P Medi-Cal" to indicate the type of claim and payer.
56	NPI	Place the hospice provider number.
66	ICD Indicator (DX)	Because this claim is submitted with a diagnosis code, an ICD indicator of "0" is required in the white space below. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.
67	Unlabeled (Primary Diagnosis Code)	Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.
77	Operating	Enter the NPI of the facility in which the recipient resides.
80	Remarks	Enter any appropriate information or on attachment.



# B Hospice Care

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1 UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN, CA 958235555	2		3a PAT. CHLT.# b. MED. REC.#		4 TYPE OF BILL 261															
8 PATIENT NAME a DOE, JANE			9 PATIENT ADDRESS a																	
10 BIRTHDATE 01231961	11 SEX F	12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT YO	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE	34 OCCURRENCE DATE	35 CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37	38	39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT						
42 REV. CO. 0658	43 DESCRIPTION ROOM AND BOARD 6/1 2 3 4 5	44 HCPCS / RATE / HPPS CODE	45 SERV. DATE 060118 060518	46 SERV. UNITS 5	47 TOTAL CHARGES 145000	48 NON-COVERED CHARGES	49													
23 001	PAGE	OF	CREATION DATE	TOTALS	135000															
50 PAYER NAME O/P MEDI-CAL	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE 135000	56 NPI 0123456789	57 OTHER PRV ID													
58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID 90000000A95001	61 GROUP NAME	62 INSURANCE GROUP NO																
63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME																		
66 DX D1D1D1D 0	67	68																		
69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73																
74 PRINCIPAL PROCEDURE DATE	75 OTHER PROCEDURE DATE	76 OTHER PROCEDURE DATE	77 ATTENDING NPI 1234567890	78 LAST	79 QUAL	80 FIRST														
74 OTHER PROCEDURE DATE	75 OTHER PROCEDURE DATE	76 OTHER PROCEDURE DATE	77 OPERATING NPI	78 LAST	79 QUAL	80 FIRST														
80 REMARKS	81 CC a	81 CC b	81 CC c	81 CC d	78 OTHER NPI	79 QUAL	80 FIRST													
					78 OTHER NPI	79 QUAL	80 FIRST													

Figure 2: Room and Board

## B Hospice Care

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### Routine Home Care High Rate, Low Rate and SIA Billing

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

#### Claim Line 1:

Enter revenue code "0650" (routine home care high rate) in the *Revenue Code* field (Box 42).

Enter the description of the service rendered (Routine Home Care High) in the *Description* field (Box 43).

Enter the beginning service (May 4, 2018) in six-digit format at "050418" in the *Service Date* field (Box 45).

#### Claim Line 2:

Enter the "through" date of service (July 2, 2018) in six-digit format as "070218" in the *Service Date* field (Box 45).

Enter a "60" to indicate the number of days the recipient received routine home care high rate services in the *Service Units* field (Box 46).

Enter the usual and customary charges in the *Total Charges* field (Box 47). In this example, each day/unit for this per-diem routine home care high rate service is \$25 per day/unit.

#### Claim Line 4:

Enter revenue code "0659" (routine home care service low rate) in the *Revenue Code* field (Box 42).

Enter the description of the service rendered (routine home care low rate) in the *Description* field (Box 45).

Enter the beginning service (July 3, 2018) in six-digit format as "070318" in the *Service Date* field (Box 45).

#### Claim Line 5:

Enter the "through" date of service (July 9, 2018) in six-digit format as "070918" in the *Service Date* field (Box 45).

Enter a "7" to indicate the number of days the recipient received routine home care low rate services in the *Service Units* field (Box 46).

Enter the usual and customary charges in the *Total Charges* field (Box 47). In this example, each day/unit for this per-diem routine home care low rate service is \$10 per day/unit.

## B Hospice Care

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### **Claim Line 7:**

Enter revenue code "0552" (routine home care service intensity add-on) in the *Revenue Code* field (Box 42).

Enter the description of the service rendered (routine home care service intensity add-on) in the *Description* field (Box 43).

Enter the beginning service (July 3, 2018) in six-digit format as "070318" in the *Service Date* field (Box 45).

### **Claim Line 8:**

Enter the specific days the services were rendered (07/3, 4, 5, 6, 7, 8, 9) in the *Description* field (Box 43).

Enter the "through" date of service (July 9, 2018) in six-digit format as "070918" in the *Service Date* field (Box 45).

Enter a "112" to indicate the number of units of routine home care SIA services the recipient received in the *Services Units* field (Box 46).

Enter the usual and customary charges in the *Total Charges* field (Box 47). In this example, each unit for the 15-minute increment routine home care SIA service is \$50 per unit, up to 4 hours (16 units max) per day.

### **Claim Line 23:**

Enter code "001" to designate that this is the total charge line in the *Revenue Code* field (Box 42).

Enter the total of all charges minus the SOC in the *Total Charges* field (Box 47).

## B Hospice Care

Page updated: September 2020

### Remaining Claim Fields

Box #	Field name	Instructions
4	Type of Bill	Enter the two-digit facility type code "81" (Special Facility Inpatient) and one-character claim frequency code "1" as "811."
12	Admission Date	Start of recipient's hospice certification period
17	Patient Status	"41" – Expired in a medical facility, such as hospital, SNF, ICF or freestanding hospice
31	Occurrence Code/Date	"55" – Death of the recipient, happened on 7/9/2018
50	Payer Name	Enter "O/P Medi-Cal" to indicate the type of claim and payer.
56	NPI	Place the hospice provider number.
63	Treatment Authorization Codes	Enter the 11-digit TAR number.
66	ICD Indicator (DX)	Because this claim is submitted with a diagnosis code, an ICD indicator of "0" is required in the white space below. An indicator is required only when an ICD-10-CM/PCS code is entered on the claim.
67	Unlabeled (Primary Diagnosis Code)	Enter all letters and/or numbers of the primary ICD-10-CM diagnosis code. Do not enter a decimal point.
77	Operating	Enter the NPI of the facility in which the recipient resides.

# B Hospice Care

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1	UPTOWN MEDICAL CENTER 140 SECOND STREET ANYTOWN, CA 95823-1200	2	33 PAT. CNTL. # 34 MED. REC. #	4 TYPE OF BILL 811
5	FED. TAX NO.	6	STATEMENT COVERS PERIOD FROM	7 THROUGH
8	PATIENT NAME a	9	PATIENT ADDRESS a	c
b	DOE, JANE	d	e	f
10	BIRTHDATE 01231961	11	SEX F	12
13	DATE	14	ADMISSION TYPE 050418	15
16	SRC	17	DHR	18
19	STAT	20	21	22
23	24	25	26	27
28	29	30	31	32
33	OCCURRENCE DATE 55 070918	34	OCCURRENCE DATE	35
36	OCCURRENCE DATE	37	OCCURRENCE DATE	38
39	OCCURRENCE DATE	40	OCCURRENCE DATE	41
42	REV. OD	43	DESCRIPTION	44
45	SERV. DATE	46	SERV. UNITS	47
48	TOTAL CHARGES	49	NON-COVERED CHARGES	50
1	0650	ROUTINE HOME CARE HIGH	050418 070218	60
2				1500 00
3				
4				
5	0659	ROUTINE HOME CARE LOW	070318 070918	7
6				70 00
7				
8				
9	0552	RHC SERVICE INTENSITY ADD-ON 07/3 4 5 6 7 8 9	070318 070918	112
10				5600 00
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23	001	PAGE OF	CREATION DATE	TOTALS
24				717000
25	50	PAYER NAME	51	HEALTH PLAN ID
26	A	O/P MEDI-CAL		
27	B			
28	C			
29	52	REL. INFO	53	ASO BEN
30	54	PRIOR PAYMENTS	55	EST. AMOUNT DUE
31	56	NPI	57	OTHER PRV ID
32	0123456789			
33	58	INSURED'S NAME	59	PREL
34	A		60	INSURED'S UNIQUE ID
35	B		90000000A95001	
36	C			
37	61	GROUP NAME	62	INSURANCE GROUP NO.
38	A			
39	B			
40	C			
41	63	TREATMENT AUTHORIZATION CODES	64	DOCUMENT CONTROL NUMBER
42	A	01234567890		
43	B			
44	C			
45	65	EMPLOYER NAME	66	DX
46	A		D1D1D1D	
47	B			
48	C			
49	67	ADMIT DX	68	PATIENT REASON DX
50	A			
51	B			
52	C			
53	74	PRINCIPAL PROCEDURE CODE	75	OTHER PROCEDURE CODE
54	A			
55	B			
56	C			
57	76	ATTENDING NPI	77	OPERATING NPI
58	A		1234567890	
59	B			
60	C			
61	78	OTHER NPI	79	OTHER NPI
62	A			
63	B			
64	C			
65	80	REMARKS	81	CC
66	A			
67	B			
68	C			
69	82	APPROVAL PENDING	83	LIC9213257
70	A			
71	B			
72	C			

Figure 3: Routine Home Care High Rate, Low Rate and SIA Billing

## B Hospice Care

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### Knowledge Review 2

1. Any Medi-Cal recipient certified by a physician as having a life expectancy of six months or less may elect to receive hospice care in lieu of normal Medi-Cal coverage for services related to the terminal condition.  
True       False
2. When billing for any subsequent days of care beyond the 60-day period, providers must utilize revenue code 0659 (routine home care low rate).  
True       False
3. Hospice care starts the day the recipient receives hospice care and ends when the 90-day or 60-day period ends.  
True       False
4. A recipient or representative may verbally revoke the election of hospice care at any time.  
True       False
5. Hospice care is intended to alleviate pain and suffering rather than to cure the illness.  
True       False
6. What are the two new fields required to be completed on the *UB-04* claim form?
  - a. \_\_\_\_\_
  - b. \_\_\_\_\_
7. Each day of hospice care is classified into one of four levels of care: routine home care, continuous home care, inpatient care and general inpatient care (no respite)/hospice general care.  
True       False
8. Hospice reimbursement rates will now be based on the recipient's length of stay.  
True       False
9. Hospice providers should not report coexisting or additional diagnose unrelated to the terminal illness on claims.  
True       False
10. Records must be kept for three years from the last service date.  
True       False

See the Appendix for the [Answer Key](#).

# Resource Information

## References

The following reference materials provide Medi-Cal program and eligibility information.

### **Provider Manual References**

#### **Part 1**

*Aid Codes Master Chart* (aid codes)

*OBRA and IRCA* (obra)

#### **Part 2**

*Form: Hospice General Inpatient Information Sheet* (DHS 6194)

*Hospice Care* (hospic)

*Hospice Care Billing Codes* (hospic bil cd)

*Hospice Care Billing Examples* (hospic bil ex)

*Hospice Care: General Billing Instructions* (hospic ge)

*Hospice Care: General Inpatient Information Sheet* (hospic ge inf)

*Revenue Codes for Inpatient Services* (rev cd ip)

*TAR and Non-Benefit: Introduction to List* (tar and non)

*TAR Completion* (tar comp)

*UB-04 Completion: Inpatient Services* (ub comp ip)

*UB-04 Completion: Outpatient Services* (ub comp op)

# Appendix

## Acronyms

<b>Acronym</b>	<b>Description</b>
<b>ACA</b>	Patient Protection and Affordable Care Act
<b>BIC</b>	Benefits Identification Card
<b>CCR</b>	California Code of Regulations
<b>CCS</b>	California Children's Services
<b>CMS</b>	Centers for Medicare & Medicaid Services
<b>DHCS</b>	Department of Health Care Services
<b>DME</b>	Durable Medical Equipment
<b>FI</b>	Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services and other dical operations of the Medi-Cal program
<b>GHPP</b>	Genetically Handicapped Persons Program
<b>HCBS</b>	Home and Community-Based Services
<b>HCPCS</b>	Health Care Procedure Coding System
<b>HHA</b>	Home Health Agencies
<b>HHCS</b>	Home Health Community Services
<b>HIPAA</b>	Health Insurance Portability and Accountability Act
<b>ICD-10-CM</b>	International Classification of Diseases – 10 <sup>th</sup> revision, Clinical Modification
<b>ID</b>	Identification
<b>IHO</b>	In-Home Operations
<b>LCSW</b>	Licensed Clinical Social Worker
<b>LNV</b>	Licensed Vocational Nurse
<b>MFT</b>	Marriage and Family Therapist
<b>MDS</b>	Minimum Data Set
<b>NF-A</b>	Nursing Facility Level A
<b>NF-B</b>	Nursing Facility Level B
<b>NFT/AH</b>	Nursing Facility/Acute Hospital



## Acronyms (continued)

<b>Acronym</b>	<b>Description</b>
<b>NP</b>	Nurse Practitioner
<b>NPI</b>	National Provider Identifier
<b>PCP</b>	Primary Care Providers
<b>PCPEA</b>	Primary Care Provider Enrollment Agreement
<b>PIN</b>	Provider Identification Number
<b>RCFE</b>	Residential Care Facilities for the Elderly
<b>RAD</b>	Remittance Advice Details
<b>RN</b>	Registered Nurse
<b>SAR</b>	Service Authorization Request
<b>SOC</b>	Share of Cost
<b>TAR</b>	Treatment Authorization Request
<b>TCN</b>	TAR Control Number

# Module A Answer Key

## Knowledge Review 1

Question 1: HHA services are provided as outpatient services.

Answer 1: True

Question 2: Treatment plans must be reviewed every:

Answer 2: 60 days

Question 3: Most HHA claims require the use of revenue codes when submitting claims for adjudication.

Answer 3: True

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

Answer 4: True

## Knowledge Review 2

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

Answer 1: False

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

Answer 2: Department of Health Care Services (DHCS)

Question 3: Two goals of the Medi-Cal Waiver Program are:

Answer 3: A) Ensure recipients' medical needs can be met safely in a home environment; B) For the recipients to experience enhanced and enriched quality of life in their homes.

Question 4: All HCBS services require prior authorization.

Answer 4: True

# Module B Answer Key

## Knowledge Review 1

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

Answer 1: A) September 1, 2017; B) November 30, 2017; C) February 28, 2018

## Knowledge Review 2

Question 1: Any Medi-Cal recipient certified by a physician as having a life expectancy of six months or less may elect to receive hospice care in lieu of normal Medi-Cal coverage for services related to the terminal condition.

Answer 1: True

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

Answer 2: True

Question 3: Hospice care starts the day the recipient receives hospice care and ends when the 90-day or 60-day period ends.

Answer 3: True

Question 4: A recipient or representative may verbally revoke the election of hospice care at any time.

Answer 4: False

Question 5: Hospice care is intended to alleviate pain and suffering rather than to cure the illness.

Answer 5: True

Question 6: What are the two new fields required to be completed on the *UB-04* claim form?

Answer 6: A) Admission Date; B) Status

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

Answer 7: True

Question 8: Hospice reimbursement rates will now be based on the recipient's length of stay.

Answer 8: True

Question 9: Hospice providers should not report coexisting or additional diagnoses unrelated to the terminal illness on claims.

Answer 9: True

Question 10: Records must be kept for three years from the last service date.

Answer 10: True

