

Hospice Services

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www.dhfs.state.wi.us/medicaid
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MEMORANDUM

DATE: January 3, 2006

TO: Wisconsin Medicaid-Certified Hospice Providers

FROM: Mark Moody, Administrator 
Division of Health Care Financing

SUBJECT: Wisconsin Medicaid Hospice Services Handbook

The Division of Health Care Financing is pleased to provide a copy of the new Hospice Services Handbook to providers. This handbook articulates current Medicaid policies found in Wisconsin Administrative Code, HFS 101-108, as they apply to hospice services.

The Hospice Services Handbook incorporates current Medicaid hospice policy information into a single reference source. The handbook replaces the Part S, the Hospice Handbook, originally issued on August 1, 1990, and the following service-specific *Wisconsin Medicaid and BadgerCare Updates*:

- The November 1996 *Update* (96-43), titled "Hospice Services: Patient Liability, Required Forms, and Commonly Asked Questions."
- The June 1999 *Update* (99-21), titled "Hospice handbook replacement pages."
- The November 2000 *Update* (2000-51), titled "Billing personal care for hospice recipients."
- The June 2003 *Update* (2003-32), titled "Changes to patient liability billing due to HIPAA."
- The June 2003 *Update* (2003-38), titled "Changes to local codes and paper claims for hospice services as a result of HIPAA."
- The August 2003 *Update* (2003-93), titled "Effective dates for claims submission changes as a result of HIPAA for hospice services."
- The December 2003 *Update* (2003-161), titled "Hospice reimbursement rate increase."
- The July 2004 *Update* (2004-57), titled "Submitting Adjustment Requests for Retroactive Rate Changes."
- The November 2004 *Update* (2004-85), titled "Hospice Reimbursement Rate Increase."

This handbook does not replace the All-Provider Handbook, all-provider *Updates*, the Wisconsin Administrative Code, or Wisconsin Statutes. Subsequent changes to hospice service policies will be published first in *Updates* and later in revisions to the Hospice Services Handbook.

Additional Copies of Publications

The Wisconsin Medicaid Web site, dhfs.wisconsin.gov/medicaid/, contains additional information for all Medicaid providers, service-specific information, and electronic versions of the Hospice Services Handbook and the All-Provider Handbook.

Providers who have questions about the information in this handbook may call Provider Services at (800) 947-9627 or (608) 221-9883.

Contacting Wisconsin Medicaid

| | | |
|---|--|---|
| Web Site | | <i>dhfs.wisconsin.gov/</i> |
| The Web site contains information for providers and recipients about the following: <ul style="list-style-type: none"> • Program requirements. • Publications. • Forms. • Maximum allowable fee schedules. • Professional relations representatives. • Certification packets. | Available 24 hours a day, seven days a week | |
| Automated Voice Response System | | (800) 947-3544 (608) 221-4247 |
| The Automated Voice Response system provides computerized voice responses about the following: <ul style="list-style-type: none"> • Recipient eligibility. • Prior authorization (PA) status. • Claim status. • Checkwrite information. | Available 24 hours a day, seven days a week | |
| Provider Services | | (800) 947-9627 (608) 221-9883 |
| Correspondents assist providers with questions about the following: <ul style="list-style-type: none"> • Clarification of program requirements. • Recipient eligibility. • Resolving claim denials. • Provider certification. | Available: 8:30 a.m. - 4:30 p.m. (M, W-F) 9:30 a.m. - 4:30 p.m. (T) Available for pharmacy services: 8:30 a.m. - 6:00 p.m. (M, W-F) 9:30 a.m. - 6:00 p.m. (T) | |
| Division of Health Care Financing Electronic Data Interchange Helpdesk | | (608) 221-9036 e-mail: <i>wiedi@dhfs.state.wi.us</i> |
| Correspondents assist providers with <i>technical</i> questions about the following: <ul style="list-style-type: none"> • Electronic transactions. • Companion documents. • Provider Electronic Solutions software. | Available 8:30 a.m. - 4:30 p.m. (M-F) | |
| Web Prior Authorization Technical Helpdesk | | (608) 221-9730 |
| Correspondents assist providers with Web PA-related <i>technical</i> questions about the following: <ul style="list-style-type: none"> • User registration. • Passwords. • Submission process. | Available 8:30 a.m. - 4:30 p.m. (M-F) | |
| Recipient Services | | (800) 362-3002 (608) 221-5720 |
| Correspondents assist recipients, or persons calling on behalf of recipients, with questions about the following: <ul style="list-style-type: none"> • Recipient eligibility. • General Medicaid information. • Finding Medicaid-certified providers. • Resolving recipient concerns. | Available 7:30 a.m. - 5:00 p.m. (M-F) | |

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Preface

This Hospice Services Handbook is issued to all Medicaid-certified hospice providers. The information in this handbook applies to Medicaid and BadgerCare.

Medicaid is a joint federal and state program established in 1965 under Title XIX of the federal Social Security Act. Wisconsin Medicaid is also known as the Medical Assistance Program, WMAP, MA, Title XIX, and T19.

BadgerCare extends Medicaid coverage through a Medicaid expansion under Titles XIX and XXI. The goal of BadgerCare is to fill the gap between Medicaid and private insurance without supplanting or crowding out private insurance. BadgerCare recipients receive the same benefits as Medicaid recipients, and their health care is administered through the same delivery system.

Wisconsin Medicaid and BadgerCare are administered by the Department of Health and Family Services (DHFS). Within the DHFS, the Division of Health Care Financing is directly responsible for managing Wisconsin Medicaid and BadgerCare.

Unless otherwise specified, all information contained in this and other Medicaid publications pertains to services provided to recipients who receive care on a fee-for-service basis. Refer to the Managed Care section of the All-Provider Handbook for information about state-contracted managed care organizations.

Handbook Organization

This Hospice Services Handbook consists of the following chapters:

- General Information.
- Covered Services.
- Required Documentation.
- Prior Authorization.
- Claims Submission.
- Reimbursement.

All-Provider Handbook

All Medicaid-certified providers receive a copy of the All-Provider Handbook, which includes the following sections:

- Certification and Ongoing Responsibilities.
- Claims Information.
- Coordination of Benefits.
- Covered and Noncovered Services.
- Informational Resources.
- Managed Care.
- Prior Authorization.
- Recipient Eligibility.

Providers are required to refer to the All-Provider Handbook for information about these topics.

Wisconsin Medicaid and BadgerCare Web Sites

Publications (including provider handbooks and *Wisconsin Medicaid and BadgerCare Updates*), maximum allowable fee schedules, telephone numbers, addresses, and more information are available on the following Web sites:

- dhfs.wisconsin.gov/medicaid/.
- dhfs.wisconsin.gov/badgercare/.

Publications

Medicaid publications apply to both Wisconsin Medicaid and BadgerCare. Publications interpret and implement the laws and regulations that provide the framework for Wisconsin Medicaid and BadgerCare. Medicaid publications provide necessary information about program requirements.

Legal Framework

The following laws and regulations provide the legal framework for Wisconsin Medicaid and BadgerCare:

- Federal Law and Regulation:
 - ✓ Law — United States Social Security Act; Title XIX (42 US Code ss. 1396 and following) and Title XXI.
 - ✓ Regulation — Title 42 CFR Parts 430-498 and Parts 1000-1008 (Public Health).
- Wisconsin Law and Regulation:
 - ✓ Law — Wisconsin Statutes: 49.43-49.499 and 49.665.
 - ✓ Regulation — Wisconsin Administrative Code, Chapters HFS 101-109.

Laws and regulations may be amended or added at any time. Program requirements may not be construed to supersede the provisions of these laws and regulations.

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General Information

Hospice care provides services for people who are terminally ill and for their family members. Hospice care is designed to do the following:

- Affirm life and neither hasten nor postpone death.
- Emphasize living one's remaining days as fully as possible.
- Provide grief support to the surviving family.
- Provide patient-directed care for the terminally ill recipient and family.
- Provide relief from the physical and emotional pain that often accompanies a terminal illness.

HFS 107.31(2)(a), Wis. Admin. Code, defines hospice services as the following:

Those services provided to an eligible recipient by a provider certified under s. HFS 105.50 which are necessary for the palliation and management of terminal illness and related conditions. These services include supportive care provided to the family and other individuals caring for the terminally ill recipient.

Core and Other Functions of Hospice

Hospice services can either be provided directly by the hospice or by an organization under contract with the hospice. The following are descriptions of core functions (those services provided directly by the hospice) and other functions (those specialty services that may be provided by an organization under contract with the hospice). The hospice is required to maintain professional, financial, and administrative responsibility for both core and other functions.

Core Functions

Core functions required under HFS 107.31(2)(c), Wis. Admin. Code, must be provided directly by the hospice unless an emergency or extraordinary circumstance exists.

The following services are core functions that must be provided directly by hospice employees unless the recipient is receiving short-term institutional care:

- Administrative and supervisory physician services.
- Counseling services, including, but not limited to, bereavement counseling, dietary counseling, and spiritual counseling. Counseling services must be available to the terminally ill and the family members or other persons caring for the individual at home.
- Medical social services provided by a social worker under the direction of a physician. The social worker is required to have at least a Bachelor's degree in social work from a college or university accredited by the Council of Social Work Education.
- Nursing care by, or under the supervision of, a registered nurse, including home health aide services.
- Volunteer services.

Other Functions

Other functions related to the terminal illness are defined as those supplemental services required under HFS 107.31(2)(d), Wis. Admin. Code, for which a hospice may contract to meet unusual staffing needs when it is not practical to hire additional staff or to obtain

Core functions required under HFS 107.31(2)(c), Wis. Admin. Code, must be provided directly by the hospice unless an emergency or extraordinary circumstance exists.

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physician specialty services. Other functions include the following:

- Physical therapy (PT).
- Occupational therapy (OT).
- Speech and language pathology (SLP).
- Durable medical equipment, disposable medical supplies, and personal care items related to palliation or management of the recipient's terminal illness, provided by the hospice for use in the recipient's home while under hospice care, as part of the written plan of care (POC).
- Drugs that are used primarily for the relief of pain and symptom control and related to the individual's terminal illness.
- Short-term inpatient care provided in a hospital or skilled nursing facility (SNF) for pain control, acute symptom management, and respite purposes.

Note: Physical therapy, OT, and SLP services may be provided for purposes of symptom control or to enable the recipient to maintain activities of daily living and basic functional skills.

Contracts with other organizations must include identification of services to be provided, the qualifications of the contractor's personnel, the role and responsibility of each party, and a stipulation that all services provided be in accordance with applicable state and federal statutes, rules and regulations, and conform to accepted standards of professional practice. Contracted functions are paid for by the hospice.

Provider Certification

Hospice providers are required, under HFS 105.50, Wis. Admin. Code, to be enrolled in Medicare as a hospice under 42 CFR s. 418.50-418.100.

The attending physician is required to be individually certified as a physician in order to submit claims to Wisconsin Medicaid. Hospices that wish to submit claims for more

than one physician may obtain a physician group billing number, but each attending physician is required to be individually Medicaid certified.

Scope of Service

Section 49.46(2)(b)10, Wis. Stats., and HFS 101.03(75m) and 107.31(2)(a), Wis. Admin. Code, provide the legal framework for the program requirements in this handbook.

Medicaid Provider Responsibilities

Wisconsin Medicaid-certified providers have several responsibilities that include, but are not limited to, the following:

- Providing the same level and quality of care to Medicaid recipients as private-pay patients.
- Submitting claims only for services that were actually provided.
- Complying with all state and federal laws related to Wisconsin Medicaid.
- Obtaining prior authorization for certain services, when applicable.
- Notifying recipients in advance if a service is not Medicaid covered.
- Maintaining accurate medical and billing records.
- Allowing recipient access to his or her records.
- Monitoring contracted staff.
- Accepting Medicaid reimbursement as payment in full for covered services.
- Keeping information current.
- Notifying Wisconsin Medicaid of changes in ownership.
- Responding to Medicaid recertification notifications.
- Safeguarding recipient confidentiality.
- Verifying recipient eligibility, including other health insurance sources and state-contracted managed care organization coverage.
- Keeping up-to-date with changes in program requirements as announced in Medicaid publications.

Hospices that wish to submit claims for more than one physician may obtain a physician group billing number, but each attending physician is required to be individually Medicaid certified.

It is essential that providers refer to the All-Provider Handbook for more information on these and other topics.

Hospice Responsibilities

Each hospice is required to have an interdisciplinary team or group to provide or supervise care and services. This group is made up of at least a physician, a registered nurse, a medical social worker, and a pastoral counselor or other counselor — all of whom are employees of the hospice.

Refer to the Certification and Ongoing Responsibilities section of the All-Provider Handbook for detailed information about specific responsibilities for Medicaid-certified providers, fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

Recipient Eligibility

Medicaid providers should *always* verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage.

Eligibility information for specific recipients is available from the Medicaid Eligibility Verification System (EVS). The EVS is used by providers to verify recipient eligibility, including whether the recipient has a Medicaid hospice as the designated primary provider, is enrolled in a Medicaid HMO or SSI MCO, has other health insurance, or is in a limited benefit category. Providers can access the EVS through the following methods:

- 270/271 Health Care Eligibility Benefit Inquiry/Response transactions.
- Automated Voice Response system.
- Commercial eligibility verification vendors (accessed through software,

magnetic stripe card readers, and the Internet).

- Provider Services at (800) 362-3002 or (608) 221-5720.

Refer to the Recipient Eligibility section of the All-Provider Handbook for more information about recipient eligibility.

Hospice Enrollment

A Medicaid recipient is eligible for hospice services if the following conditions are met:

1. *A physician certifies that the recipient has a terminal illness that reduces his or her life expectancy to six months or less if the terminal illness runs its normal course.* The physician accomplishes this by completing a Physician Certification/Recertification of Terminal Illness form, HCF 1011, and retaining a copy in the recipient's records. Refer to the Required Documentation chapter of this handbook for more information and to Appendix 3 of this handbook for the Physician Certification/Recertification of Terminal Illness form.
2. *The recipient elects the hospice benefit and waives regular Medicaid benefits for care and/or treatment of the terminal illness or related condition.* The recipient indicates this election by completing and signing the Recipient Election of Medicaid Hospice Benefit form, HCF 1009. Refer to the Required Documentation chapter of this handbook for more information and to Appendix 5 of this handbook for the Recipient Election of Medicaid Hospice Benefit form.
3. *The hospice notifies Wisconsin Medicaid of the recipient's hospice election by completing and sending in the Notification of Medicaid Hospice Benefit Election form, HCF 1008.* Refer to the Required Documentation chapter of this handbook for more information and to Appendix 4 of this handbook for the

M Medicaid providers should *always* verify a recipient's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the recipient's coverage.

Notification of Medicaid Hospice Benefit Election form.

4. *The attending physician and the interdisciplinary team establish a written POC before hospice services are provided.* Refer to the Required Documentation chapter of this handbook for more information.

Hospice Recipient Requirements

Designated Primary Provider

When Wisconsin Medicaid receives the Notification of Medicaid Hospice Benefit Election form, the recipient is required to receive all services related to the terminal illness from the hospice and attending physician selected, regardless of whether or not that physician is employed by the hospice. The recipient remains eligible for some Medicaid benefits to treat conditions not directly related to the terminal illness, such as diabetes or other illnesses.

Discontinuation or Transfer

A recipient may discontinue the election of hospice care at any time. To discontinue receiving hospice services, a recipient is required to complete and sign the Hospice Benefit Revocation (Non-recertification)/Voluntary Discharge form, HCF 1010. Refer to Appendix 6 of this handbook for a copy of this form. The hospice is required to keep this form in the recipient's records. The hospice is required to complete and send the Notification of Medicaid Hospice Benefit Election form to notify Wisconsin Medicaid of the discontinuation of hospice services. The termination date for hospice services is the date the recipient signed the Hospice Benefit Revocation (Non-recertification)/Voluntary Discharge form.

According to HFS 131.44(3), Wis. Admin. Code, the hospice may be required to give written notice to the recipient, or authorized

person acting on behalf of the recipient, and his or her attending physician at least 14 days prior to the recipient's voluntary or involuntary discharge. The recipient may agree to waive this waiting period by indicating so on the Hospice Benefit Revocation (Non-recertification)/Voluntary Discharge form.

Upon discontinuation of hospice care, the recipient resumes regular Medicaid coverage, so long as the recipient remains eligible for Wisconsin Medicaid. A recipient may re-elect to receive hospice coverage at any time, provided he or she remains eligible for the hospice benefit.

A recipient may change the hospice from which he or she receives care. The change of the designated hospice is not considered a discontinuation of the election. To change the designation of a hospice program, a recipient must file a statement with both the hospice from which he or she has received care and the newly designated hospice that includes the following:

- The name of the hospice from which the recipient has been receiving care.
- The name of the hospice from which he or she plans to receive care.
- The date the change will be effective.

If a hospice recipient chooses to discontinue or transfer hospice services, the hospice is required to notify Wisconsin Medicaid within five working days of the date of discontinuation or transfer at the following address:

Wisconsin Medicaid
Recipient Services
PO Box 6678
Madison WI 53716-0678

Recipients Residing in Nursing Homes

When a resident of a Medicaid-certified SNF elects to receive hospice care services and the hospice has a contract with that nursing home, the provider is required to complete Section II

A recipient may discontinue the election of hospice care at any time. To discontinue receiving hospice services, a recipient is required to complete and sign the Hospice Benefit Revocation (Non-recertification)/Voluntary Discharge form, HCF 1010.

Providers are prohibited from collecting copayment for hospice services.

of the Notification of Medicaid Hospice Benefit Election form and submit it to Wisconsin Medicaid. If a recipient enters a nursing home after admission to a hospice, the provider is required to complete Section III of the Notification of Medicaid Hospice Benefit Election form and submit it to Wisconsin Medicaid.

Copayment

Providers are prohibited from collecting copayment for hospice services. Services that are provided outside the hospice benefit, which are not directly related to management or palliation of the recipient's terminal illness, may be subject to copayment.

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Covered Services

Hospice Care Service Categories

A hospice is reimbursed for services it provides to a recipient based on the following categories of hospice care:

- *Routine care*, with a per diem rate for less than eight hours of care per day.
- *Continuous care*, with an hourly rate for eight to 24 hours of care per day.
- *Inpatient respite care* in a hospital or skilled nursing facility (SNF) meeting SNF staffing, hourly, and environmental requirements.
- *General inpatient care* in a hospital or SNF.

Hospice Care Services and Limitations

Hospice services covered by Wisconsin Medicaid are billed under the categories of care listed previously. Refer to the Claims Submission chapter of this handbook for more information and Appendix 7 of this handbook for allowable revenue codes.

Wisconsin Medicaid will reimburse only one of the four categories of hospice care on a single date of service (DOS).

Routine Care

Routine care is hospice care that is needed on a regular, part-time basis and is provided in the recipient's place of residence (e.g., home or nursing facility).

Routine care may be reimbursed for each day that the recipient is receiving hospice care and at home or permanently residing in a nursing facility. Wisconsin Medicaid will reimburse a hospice for routine care if less than eight hours of care is provided in a day.

Continuous Care

Wisconsin Medicaid will reimburse a hospice for continuous care if a minimum of eight hours of care is provided on a DOS. A DOS begins and ends at midnight. The recipient may be at home or permanently residing in a nursing facility.

Continuous care is nursing care provided by either a registered nurse (RN) or licensed practical nurse (LPN). An RN or LPN is required to provide care for more than half of the minimum eight-hour period within a 24-hour period. The time billed does not need to be continuous (e.g., four hours in the morning and four hours in the afternoon). Homemaker and aide services may be provided to supplement the nursing care.

Inpatient Respite Care

Inpatient respite care is short-term inpatient care provided to the hospice recipient only when necessary to relieve the family members or others caring for the recipient at home.

For each day inpatient respite care is provided, the hospice is required to submit claims to Wisconsin Medicaid for services using the inpatient respite care revenue code. The hospice is responsible for paying the hospital or SNF that provided the care.

Inpatient care for respite purposes must be provided by a Medicaid-certified hospital or SNF that meets the *additional certification* requirements noted in HFS 132, Wis. Admin. Code, regarding staffing, patient areas, and 24-hour nursing service for SNFs.

Limitations Applicable to Inpatient Respite Care

An inpatient stay for respite care must not exceed *five* consecutive days per instance, including the date of admission but not counting the date of discharge.

Wisconsin Medicaid will reimburse only one of the four categories of hospice care on a single date of service (DOS).

Inpatient care exceeding five consecutive days must be medically necessary for pain control and symptom management and must be billed as general inpatient care.

General Inpatient Care

General inpatient care is short-term inpatient care necessary for pain control and symptom management.

For each day general inpatient care is provided, the hospice is required to submit claims to Wisconsin Medicaid for services using the general inpatient care revenue code. The hospice is responsible for paying the hospital or SNF that provided the care.

General inpatient care must be provided by a Medicaid-certified hospital, an SNF certified by Wisconsin Medicaid, or a hospice certified under 42 CFR Part 418 meeting conditions specified under 42 CFR s. 418.98.

Limitations Applicable to Inpatient Respite and General Inpatient Care

For each hospice, the total number of inpatient days (both for general inpatient care and inpatient respite care) must not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients enrolled in the hospice during the same period, beginning with services rendered November 1 of each year and ending October 31 of the next year. This limitation is applied once each year, at the end of the hospice cap period. Inpatient days for persons with Acquired Immune Deficiency Syndrome (AIDS) diagnoses are not included in these limitations.

If the aggregate number of inpatient days does exceed 20 percent of the aggregate total number of days of hospice care, the hospice is required to reimburse Wisconsin Medicaid for the amount of reimbursement for days over the 20 percent cap. Wisconsin Medicaid will notify the hospice of the amount to be refunded.

For the date of discharge from an inpatient unit, the appropriate routine or continuous care procedure code must be billed rather than an inpatient code, unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the general or respite inpatient care procedure code must be billed for the discharge date.

Nursing Home Room and Board

When a resident of a Medicaid-certified SNF elects to receive hospice care services, the hospice must contract with that facility to provide the recipient's *room and board* and the hospice assumes responsibility for the management of the individual's hospice care.

Room and board includes assistance in activities of daily living and personal care, socializing activities, administration of medications, maintaining cleanliness of the recipient's room, and supervising and assisting in the use of durable medical equipment (DME) and prescribed therapies. In this situation, Wisconsin Medicaid will reimburse the hospice for room and board charges and the hospice will pay the nursing facility.

Each day that room and board is provided must be billed using the room and board revenue code. Routine and continuous care hospice services may be billed, as appropriate, on the same DOS that nursing home room and board is billed.

Wisconsin Medicaid will reimburse the hospice 95 percent of the nursing home's current SNF rate for each DOS on which room and board is provided.

Limitations Applicable to Nursing Home Room and Board

Room and board for an SNF resident is not reimbursed for the same DOS as inpatient respite or general inpatient care.

When a resident of a Medicaid-certified SNF elects to receive hospice care services, the hospice must contract with that facility to provide the recipient's *room and board* and the hospice assumes responsibility for the management of the individual's hospice care.

Physician Services

Reimbursable physician services are those face-to-face care services provided by the recipient's attending physician that are related to his or her terminal illness. These services are *not* included in the hospice cap amount, but are billed separately by the attending physician. Wisconsin Medicaid will reimburse the lesser of the provider's usual and customary charge for the services provided or the maximum allowable fee established for each allowable procedure.

The rates for the various types of hospice care and room and board include reimbursement for the general supervisory functions of attending physicians who are employed by, or under contract with, the hospice. Services such as participation in the establishment of plans of care (POC), supervision of care and services, review or updating of POC, or establishment of governing policies are not separately reimbursed since these costs are included in the hospice rates.

Services provided by a referred physician are reimbursable only when deemed medically necessary by the attending physician and the recipient is referred by the attending physician.

Durable Medical Equipment/Personal Care Services

In the limited situations where DME, oxygen-related services, or personal care services are provided to a hospice recipient but are not reimbursable under the hospice benefit because they are not directly related to the care of the terminal illness, providers of these services are required to follow Medicaid requirements for prior authorization (PA) and claims submission. Refer to the Prior Authorization chapter of this handbook for information on PA for personal care services.

Reimbursement Not Available

Wisconsin Medicaid may deny or recoup payment for covered services that fail to meet program requirements. Medicaid reimbursement is also not available for noncovered services.

Refer to the Covered and Noncovered Services section of the All-Provider Handbook for more information about services that do not meet program requirements, noncovered services, and situations when it is permissible to collect payment from recipients for noncovered services.

Hospice providers may not receive Medicaid reimbursement for the following:

- Administrative and supervisory physician services that are included in the hospice daily rate.
- Physician services that are not covered for all Medicaid recipients.
- Services related to the terminal illness that are provided by providers other than the hospice, its contractees, or the attending physician.
- Services that are curative rather than palliative.

Refer to Appendix 9 of this handbook for information about services provided outside the hospice benefit.

Services such as participation in the establishment of plans of care (POC), supervision of care and services, review or updating of POC, or establishment of governing policies are not separately reimbursed since these costs are included in the hospice rates.

Refer to the Online Handbook for more information about policy.

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Required Documentation

The recipient must have written certification by the hospice medical director, the physician member of the interdisciplinary team, or the recipient's attending physician stating that the recipient has a terminal illness that reduces life expectancy to six months or less if the terminal illness runs its normal course.

The documentation outlined in this chapter is required for all Medicaid recipients receiving the hospice benefit. With the exception of the Notification of Medicaid Hospice Benefit Election form, HCF 1008, providers may use the forms in this handbook or substitute their own forms, as long as the provider's form contains all of the same information as the Medicaid form.

Note: Not all forms discussed in this chapter should be sent to Wisconsin Medicaid; the following forms should be kept in the recipient's record:

- Physician Certification/Recertification of Terminal Illness, HCF 1011.
- Recipient Election of Medicaid Hospice Benefit, HCF 1009.

Physician Certification/Recertification of Terminal Illness

The recipient must have written certification by the hospice medical director, the physician member of the interdisciplinary team, or the recipient's attending physician stating that the recipient has a terminal illness that reduces life expectancy to six months or less if the terminal illness runs its normal course. An interdisciplinary group is defined as a group of persons designated by a hospice to provide or supervise care and services made up of at least a physician, a registered nurse, a medical social worker and a pastoral counselor or other counselor, all of whom are employees of the hospice.

The physician(s) is required to sign a Physician Certification/Recertification of Terminal Illness form and the hospice is required to keep a record of it in the recipient's record; the form in Appendix 3 of this handbook may be used for this purpose. If the recipient is not

deceased at the end of six months, the physician is required to recertify that the recipient's terminal illness reduces his or her life expectancy to six months or less.

If a recipient discontinues hospice care and later wishes to have hospice care reinstated, the attending physician must recertify that the recipient has a terminal illness that reduces his or her life expectancy to six months or less. The recipient will then be recertified for hospice care for a full six months. Refer to Appendix 3 of this handbook for a copy of the Physician Certification/Recertification of Terminal Illness form.

If a verbal certification is obtained within two calendar days after the initial six-month period of care begins, the hospice has up to eight calendar days after the six-month period begins to obtain a written physician certification of a recipient's terminal illness. If the physician's written certification is not obtained within eight calendar days, only services provided on and after the signature date of the physician's certification are reimbursed.

The hospice is required to keep the Physician Certification/Recertification of Terminal Illness form in the recipient's record and should not send it to Wisconsin Medicaid.

Recipient Election of Medicaid Hospice Benefit

A Recipient Election of Medicaid Hospice Benefit form must be completed and filed with the hospice for a Medicaid recipient who has been certified as terminally ill and who elects to receive hospice care. The election date designates the first date of service for which hospice care can be reimbursed by Wisconsin Medicaid. A recipient who signs an election statement elects hospice care benefits and waives regular Medicaid benefits, except for

the services provided by an attending physician. An attending physician is defined as a physician who is a doctor of medicine or osteopathy certified under HFS 105.05, Wis. Admin. Code, and identified by the recipient as having the most significant role in the determination and delivery of his or her medical care at the time the recipient elects to receive hospice care.

The recipient may discontinue the election of hospice care at any time and thereby have all Medicaid benefits reinstated. A recipient may choose to reinstate hospice care services after they have discontinued these services. In the event of reinstatement, the documentation requirements of hospice apply.

The hospice is required to obtain a signed Recipient Election of Medicaid Hospice Benefit form, or its equivalent, prior to providing hospice services to the recipient. Refer to Appendix 5 of this handbook for the Recipient Election of Medicaid Hospice Benefit form for photocopying.

Notification of Medicaid Hospice Benefit Election

After a Medicaid recipient elects the hospice benefit, the hospice is required to notify Wisconsin Medicaid of the election within 30 calendar days by using the Notification of Medicaid Hospice Benefit Election form. The use of this form is mandatory; substitute forms will not be accepted by Wisconsin Medicaid.

For dual eligibles who elect hospice benefits under Medicare, the hospice is required to submit a copy of the Notification of Medicaid Hospice Benefit Election form to both Wisconsin Medicaid and Medicare.

The hospice is required to indicate the attending physician's name and Medicaid provider number on the election form. This allows Wisconsin Medicaid to reimburse claims for the attending physician.

If the recipient electing hospice care is currently, or becomes, a resident of a skilled nursing facility, the hospice is required to notify Wisconsin Medicaid of the nursing home residency by completing Section II or III on the Notification of Medicaid Hospice Benefit Election form and submitting it to Wisconsin Medicaid. Claims submitted for room and board will be denied if Wisconsin Medicaid has not received notice of the recipient's nursing home residence. The nursing home's Medicaid provider number and the recipient's Medicaid identification number must be indicated. Refer to Appendix 4 of this handbook for the Notification of Medicaid Hospice Benefit Election form that all hospice providers are required to use.

If a recipient is enrolled in a Medicaid HMO, the hospice should contact the recipient's HMO for its hospice procedures. Hospices should not submit the Notification of Medicaid Hospice Benefit Election form for recipients enrolled in a Medicaid HMO.

Plan of Care

A written plan of care (POC) must be established for recipients who elect to receive hospice services *before* hospice care is provided. The POC should be kept in the recipient's record and should *not* be sent to Wisconsin Medicaid.

The attending physician, the medical director or physician designee, and the interdisciplinary team are required to establish the POC. The POC must include:

- An assessment of the needs of the recipient.
- The identification of services to be provided, including management of discomfort and symptom relief.
- A description of the scope and frequency of services to the recipient and the recipient's family.
- A schedule for periodic review (at least every two weeks) and updating of the

After a Medicaid recipient elects the hospice benefit, the hospice is required to notify Wisconsin Medicaid of the election within 30 calendar days by using the Notification of Medicaid Hospice Benefit Election form.



Hospice enrollment records must be kept with the recipient's record in accordance with HFS 106.02(9), Wis. Admin. Code.

POC (as needed), evidenced by the physician's signature and date.

Ordering Forms

Medicaid hospice forms may be downloaded from the Medicaid Web site.

Copies of these forms may also be obtained by writing to the following address:

Wisconsin Medicaid
Form Reorder
6406 Bridge Rd
Madison WI 53784-0003

Form Retention and Submission

Hospice enrollment records must be kept with the recipient's record in accordance with HFS 106.02(9), Wis. Admin. Code.

Upon enrollment or a change of enrollment, the Notification of Medicaid Hospice Benefit Election form must be sent to Wisconsin Medicaid at the following address within 30 calendar days of election:

Wisconsin Medicaid
Recipient Services
PO Box 6678
Madison WI 53716-0678

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Prior Authorization

Hospice services (core or other functions) do *not* require prior authorization (PA). Medicaid-covered services that would otherwise require PA do *not* require PA when billed by the attending physician for a hospice recipient.

Hospice services (core or other functions) do *not* require prior authorization (PA). Medicaid-covered services that would otherwise require PA do *not* require PA when billed by the attending physician for a hospice recipient.

Providers of other Medicaid-covered services should follow the program requirements outlined in their service-specific publications.

Prior Authorization for Personal Care Services

Recipients receiving personal care through Wisconsin Medicaid who elect the hospice benefit may be eligible to continue receiving personal care services from the personal care agency if those services are not directly related to the terminal illness.

If this criterion is met, the agency providing personal care services will have already received PA for the recipient. The personal care agency is required to submit a Prior

Authorization Amendment Request, HCF 11042, and attach a copy of the hospice plan of care (POC) that identifies the need for continued personal care services as well as the specific services provided directly by the hospice. The POC must also indicate any aide services to be provided by the hospice. This must be sent within seven calendar days of the recipient's election of hospice care. The completion instructions and Prior Authorization Amendment Request form are located in the Prior Authorization section of the All-Provider Handbook for photocopying and may also be downloaded and printed from the Medicaid Web site.

When the personal care PA needs to be renewed, a current hospice POC must be included. Renewal of PA for personal care services may be granted up to, but not exceeding, the current level of service. Additional personal care needs resulting from the terminal illness are the responsibility of the hospice.

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for current policy

Claims Submission

To receive reimbursement, claims and adjustment requests must be received by Wisconsin Medicaid within 365 days of the date of service (DOS). To receive reimbursement for services that are allowed by Medicare, claims and adjustment requests for coinsurance, copayment, and deductible must be received by Wisconsin Medicaid within 365 days of the DOS, or within 90 days of the Medicare processing date, whichever is later.

For more information about exceptions to the claims submission deadline, Medicaid remittance information, adjustment requests, and returning overpayments, refer to the Claims Information section of the All-Provider Handbook.

Coordination of Benefits

Except for a few instances, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. Therefore, the provider is required to make a reasonable effort to exhaust all existing other health insurance sources before submitting claims to Wisconsin Medicaid or to state-contracted managed care organizations.

Because room and board are not covered by Medicare, claims for room and board for dual eligibles may be submitted directly to Wisconsin Medicaid.

Refer to the Coordination of Benefits section of the All-Provider Handbook for more information about services that require other health insurance billing, exceptions, claims submission procedures for recipients with other health insurance, and the Other Coverage Discrepancy Report, HCF 1159.

837 Health Care Claim: Institutional

Providers are encouraged to submit claims electronically since electronic claims submission usually reduces claim errors. Claims for hospice services may be submitted using the 837 Health Care Claim: Institutional (837I) transaction except when submitting claims that require additional documentation. In these situations, providers are required to submit paper claims.

Refer to the Informational Resources section of the All-Provider Handbook for more information about electronic transactions.

UB-92

Paper claims for hospice services must be submitted using the UB-92 claim form (with the exception of physician services). Wisconsin Medicaid denies claims for hospice services submitted on any paper claim form other than the UB-92.

When Medicare is the primary payer, hospices are required to follow the Medicare instructions. All other UB-92 claim forms submitted must follow the UB-92 claim form instructions developed by Wisconsin Medicaid.

Wisconsin Medicaid does not provide the UB-92 claim form. The form may be obtained from any federal forms supplier.

The UB-92 completion instructions and a sample claim form for hospice services can be found in Appendices 1 and 2 of this handbook.

Service limitations and billing instructions for physician services are included in the Physician Services Handbook, which is available on the Medicaid Web site.

Because room and board are not covered by Medicare, claims for room and board for dual eligibles may be submitted directly to Wisconsin Medicaid.

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Billed Amounts

Hospice providers submitting claims to Wisconsin Medicaid for routine care, continuous care, inpatient respite care, or general inpatient care are required to indicate their usual and customary charge for services provided.

Hospice providers submitting claims for room and board are required to indicate the nursing home room and board rate. Wisconsin Medicaid reimburses up to the Medicaid-established skilled nursing facility rate for that nursing home.

The hospice or attending physician submitting claims for physician services is required to indicate his or her usual and customary charge for services provided.

Billing Increments

When submitting claims for continuous care services, hospice providers are required to indicate services in hour or half-hour increments, rounded to the nearest half-hour. Refer to Appendix 8 of this handbook for rounding guidelines for these services.

When submitting claims for routine care, general inpatient care, inpatient respite care, and room and board, the service must be indicated as a quantity of "1" per DOS.

Diagnosis Codes

All diagnoses must be from the *International Classification of Diseases, Ninth Revision, Clinical Modifications (ICD-9-CM)* coding structure and must be allowed for the DOS.

Claims received without an allowable ICD-9-CM code are denied.

Hospice providers should note the following diagnosis code restrictions:

- Codes with an "E" prefix must not be used as the primary or sole diagnosis on a claim submitted to Wisconsin Medicaid.
- Codes with an "M" prefix are not acceptable on a claim submitted to Wisconsin Medicaid.
- Recipients with a diagnosis of Acquired Immune Deficiency Syndrome (AIDS)/AIDS Related Condition (AIDS/ARC) must be identified with ICD-9-CM code 042 for their services to be exempt from the hospice cap.

Revenue Codes

Revenue codes are required on all claims submitted using the UB-92 or 837I. Claims or adjustment requests for hospice services without revenue codes are denied. Allowable revenue codes and their descriptions for hospice services are included in Appendix 7 of this handbook.

Fee Schedule

The maximum allowable fee is the maximum amount that Wisconsin Medicaid will pay a provider for an allowable procedure code. Hospice providers may obtain a maximum allowable fee schedule that contains reimbursement rates from one of the following sources:

- An electronic version on the Medicaid Web site.
- A paper copy, which may be purchased by doing either of the following:
 - ✓ Calling Provider Services at (800) 947-9627 or (608) 221-9883 for the cost of the fee schedule.
 - ✓ Writing to the following address:

Wisconsin Medicaid
Provider Maintenance
6406 Bridge Rd
Madison WI 53784-0006

Revenue codes are required on all claims submitted using the UB-92 or 837I. Claims or adjustment requests for hospice services without revenue codes are denied.

Reimbursement

Wisconsin Medicaid reimburses the hospice for the following services under five national revenue codes:

- 0651: Hospice Services — Routine home care.
- 0652: Hospice services — Continuous home care.
- 0655: Hospice services — Inpatient respite care.
- 0656: Hospice services — General inpatient care.
- 0169: Room and board — Other (for skilled nursing facility).

Hospice services are reimbursed at the per diem or hourly amounts allowed by the federal Centers for Medicare and Medicaid Services (CMS). Wisconsin Medicaid reimburses the hospice directly; the hospice is then responsible for paying the nursing home or hospital. Refer to the Covered Services chapter of this handbook for more information about hospice services and nursing home room and board. Refer to Appendix 7 of this handbook for more information about revenue codes.

Nursing Home Room and Board

For hospice recipients who permanently reside in a nursing home, Wisconsin Medicaid reimburses the hospice for nursing home room and board at 95 percent of the nursing home's current skilled nursing facility (SNF) rate, regardless of the recipient's level of care designation.

Wisconsin Medicaid does *not* automatically adjust paid hospice claims for nursing home room and board if the nursing home's rate is changed retroactively. To receive a retroactive rate change, the hospice provider is required to submit an adjustment request for the affected claim.

The hospice is required to reimburse any provider with whom it has contracted for service, including a facility providing inpatient care under HFS 107.31(3)(d)3, Wis. Admin. Code.

Refer to the Claims Information section of the All-Provider Handbook for more information about submitting adjustment requests.

Paper Adjustment Requests

The completion instructions and Adjustment/Reconsideration Request form, HCF 13046, which are used to request a retroactive rate change on paper, are located in the Claims Information section of the All-Provider Handbook for photocopying and may also be downloaded and printed from the Medicaid Web site. Refer to Appendix 10 of this handbook for a sample Adjustment/Reconsideration Request for a retroactive nursing home rate adjustment. On Element 16 of the Adjustment/Reconsideration Request, "Other" should be checked and the following should be written as a comment: "To obtain retroactive rate increase for nursing home room and board."

Wisconsin Medicaid does *not* automatically adjust paid hospice claims for nursing home room and board if the nursing home's rate is changed retroactively.

RESEARCH/INTERNAL USE ONLY
Refer to the All-Provider Handbook for current policy.

Patient Liability

For a hospice recipient residing in a nursing home, the nursing home, hospice, and Wisconsin Medicaid each play a role in collecting patient liability. Patient liability is the amount of an individual's income that is available to apply on a monthly basis toward the recipient's cost of care.

The nursing home is responsible for:

- Collecting patient liability from the Medicaid recipient residing in their facility.
- Transferring the patient liability amount to the recipient's hospice.
- Billing the hospice its contracted amount for room and board.

The hospice is responsible for:

- Paying the nursing home the contracted amount for room and board.
- Accepting as income the patient liability amount received from the nursing home and reporting this amount on the claim submitted to Wisconsin Medicaid.
- Indicating its usual and customary amount for nursing home room and board using revenue code 0169 for claims submitted to Wisconsin Medicaid and submitting claims to Wisconsin Medicaid only once per calendar month.

Wisconsin Medicaid is responsible for:

- Deducting the patient liability, as reported to the state by the county, from the amount to be reimbursed to the hospice.
- Reimbursing the hospice 95 percent of the nursing home's SNF rate minus the patient's liability.

Hospice Cap on Overall Reimbursement

Each year, CMS establishes a maximum amount for aggregate payments made to a hospice during a hospice cap period that runs from November 1 through October 31 of the following year. The hospice cap period is defined as the period of time during which the payment for those hospice services counting towards the cap will be counted, by *date of service*.

The aggregate payments do not include payment for direct care by the attending physician or inpatient days for persons with Acquired Immune Deficiency Syndrome (AIDS). Payments made to hospices by Wisconsin Medicaid in excess of the cap on overall reimbursement will be recouped. The Division of Health Care Financing (DHCF) will notify the hospice of the overpayment and the required repayment.

Payments are measured in terms of all payments made to hospices on behalf of all Medicaid hospice beneficiaries receiving services during the cap year, regardless of the year in which a beneficiary is counted when determining the cap.

The computation and application of the cap amount is made by the DHCF at the end of the cap period. The hospice will be responsible for reporting the number of Medicaid recipients electing hospice care during the period to the DHCF. This must be done by November 30 of each year.

E Each year, CMS establishes a maximum amount for aggregate payments made to a hospice during a hospice cap period that runs from November 1 through October 31 of the following year.

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A Appendix

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Appendix 1

UB-92 (CMS 1450) Claim Form Instructions for Hospice Services

Use the following claim form completion instructions, *not* the form locator descriptions printed on the claim form, to avoid denied claims or inaccurate claim payment. Complete all required form locators as appropriate. Do not include attachments unless instructed to do so.

These instructions are for the completion of the UB-92 (CMS 1450) claim for Wisconsin Medicaid. For complete billing instructions, refer to the National UB-92 Uniform Billing Manual prepared by the National Uniform Billing Committee (NUBC). The National UB-92 Uniform Billing Manual contains important coding information not available in these instructions. Providers may purchase the National UB-92 Uniform Billing Manual by writing or calling:

American Hospital Association
National Uniform Billing Committee
29th Fl
1 N Franklin
Chicago IL 60606
(312) 422-3390

For more information, go to the NUBC Web site at www.nubc.org/.

Wisconsin Medicaid recipients receive a Medicaid identification card upon being determined eligible for Wisconsin Medicaid. Always verify a recipient's eligibility before providing nonemergency services by using the Eligibility Verification System (EVS) to determine if there are any limitations on covered services and to obtain the correct spelling of the recipient's name. Refer to the Informational Resources section of the All-Provider Handbook or the Medicaid Web site for more information about the EVS.

Submit completed paper claims to the following address:

Wisconsin Medicaid
Claims and Adjustments
6406 Bridge Rd
Madison WI 53784-0002

Form Locator 1 — Provider Name, Address, and Telephone Number

Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, street, city, state, and ZIP code. The name in Form Locator 1 should correspond with the provider number in Form Locator 51.

Form Locator 2 — ERO Assigned Number (not required)

Form Locator 3 — Patient Control No. (not required)

Appendix 1 (Continued)

Form Locator 4 — Type of Bill

Enter the three-digit type of bill number. The first digit identifies the type of facility. The second digit classifies the type of care. Hospice providers should use bill types 81X (non-hospital-based hospice) and 82X (hospital-based hospice). The third digit (“X”) indicates the billing frequency, and providers should enter one of the following for “X”:

- 1 = Admit through discharge claim.
- 2 = Interim — first claim.
- 3 = Interim — continuing claim.
- 4 = Interim — final claim.

Form Locator 5 — Fed. Tax No. (not required)

Form Locator 6 — Statement Covers Period (From - Through) (not required)

Form Locator 7 — Cov D. (not required)

Form Locator 8 — N-C D. (not required)

Form Locator 9 — C-I D. (not required)

Form Locator 10 — L-R D. (not required)

Form Locator 11 — Unlabeled Field (not required)

Form Locator 12 — Patient Name

Enter the recipient’s last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the recipient’s name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Form Locator 13 — Patient Address (not required)

Form Locator 14 — Birthdate (not required)

Form Locator 15 — Sex (not required)

Form Locator 16 — MS (not required)

Form Locator 17 — Admission Date (not required)

Form Locator 18 — Admission Hr (not required)

Form Locator 19 — Admission Type (not required)

Form Locator 20 — Admission Src (not required)

Form Locator 21 — D Hr (not required)

Form Locator 22 — Stat (not required)

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Appendix 1 (Continued)

Form Locator 23 — Medical Record No.

This is an optional field. Enter the number assigned to the patient’s medical/health record by the provider. This number will appear on the Remittance and Status Report and/or the 835 Health Care Claim Payment/Advice transaction.

Form Locators 24-30 — Condition Codes (required, if applicable)

If appropriate, enter a code to identify conditions relating to this claim.

Form Locator 31 — Unlabeled Field (not required)

Form Locators 32-35 a-b — Occurrence Code and Date (required, if applicable)

If appropriate, enter the code and associated date defining a significant event relating to this claim that may affect payer processing. Enter dates in MM/DD/YY format (e.g., January 1, 2004, would be 010104).

Form Locator 36 a-b — Occurrence Span Code (From - Through) (not required)

Form Locator 37 A-C — Internal Control Number/Document Control Number (not required)

Form Locator 38 — Responsible Party Name and Address (not required)

Form Locators 39-41 a-d — Value Code and Amount (required, if applicable)

Wisconsin Medicaid uses the following value codes.

| Code | Description |
|------|---|
| 81 | <i>Medicare Part B Charges When Part A Exhausted.</i> Enter the full amount of Medicare Part B charges when billing for services after Medicare Part A has been exhausted. |
| 83 | <i>Medicare Part A Charges When Part A Exhausted.</i> Enter the sum of the Medicare paid amount, the coinsurance amount, and the deductible when billing for services after Medicare Part A has been exhausted. |

Form Locator 42 — Rev. Cd.

Enter the national four-digit revenue code that identifies a specific accommodation, ancillary service, or billing calculation. Enter revenue code “0001” on the line with the sum of all the charges.

Form Locator 43 — Description

Enter the date of service (DOS) in MM/DD/YY format in Form Locator 43 or Form Locator 45.

When series billing (i.e., billing from two to four DOS on the same line), indicate the DOS in the following format: MM/DD/YY MM/DD MM/DD MM/DD. Indicate the dates in ascending order. Providers may enter up to four DOS for each revenue code if:

- All DOS are in the same calendar month.
- All procedures performed are identical.
- All procedures were performed by the same provider.
- The number of units indicated in Form Locator 46 must be divisible by the number of DOS.

If it is necessary to indicate more than four DOS per revenue code, indicate the dates on the subsequent lines. On paper claims, no more than 23 lines may be submitted on a single claim including the “Total Charges” line.

Form Locator 44 — HCPCS/Rates (not required)

Appendix 1 (Continued)

Form Locator 45 — Serv. Date

Enter the DOS in MM/DD/YY format in Form Locator 45 or Form Locator 43. Multiple DOS must be indicated in Form Locator 43.

Form Locator 46 — Serv. Units

Enter the number of reimbursable accommodations days, ancillary units of service, or visits, where appropriate. Units are measured in days for revenue codes “0169,” “0651,” “0655,” and “0656,” and in hours for revenue code “0652.”

Form Locator 47 — Total Charges

Enter the usual and customary charge for each line item. Enter revenue code “0001” to report the sum of all charges in Form Locator 47.

Form Locator 48 — Non-covered Charges (not required)

Form Locator 49 — Unlabeled Field (not required)

Form Locator 50 A-C — Payer

Enter all health insurance payers here. For example, enter “T19” for Wisconsin Medicaid and/or the name of private insurance. Enter “patient liability amount” to identify any patient liability.

Form Locator 51 A-C — Provider No.

Enter the number assigned to the provider by the payer indicated in Form Locator 50 A-C. For Wisconsin Medicaid, enter the eight-digit provider number. The provider number in Form Locator 51 should correspond with the name in Form Locator 1.

Form Locator 52 A-C — Rel Info (not required)

Form Locator 53 A-C — Asg Ben (not required)

Form Locator 54 A-C & P — Prior Payments (required, if applicable)

Enter the actual amount paid by commercial insurance. (If the dollar amount indicated in Form Locator 54 is greater than zero, “OI-P” must be indicated in Form Locator 84.) If the commercial insurance denied the claim, enter “000.” Do *not* enter Medicare-paid amounts in this field, but attach a copy of the Medicare remittance information.

Form Locator 55 A-C & P — Est Amount Due (required, if applicable)

Enter the dollar amount of any patient liability.

Form Locator 56 — Unlabeled Field (not required)

Form Locator 57 — Unlabeled Field (not required)

Form Locator 58 A-C — Insured’s Name (not required)

Form Locator 59 A-C — P. Rel (not required)

Form Locator 60 A-C — Cert. - SSN - HIC. - ID No.

Enter the recipient’s 10-digit Medicaid identification number. Do not enter any other numbers or letters. Use the Medicaid identification card or EVS to obtain the correct identification number.

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**Appendix 1
(Continued)**

Form Locator 61 A-C — Group Name (not required)

Form Locator 62 A-C — Insurance Group No. (not required)

Form Locator 63 A-C — Treatment Authorization Codes (not required)

Form Locator 64 A-C — ESC (not required)

Form Locator 65 A-C — Employer Name (not required)

Form Locator 66 A-C — Employer Location (not required)

Form Locator 67 — Prin. Diag Cd.

Enter the full *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) code (up to five digits) describing the principal diagnosis (e.g., the condition established after study to be chiefly responsible for causing the admission or other health care episode). Do not enter manifestation codes as the principal diagnosis; code the underlying disease first. The principal diagnosis may not include “E” codes.

Form Locators 68-75 — Other Diag. Codes

Enter valid ICD-9-CM diagnosis codes corresponding to additional conditions that coexist at the time of admission, or develop subsequently, and that have an effect on the treatment received or the length of stay. Diagnoses that relate to an earlier episode and that have no bearing on this episode are to be excluded. Providers should prioritize diagnosis codes as relevant to this claim.

Form Locator 76 — Adm. Diag. Cd. (not required)

Form Locator 77 — E-Code (not required)

Form Locator 78 — Race/Ethnicity (not required)

Form Locator 79 — P.C. (not required)

Form Locator 80 — Principal Procedure Code and Date (not required)

Form Locator 81 — Other Procedure Code and Date (not required)

Form Locator 82 a-b — Attending Phys. ID

Enter the Universal Provider Identification Number or license number and name.

Form Locator 83 a-b — Other Phys. ID (not required)

Form Locator 84 a-d — Remarks (enter information when applicable)

Commercial Health Insurance Billing Information

Commercial health insurance coverage must be billed prior to billing Wisconsin Medicaid, unless the service does not require commercial health insurance billing as determined by Wisconsin Medicaid.

Appendix 1 (Continued)

If the recipient has dental (“DEN”) or has no commercial health insurance, do not indicate an other insurance (OI) explanation code in Form Locator 84.

When the recipient has Wausau Health Protection Plan (“HPP”), BlueCross & BlueShield (“BLU”), Wisconsin Physicians Service (“WPS”), Medicare Supplement (“SUP”), TriCare (“CHA”), Vision only (“VIS”), a health maintenance organization (“HMO”), or some other (“OTH”) commercial insurance, *and* the service requires commercial health insurance billing according to the Coordination of Benefits section of the All-Provider Handbook, then one of the following three OI explanation codes *must* be indicated in Form Locator 84. The description is not required, nor is the policyholder, plan name, group number, etc.

| Code | Description |
|------|---|
| OI-P | PAID in part or in full by commercial health insurance or commercial HMO. In Form Locator 54 of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured. |
| OI-D | DENIED by commercial health insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. Do not use this code unless the claim was actually billed to the commercial health insurer. |
| OI-Y | YES, the recipient has commercial health insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to: <ul style="list-style-type: none"> ✓ The recipient denied coverage or will not cooperate. ✓ The provider knows the service in question is not covered by the carrier. ✓ The recipient's commercial health insurance failed to respond to initial and follow-up claims. ✓ Benefits are not assignable or cannot get assignment. ✓ Benefits are exhausted. |

Refer to the Online Handbook

Note: The provider may not use OI-D or OI-Y if the recipient is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not submit claims to Wisconsin Medicaid for services that are included in the capitation payment.

Medicare Information

Use Form Locator 84 for Medicare information. Submit claims to Medicare before billing Wisconsin Medicaid.

Do not indicate a Medicare disclaimer code when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- Wisconsin Medicaid indicates the recipient does *not* have any Medicare coverage including Medicare Cost (“MCC”) or Medicare + Choice (“MPC”) for the service provided. For example, the service is covered by Medicare Part A, but the recipient does not have Medicare Part A.
- Wisconsin Medicaid indicates the provider is not Medicare certified.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits or Medicare Remittance Advice, but do not indicate on the claim form the amount Medicare paid.

Appendix 1 (Continued)

If none of the previous Medicare information is true, a Medicare disclaimer code is necessary. The following Medicare disclaimer codes may be used when appropriate:

| Code | Description |
|------|--|
| M-5 | <p>Provider is not Medicare certified. This code may be used when providers are identified in Wisconsin Medicaid files as being Medicare certified, but are billing for DOS before or after their Medicare certification effective dates. Use M-5 in the following instances:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part A. ✓ The procedure provided is covered by Medicare Part A. <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B, but the provider was not certified for the date the service was provided. ✓ The recipient is eligible for Medicare Part B. ✓ The procedure provided is covered by Medicare Part B. |
| M-7 | <p>Medicare disallowed or denied payment. This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the recipient's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. Use M-7 in the following instances:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or the service is not payable due to benefits being exhausted. |
| M-8 | <p>Noncovered Medicare service. This code may be used when Medicare was not billed because the service is not covered in this circumstance. Use M-8 in the following instances:</p> <p><i>For Medicare Part A (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part A. ✓ The recipient is eligible for Medicare Part A. ✓ The service is usually covered by Medicare Part A but not in this circumstance (e.g., recipient's diagnosis). <p><i>For Medicare Part B (all three criteria must be met):</i></p> <ul style="list-style-type: none"> ✓ The provider is identified in Wisconsin Medicaid files as certified for Medicare Part B. ✓ The recipient is eligible for Medicare Part B. ✓ The service is usually covered by Medicare Part B but not in this circumstance (e.g., recipient's diagnosis). |

Appendix 1 (Continued)

Form Locator 85 — Provider Representative

The provider or the authorized representative must sign in Form Locator 85.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with the date.

Form Locator 86 — Date

Enter the month, day, and year on which the claim is submitted to the payer. The date must be entered in MM/DD/YY or MM/DD/YYYY format.

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Appendix 2 UB-92 Claim Form Sample

APPROVED OMB NO. 0938-0279

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|----------------|--------------------------------|------|--------------------------------------|------------------|--------------------|---------------|---|------------------|--|------------------------|------------------------------|----|---|--|--------------------|--|-----------------------|--|----|--|----|--|----|--|----|--|----|--|----|--|----|--|----|--|
| IM BILLING HOSPICE 321 HOSPICE RD ANYTOWN, WI 55555 (555) 321-1234 | | | | 2 | | | | 3 PATIENT CONTROL NO. | | | | 4 TYPE OF BILL 811 | | | | | | | | | | | | | | | | | | | | | | | |
| 5 FED. TAX NO. | | 6 STATEMENT COVERS PERIOD FROM | | 7 COV D | | 8 N-C-D | | 9 C-I-D | | 10 L-R-D | | 11 | | | | | | | | | | | | | | | | | | | | | | | |
| 12 PATIENT NAME RECIPIENT, IMA H. | | | | | | 13 PATIENT ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 BIRTHDATE | | 15 SEX | | 16 MS | | 17 DATE | | 18 HR | | 19 TYPE | | 20 SRC | | 21 D HR | | 22 STAT | | 23 MEDICAL RECORD NO. | | 24 | | 25 | | 26 | | 27 | | 28 | | 29 | | 30 | | 31 | |
| 32 CODE | | OCCURRENCE DATE | | 34 CODE | | OCCURRENCE DATE | | 36 CODE | | OCCURRENCE SPAN FROM | | THROUGH | | 37 A | | B | | C | | | | | | | | | | | | | | | | | |
| 38 | | a | | b | | c | | d | | 39 CODE | | VALUE CODES AMOUNT | | 41 CODE | | VALUE CODES AMOUNT | | | | | | | | | | | | | | | | | | | |
| 42 REV. CD. | 43 DESCRIPTION | | | | 44 HCPCS / RATES | | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | | 48 NON-COVERED CHARGES | | 49 | | | | | | | | | | | | | | | | | | | | | | |
| 1 | 0169 | 020104 | 0202 | 0203 | 0204 | | | 4.0 | XXX | XX | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 | | 0205 | 0206 | 0207 | 0208 | | | 4.0 | XXX | XX | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 | | 0209 | 0210 | 0211 | 0212 | | | 4.0 | XXX | XX | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4 | | 0213 | 0214 | 0215 | 0216 | | | 4.0 | XXX | XX | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5 | | 0217 | 0218 | 0219 | 0220 | | | 4.0 | XXX | XX | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6 | | 0221 | 0222 | 0223 | 0224 | | | 4.0 | XXX | XX | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7 | | 0225 | 0226 | 0227 | 0228 | | | 4.0 | XXX | XX | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8 | | 0229 | | | | | | 1.0 | XX | XX | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 | 0651 | 022504 | 0226 | 0227 | 0228 | | | 4.0 | XXX | XX | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11 | | 0229 | | | | | | 1.0 | XX | XX | | | | | | | | | | | | | | | | | | | | | | | | | |
| 12 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23 | 0001 | TOTAL CHARGES | | | | | | | XXXX | XX | | | | | | | | | | | | | | | | | | | | | | | | | |
| 50 PAYER A 45009 BLUE CROSS B T19 MEDICAID C PATIENT LIABILITY | | | | 51 PROVIDER NO. BC111 87654321 | | | | 52 REL INFO | | 53 ASG BEN | | 54 PRIOR PAYMENTS XXXX XX | | 55 EST AMOUNT DUE XX XX | | 56 | | | | | | | | | | | | | | | | | | | |
| 57 DUE FROM PATIENT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 58 INSURED'S NAME | | | | 59 P. REL. | | | | 60 CERT. - SSN - HIC - ID NO. 1234567890 | | | | 61 GROUP NAME | | 62 INSURANCE GROUP NO. | | | | | | | | | | | | | | | | | | | | | |
| 63 TREATMENT AUTHORIZATION CODES | | | | 64 ESC | | 65 EMPLOYER NAME | | | | 66 EMPLOYER LOCATION | | | | | | | | | | | | | | | | | | | | | | | | | |
| 67 PRIN DIAG CD | | 68 CODE | | 70 CODE | | OTHER DIAG. CODES | | 72 CODE | | 74 CODE | | 76 ADM DIAG. CD | | 77 E-CODE | | 78 | | | | | | | | | | | | | | | | | | | |
| 042 | | 486 | | 7070 | | 4280 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 79 P.C. | | 80 PRINCIPAL PROCEDURE CODE | | 81 OTHER PROCEDURE CODE | | DATE | | DATE | | DATE | | DATE | | DATE | | DATE | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 84 REMARKS OI-P | | | | | | | | | | 82 ATTENDING PHYS. ID N24680 I.M. Physician | | 83 OTHER PHYS. ID | | 85 PROVIDER REPRESENTATIVE X Ima H. Provider | | 86 DATE 030104 | | | | | | | | | | | | | | | | | | | |

UB-92 HCFA-1450

OCR/Original

CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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Appendix 3
Physician Certification/Recertification of Terminal Illness
(for photocopying)

(A copy of the Physician Certification/Recertification of Terminal Illness form is located on the following page.)

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Refer to the Online Handbook
for current policy

**WISCONSIN MEDICAID
PHYSICIAN CERTIFICATION / RECERTIFICATION OF TERMINAL ILLNESS**

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

If a verbal certification is obtained within two calendar days after the initial six-month period of care begins, the hospice has up to eight calendar days after the six-month period begins to obtain a written physician certification of a recipient's terminal illness. If the physician's written certification is not obtained within eight calendar days, only services provided on or after the signature date of the physician's certification are reimbursed.

Provision of the information requested on this form is mandatory. However, the use of this version of the form is voluntary. Providers may develop their own version of this form as long as it includes all the information on this form.

Instructions: Type or print clearly. Keep this information in the recipient's records; *do not* send it to Wisconsin Medicaid.

SECTION I — CERTIFICATION STATEMENT

Name — Recipient

Recipient's Medicaid Identification Number

Description of Disease

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We (or I) certify that the above-named Medicaid recipient is terminally ill with the disease described above. His or her life expectancy is six (6) months or less if the disease runs its normal course.

SIGNATURE — Hospice Medical Director or Designee

Certification Date

SIGNATURE — Attending Physician

Certification Date

Medicaid Provider Number

Date Signed

SECTION II — RECERTIFICATION STATEMENT

I recertify that the above patient is still considered terminally ill with the above-stated disease and has a life expectancy of six (6) months or less if the disease runs its normal course.

SIGNATURE — Hospice Medical Director or Designee

Recertification Date

Date Signed

Appendix 4
Notification of Medicaid Hospice Benefit Election
(for photocopying)

(A copy of the Notification of Medicaid Hospice Benefit Election form
is located on a following pages.)

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Refer to the Online Handbook
for current policy

ARCHIVAL USE ONLY
(This page was intentionally left blank.)
Refer to the Online Handbook
for current policy

**WISCONSIN MEDICAID
NOTIFICATION OF MEDICAID HOSPICE BENEFIT ELECTION**

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

This form is mandatory; use an exact copy of this form. Wisconsin Medicaid will not accept alternate versions (i.e., retyped or otherwise reformatted) of this form.

Instructions: Type or print clearly. This form has two pages; always complete Section I and any other sections of the form that apply to the recipient. When complete, mail the form to the following address:

Wisconsin Medicaid
Recipient Services
PO Box 6678
Madison WI 53716-0678

SECTION I — COMPLETE FOR ALL HOSPICE RECIPIENTS

The recipient named on this form has elected to receive Medicaid hospice benefits. The recipient signed the Recipient Election of Medicaid Hospice Benefit form, HCF 1009, on the date indicated below and has been certified by a physician as having six (6) months or less life expectancy if the illness follows its usual course. The recipient's hospice has the Physician Certification/Recertification of Terminal Illness form, HCF 1011, on file.

| | | |
|--|---|---|
| Name — Recipient (First, middle initial, last) | Recipient's Medicaid Identification Number | Date Election Form Signed |
| Name — Hospice | Hospice's Medicaid Provider Number | |
| Name — Attending Physician | Attending Physician's Medicaid Provider No. | Is the Attending Physician Employed by the Hospice? <input type="checkbox"/> Yes <input type="checkbox"/> No |

SECTION II — COMPLETE FOR RECIPIENTS RESIDING IN A NURSING HOME AT THE TIME OF HOSPICE ELECTION

The hospice and nursing home named below are in agreement that the hospice shall provide hospice services, while the nursing home shall provide room and board services as defined under COBRA, P.L. 99-272. "Room and board" includes the performance of personal care services, including assistance in the activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of the resident's room, and supervision and assistance in the use of durable medical equipment (DME) and prescribed therapies.

Wisconsin Medicaid will reimburse the hospice for room and board at 95 percent of the nursing home's current skilled nursing facility (SNF) daily rate, for the appropriate number of days, for the hospice recipient in the nursing home. The hospice will in turn reimburse the nursing home.

| | | |
|---------------------|---|---------------|
| Name — Nursing Home | Nursing Home's Medicaid Provider Number | Level of Care |
|---------------------|---|---------------|

Continued

SECTION III — COMPLETE FOR RECIPIENTS ENTERING A NURSING HOME AFTER HOSPICE ADMISSION

The hospice and nursing home named below are in agreement that the hospice shall provide hospice services, while the nursing home shall provide room and board services as defined under COBRA, P.L. 99-272. "Room and board" includes the performance of personal care services, including assistance in the activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of the resident's room, and supervision and assistance in the use of DME and prescribed therapies.

Wisconsin Medicaid will reimburse the hospice for room and board at 95 percent of the nursing home's current SNF daily rate, for the appropriate number of days, for the hospice recipient in the nursing home. The hospice will in turn reimburse the nursing home.

| | | |
|---------------------|---|-------------------------------|
| Name — Nursing Home | Nursing Home's Medicaid Provider Number | Date Admitted to Nursing Home |
|---------------------|---|-------------------------------|

SECTION IV — COMPLETE FOR REVOCATION OF MEDICAID HOSPICE BENEFITS

The recipient named below has decided to discontinue the Medicaid hospice benefit on the date indicated.

| | | |
|--|---|---|
| Medicaid Identification Number — Recipient | Hospice's Medicaid Provider Number | Date Recipient Signed Revocation Form |
| Name — Attending Physician | Attending Physician's Medicaid Provider No. | Is the Attending Physician Employed by the Hospice? <input type="checkbox"/> Yes <input type="checkbox"/> No |

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Appendix 5
Recipient Election of Medicaid Hospice Benefit
(for photocopying)

(A copy of the Recipient Election of Medicaid Hospice Benefit form
is located on the following page.)

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WISCONSIN MEDICAID RECIPIENT ELECTION OF MEDICAID HOSPICE BENEFIT

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Provision of the information requested on this form is mandatory; however, the use of this version of the form is voluntary. Providers may develop their own version of this form as long as it includes all the information on this form.

Instructions: Type or print clearly. Keep this information in the recipient's records; *do not* send it to Wisconsin Medicaid.

| | | |
|----------------------------|----------------|------------------------------------|
| Name — Recipient | Name — Hospice | Hospice's Medicaid Provider Number |
| Name — Attending Physician | | Start Date for Hospice Services |

I, the recipient named above, choose to receive hospice care from the hospice program named above. I acknowledge and understand the following:

- The hospice program is palliative, not curative, in its goals. This means that the program does not attempt to cure disease, but emphasizes the relief of symptoms such as pain, physical discomfort, and emotional stress that may accompany a life-threatening illness.
- By choosing Medicaid hospice benefits, I agree to receive all services from the hospice and attending physician I designated above.
- I can choose to discontinue hospice care at any time. To discontinue, I must complete a revocation statement. I can obtain this statement from the hospice coordinator.
- If I choose to withdraw from my Medicaid hospice benefit, I understand that I may re-elect hospice at a later time.
- I can choose to receive hospice care from another hospice program at any time. To change programs, I must first confirm that the hospice to which I wish to be admitted can admit me and on what date. I must inform my current hospice program of my wishes so that arrangements for the transfer can be made. I must document the date I wish to discontinue care from my current hospice, the name of the hospice from which I wish to receive care, and the date that care will start.

Acknowledging and understanding the above, I authorize the above-named hospice to begin providing Medicaid-covered services on the date indicated above. I designate the physician named above as my attending physician.

| | | |
|--|----------------|-------------|
| SIGNATURE — Recipient or Legal Representative | | Date Signed |
| SIGNATURE — Witness | Name — Witness | Date Signed |

Appendix 6
Hospice Benefit Revocation
(Non-recertification)/Voluntary Discharge
(for photocopying)

(A copy of the Hospice Benefit Revocation [Non-recertification]/Voluntary Discharge form is located on the following page.)

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**WISCONSIN MEDICAID
HOSPICE BENEFIT REVOCATION
(NON-RECERTIFICATION) / VOLUNTARY DISCHARGE**

Wisconsin Medicaid requires certain information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Provision of the information requested on this form is mandatory. However, the use of this version of the form is voluntary. Providers may develop their own version of this form as long as it includes all the information on this form.

Instructions: Type or print clearly. Keep this information in the recipient's records; *do not* send it to Wisconsin Medicaid.

| | |
|------------------|----------------|
| Name — Recipient | Name — Hospice |
|------------------|----------------|

I, the recipient, (check one):

- Understand that my attending physician and the Hospice Interdisciplinary Team have determined that at this time I do not meet the Medicaid criteria for the hospice benefit. The basis for this has been explained to me.
- Choose to revoke election for Medicaid coverage for hospice care provided by the hospice program named above.

Hospice coverage will continue through _____ (MM/DD/YY). Medicaid hospice reimbursement will continue through _____ (MM/DD/YY).

I understand that my Medicaid hospice benefits will cease. If it is determined that I once again meet the Medicaid criteria for the hospice benefit, I may re-elect Medicaid hospice coverage.

I understand that the Medicaid health care benefits I waived to receive Medicaid hospice coverage will resume on _____ (MM/DD/YY, the day following the last day of hospice coverage).

I agree / I do not agree (check one) to waive the 14-day waiting period required by the State of Wisconsin for voluntary discharge from the hospice named above.

| | |
|--|-------------|
| SIGNATURE — Recipient or Legal Representative | Date Signed |
| SIGNATURE — Hospice Representative | Date Signed |

Appendix 7 Allowable Revenue Codes for Hospice Care

Wisconsin Medicaid uses nationally recognized four-digit revenue codes for hospice services. Hospices are required to use the allowable revenue codes for all dates of service. Revenue codes are subject to change. The current national revenue codes are listed below.

| National Revenue Code | Description |
|-----------------------|--|
| 0169 | Room and board — Other (for skilled nursing facility) |
| 0651 | Hospice services — Routine home care (up to 7.5 hours/day) |
| 0652 | Hospice services — Continuous home care (8-24 hours/day) |
| 0655 | Hospice services — Inpatient respite care |
| 0656 | Hospice services — General inpatient care |

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Appendix 8

Rounding Guidelines for Continuous Care

The following chart illustrates the rules of rounding. Hospices are reminded that continuous care is billed for eight or more hours of care per day.

| Time (In Minutes) | Unit(s) Billed |
|-------------------|----------------|
| 1-30 | .5 |
| 31-44 | .5 |
| 45-60 | 1.0 |
| 61-74 | 1.0 |
| 75-90 | 1.5 |
| 91-104 | 1.5 |
| 105-120 | 2.0 |
| 121-134 | 2.0 |

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Appendix 9 Services Provided Outside the Hospice Benefit

This appendix presents guidelines for claims submitted for services other than hospice services and allowed attending physician services. Wisconsin Medicaid will only reimburse services unrelated to the terminal illness that are otherwise medically necessary, Medicaid-covered benefits.

| Provider Category | Separately Reimbursable for Hospice Recipients | Not Separately Reimbursable for Hospice Recipients | Consultant Reviewed |
|--|--|--|---------------------|
| Ambulatory surgical center | X | | |
| Audiology | X | | |
| Case management | | X | |
| Chiropractic | X | | |
| Community support program | X | | |
| Certified registered nurse anesthetist services | | | X |
| Dental | X | | |
| End-stage renal disease | X | | |
| Family planning | | X | |
| HealthCheck | | X | |
| Hearing instruments | X | | |
| Home health | | X | |
| Intermediate care facility/ mentally retarded | | X | |
| Institutions for mental disease | | X | |
| Inpatient hospital | | | X |
| Laboratory | X | | |
| Medical vendor | X | | |
| Medical day treatment | X | | |
| Nursing facility | | X | |
| Optical care (optometrist, optician) | X | | |
| Outpatient hospital | | | X |
| Outpatient mental health/substance abuse | X | | |

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Appendix 10

Sample Adjustment/Reconsideration Request for Retroactive Nursing Home Rate Adjustment

DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 13046 (Rev. 08/05)

STATE OF WISCONSIN

WISCONSIN MEDICAID ADJUSTMENT / RECONSIDERATION REQUEST

Instructions: Type or print clearly. Refer to the Adjustment/Reconsideration Request Completion Instructions, HCF 13046A, for information about completing this form.

SECTION I — BILLING PROVIDER AND RECIPIENT INFORMATION

| | |
|---|---|
| 1. Name — Billing Provider <b style="font-size: 1.2em;">I M Hospice Provider | 2. Billing Provider's Medicaid Provider Number <b style="font-size: 1.2em;">87654321 |
| 3. Name — Recipient <b style="font-size: 1.2em;">Ima Recipient | 4. Recipient Medicaid Identification Number <b style="font-size: 1.2em;">0987654321 |

SECTION II — CLAIM INFORMATION

| | |
|--|---|
| 5. Remittance and Status (R/S) Report Date / Check Issue Date <b style="font-size: 1.2em;">MM/DD/YY | 6. Internal Control Number / Payer Claim Control Number <b style="font-size: 1.2em;">123456789012345 |
|--|---|

Add a new service line(s) to previously paid / allowed claim (in Elements 7-15, enter information to be added).

| 7. Date(s) of Service | | 8. POS | 9. Procedure / NDC / Revenue Code | 10. Modifiers 1-4 | | | | 11. Billed Amount | 12. Unit Quantity | 13. Family Plan | 14. EMG | 15. Performing Provider |
|-----------------------|----|--------|-----------------------------------|-------------------|-------|-------|-------|-------------------|-------------------|-----------------|---------|-------------------------|
| From | To | | | Mod 1 | Mod 2 | Mod 3 | Mod 4 | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | | | | |

SECTION III — ADJUSTMENT INFORMATION

16. Reason for Adjustment
- Consultant review requested.
 - Recoup entire Medicaid payment.
 - Other insurance payment (OI-P) \$_____.
 - Copayment deducted in error Recipient in nursing home. Covered days ____.
 - Emergency.
 - Medicare reconsideration. (Attach the Medicare remittance information.)
 - Correct service line. (Provide specific information in the comments section below or attach a corrected claim.)
 - Other / comments.

To obtain retroactive rate increase for nursing home room and board.

| | |
|---|--|
| 17. SIGNATURE — Provider <i style="font-size: 1.2em;">I M Hospice Provider</i> | 18. Date Signed <b style="font-size: 1.2em;">MM/DD/YY |
| Mail to: Wisconsin Medicaid Claims and Adjustments 6406 Bridge Rd Madison WI 53784-0002 | 19. Claim Form Attached (Optional) <input type="checkbox"/> Yes <input type="checkbox"/> No |

Maintain a copy of this form for your records.

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