18 Hospice

Hospice is an interdisciplinary program of palliative care and supportive services that address the physical, spiritual, psychosocial, and economic needs of terminally ill patients and their families. This care may be provided in the patient's home or in a nursing facility, if that is the recipient's place of residence.

The Alabama Medicaid Hospice Care Services Program began October 1, 1990, in order to help people who meet the criteria for hospice services remain in their homes.

Medicaid offers hospice care services to Medicaid-eligible recipients who are terminally ill as certified by the medical director of the hospice, or by the physician member of the hospice inter-disciplinary group and the individual's attending physician, if present. An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less. Hospice care consists of services necessary to relieve or reduce symptoms of the terminal illness and related conditions.

Medicaid hospice care services are subject to Medicare special election periods applicable to hospice care. Medicaid uses the most recent benefit periods established by the Medicare Program.

Effective June 16, 2005, all Hospice Providers are required to use criteria specific to the Medicaid program to determine medical necessity for recipients electing the hospice benefit when Medicaid is the primary payor. Providers should no longer use the Palmetto GBA Medicare Local Medical Review Policy (LMRP) to determine medical necessity for the hospice program when Medicaid is the primary payor for the hospice services. Providers should continue to use the Palmetto GBA LMRP for dually eligible recipients with Medicare Part A who reside in the community or a nursing facility because Medicare is considered the primary payor for these individuals. The Medicaid hospice criteria should be used to establish eligibility for the following categories of hospice recipients:

- All recipients with full Medicaid benefits
- All recipients with Medicaid and Medicare Part B
- All recipients who are Qualified Medicare Beneficiaries (QMBs) with full Medicaid coverage.

The policy provisions for Hospice providers can be found in Chapter 51 of the *Alabama Medicaid Agency Administrative Code,* and on the agency website *at* www.medicaid.alabama.gov. For diagnoses not found in the Alabama Medicaid Agency Administrative Code for cases with evidence of other co-morbidities and the evidence of rapid decline and for pediatric cases medical necessity review will be conducted on a case-by-case basis.

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

18.1 Enrollment

Gainwell enrolls hospice providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as a hospice provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for hospice-related claims.

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-validate. Failure to re-validate and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-validate, providers will have to submit a new application for enrollment.

Effective January 1, 2024, newly enrolling hospices and hospices undergoing a change in ownership have been elevated from the “moderate” to the “high” screening level. Revalidating hospices fall under the “moderate” screening level. See ALERT dated April 25, 2024, for information on “Fingerprint-Based Criminal Background Checks (FCBC) on Providers.” https://medicaid.alabama.gov/alert_detail.aspx?ID=16356

NOTE:
The 10-digit NPI is required when filing a claim.

Hospice providers are assigned a provider type of 06(Hospice). Valid specialties for hospice providers include Hospice (060).

Enrollment Policy for Hospice Providers

To participate in Medicaid, hospice providers must meet the following requirements:

Receive certification from the Centers for Medicare and Medicaid Services that the hospice meets the conditions to participate in the Medicare program.

- Possess a letter from the state licensing unit showing the permit number and effective date of the permit
- Possess a document from the licensing unit showing that the hospice meets requirements for the Medicare program
- Possess a signed document indicating that the hospice is in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975
- Possess a copy of the written notification to the hospice from the Medicare fiscal intermediary showing the approved Medicare reimbursement rate, the fiscal year end, and the NPI

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

- The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal medical necessity and eligibility requirements are not met.
- Multiple location means a Medicare-approved location from which the hospice provides the same full range of hospice care and services that is required of the hospice who is issued the certification number. These locations also require Medicaid enrollment to enable proper reimbursement rates.
- **A multiple location must meet all of the conditions of participation applicable to hospices.**

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

18.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Hospice providers must establish and maintain a written plan of care for each individual admitted to a hospice program. All services provided by the hospice must adhere to the plan. When discharging a recipient, hospice providers must follow state and federal guidelines (Code of *Federal Regulations* § 418.26 Discharge from Hospice Care).

The hospice must submit required hospice election and physician certification documentation to Medicaid, or its designee, for coverage of hospice care. If the hospice provider submits documentation which appears to be incomplete (i.e. Medicaid Hospice Election Form 165 is missing or incomplete, etc.), the provider will receive a letter requesting the additional information. If the additional information is not received within 30 days, the application will be denied. This information shall be kept on file and shall be made available to the Alabama Medicaid Agency for auditing purposes.

18.2.1 Physician Certification

The hospice provider must obtain physician certification that the individual recipient is terminally ill.

For the first period, the hospice provider must obtain written certification statements signed by the medical director of the hospice or the physician member of the interdisciplinary team and the recipient's attending physician, if present. The hospice must obtain physician certification no later than two calendar days after hospice care begins.

If the hospice provider does not obtain written certification as described, the hospice may obtain verbal certification within the two-day period, but must obtain written certification no later than 30 calendar days after care begins. If every effort is made to secure written certification within 30 calendar days and the hospice provider has not obtained the written certification, then a physician signature obtained by fax will meet the certification requirement.

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

Written certification must be secured and retained in the client record within 30 days of the hospice election.

For each subsequent period, the hospice may submit written certification as early as 15 days before the subsequent period begins, but in no event may the written certification be submitted later than two calendar days after the beginning of a subsequent period.

Each written certification must indicate that the recipient's medical prognosis is such that his or her life expectancy is six months or less. The hospice must retain these certification statements.

Signature Requirement

For information regarding electronic signature, refer to ***Chapter 1 – General Chapter (Rule No. 560-X-1-.18)*** of the Administrative Code.

18.2.2 Election Procedures

In order to receive hospice care benefits, an individual must qualify for Medicaid and be certified as terminally ill by a doctor of medicine or osteopathy.

An election period is a predetermined timeframe for which an individual may elect to receive medical coverage of hospice care. Individuals may receive hospice care for two 90-day election periods, followed by an unlimited number of subsequent periods of 60 days each.

An individual eligible for hospice care must file an election certification statement with a particular hospice. Beginning April 1, 2005, all Hospice providers must complete the Medicaid Hospice Election and Physician's Certification Form 165 to certify Medicaid recipients for the hospice program. The Medicaid Agency will recognize the Medicare election form as election for both Medicare and Medicaid for dually eligible recipients receiving hospice services. When a dually eligible recipient enters the nursing facility the Hospice Recipient Status Change Form 165B must be completed and returned to the Alabama Medicaid Agency, or its designee. Hospice providers must also use this form to report subsequent changes for all hospice recipients during the hospice certification period. Due to the terminally ill individual's mental or physical incapacity, a representative may be authorized to file an election.

An election to receive hospice care is considered to continue from the initial election period through the subsequent election periods without a break in care as long as the following criteria are met:

- Recipient remains in the care of a hospice
- Recipient does not revoke the election provisions
- Recipient is not discharged from the hospice under the provisions of §418.26.

An individual or representative may designate an effective date that begins with the first day of hospice care or any subsequent day of hospice care. The two 90-day election periods must be used before the 60-day periods. If an individual revokes the hospice election, any days remaining in that election period are forfeited. An individual or representative may not designate an effective date earlier than the date that hospice care begins. A Medicaid beneficiary who resides in a nursing facility may elect to receive hospice services. The hospice must have a contract with the nursing facility that

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

clearly states which services each has responsibility to provide and details how the nursing facility and hospice will work together.

18.2.3 Medical Records

The hospice has the responsibility to establish and maintain a permanent medical record for each patient that includes the following:

- Physician certifications
- Services provided
- Recipient election statement(s)
- Interdisciplinary treatment plan of care and updates
- Advance directive documentation

The documentation contained in the medical record must be a chronological, complete record of the care provided to the hospice recipient. The medical record must contain the Medicaid Hospice Election and Physician's Certification, Form 165 that is signed and dated by the physician. A Form 165 must be present for each election period. The documentation must contain the physicians' orders that include medication(s) taken by the recipient, an assessment and a plan of care developed prior to providing care by the attending physician, the medical director or physician designee, and the interdisciplinary team. Identification of a specific terminal illness must be documented and substantiated by labs, x-rays and other medical documentation supporting the terminal illness as set forth by the Medicaid guidelines.

The hospice retains medical records for at least three years after the current year.

Recipients residing in nursing facilities that elect the hospice benefit, but are subsequently determined to be ineligible for hospice care by Medicare or Medicaid, are not automatically approved for Medicaid reimbursement for nursing facility care if hospice payments are denied or recouped. Election of hospice care forfeits other Medicaid benefits.

Recipients who are denied hospice benefits in the nursing facility who intend to remain in the facility must apply and meet the nursing facility level of care criteria and the financial criteria for nursing home coverage by Medicaid.

18.2.4 Advance Directives

The hospice must document in the patient medical records that each adult recipient has received written information regarding rights to make decisions about his or her medical care, under state law.

The hospice must comply with requirements in the Medicaid contract concerning advance directives.

18.2.5 Waiver of Other Benefits

An individual receiving hospice care waives all rights to Medicaid services covered under Medicaid for the duration of hospice care. Waived services include the following:

- Hospice care provided by any hospice other than the hospice designated by the recipient, unless provided under arrangements made by the designated hospice

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

- Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition
- Any Medicaid services that are equivalent to hospice care

Individuals receiving hospice care **do not waive** the following benefits:

- Services provided by the designated hospice
- Services provided by another hospice under arrangements made by the designated hospice
- Services provided by the individual's attending physician if that physician is not an employee of and does not receive compensation from the designated hospice for those services
- Medicaid-covered services that are not related to the hospice recipient's terminal illness

NOTE:

Children under the age of 21 can now receive services related to the treatment of the condition for which a diagnosis of terminal illness was made. In addition, TPN for children only may be billed as a separate pharmacy claim.

18.2.6 Election Revocation

An individual or representative may revoke the individual's election of hospice care at any time during an election period. If an individual revokes the election to receive hospice care, any days remaining in that election period are forfeited.

The hospice sends the Alabama Medicaid Hospice Care Program the **Hospice Recipient Status Change Form 165B** to revoke the individual's election for Medicaid coverage of hospice care.

Upon revocation of the election of Medicaid coverage of hospice care, an otherwise Medicaid eligible recipient resumes Medicaid coverage of the benefits waived when hospice care was elected.

NOTE:

An individual should not revoke the hospice benefit when admitted to the hospital for a condition related to the terminal illness for the purpose of pain control or acute or chronic symptom management.

18.2.7 Change of Hospice

An individual or representative may change the designation of the particular hospice that provides hospice care one time per election period. The change of the designated hospice is not a revocation of the election for the period in which it is made.

To change the designated hospice provider, the individual or representative must file a signed statement that includes the following information:

- The name of the hospice from which care has been received
- The name of the hospice from which the individual plans to receive care
- The effective date of the hospice change
- The hospice provider transferring the recipient should submit a Hospice Recipient Status Change Form 165B indicating transfer of the recipient

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

- The accepting hospice provider should submit documentation to the Alabama Medicaid Agency, or its designee, for review and processing to the LTC file. (Form 165B LTC Hospice Recipient Status Change). The new provider must explain on Form 165B that this is a transfer from another hospice provider
- The approval letter from the previous hospice provider
- If Form 165B from the previous provider indicating the discharge date is available, the new provider should submit that documentation as well

The individual or representative must provide a copy of this statement to the hospice provider and to Medicaid.

The waiver of other benefits remains in effect.

18.2.8 Covered Services

Nursing care, physician services, medical social services, and counseling are core hospice services routinely provided directly by hospice employees.

Appropriately qualified personnel as determined by the nature of the service must perform all covered services.

The following are covered hospice services:

Covered Services	***Description***
Nursing facility care	Provided by or under the supervision of a registered nurse
Medical social services	Provided by a social worker who has at least a bachelor's degree from an approved or accredited school and who works under the direction of a physician
Physician services	Performed by a licensed physician. The medical director and physician member of the interdisciplinary group must be a doctor of medicine or osteopathy.
Counseling services	Provided to the terminally ill individual and the family or other person(s) caring for the patient at home. Counseling includes dietary advice, caregiver training, and counseling for adjustment to approaching death for patients and caregivers.
Short-term inpatient care	Provided in a participating hospice inpatient unit or a hospital or nursing facility that provides services through a contract with the hospice. General inpatient procedures necessary for pain control or acute or chronic symptom management that cannot be provided in another setting; respite inpatient care lasting up to five consecutive days may provide relief for the individual's caregiver at home. Medicaid will not cover respite care when the recipient is a nursing facility resident. These inpatient services must be part of the written plan of care.
Medical appliances and supplies	Includes drugs and biologicals provided to the patient. Drugs must be used primarily for relief of pain and symptom control related to the individual's terminal illness and related conditions. Appliances include durable medical equipment as well as other self-help and personal comfort items provided by the hospice for use in the patient's home for the palliation or management of the patient's terminal illness and/or related condition. These appliances and supplies must be included in the written plan of care.
Home health aide services	Furnished by qualified aides and homemaker services provided under the general supervision of a registered nurse. These services include personal care and maintenance of a safe and healthy environment as outlined in the plan of care.

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

Covered Services	*Description*
Physical Therapy, Occupational Therapy, and Speech Language Pathology	Provided for symptom control or to allow the recipient to maintain basic functional skills and/or activities of daily living

Hospices may contract for supplemental services during periods of peak patient loads and to obtain physician specialty services.

18.2.9 Reimbursement for Levels of Care

With the exception of payment for direct patient care services by physicians, Medicaid pays the hospice for all covered services related to the treatment of the recipient's terminal illness for each day the recipient is Medicaid-eligible and under the care of the hospice, regardless of the services furnished on any given day.

Payment for hospice care shall conform to the methodology and amounts calculated by the Centers for Medicare and Medicaid Services (CMS). Medicaid bases hospice payment rates on the same methodology used to set Medicare rates and adjusts rates to disregard offsets due to Medicare co-insurance amounts. Each rate comes from a CMS estimate of the costs generally incurred by a hospice in efficiently providing hospice care services to Medicaid beneficiaries. Medicaid adjusts the rates of reimbursement to reflect local differences in wages.

Medicaid pays reimbursements to the dispensing pharmacy for drugs not related to the recipient's terminal illness through the Medicaid Pharmacy Program.

The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal medical necessity and eligibility requirements are not met.

Claims Processing for the Hospice Program

Medicare pays 100% of hospice care if a Medicare/Medicaid (dually eligible) recipient meets Medicare’s criteria.

- For a dually eligible recipient in the community, the recipient is not on the Level of Care panel; therefore, Hospice does not bill Medicaid for Medicare services.
- For a dually eligible recipient in a nursing facility, for each day service is rendered, the recipient is on the Level of Care panel; however, Hospice only bills Medicaid for 95% Room & Board for the days Medicaid would have reimbursed if the nursing facility was billing Medicaid directly. Hospice is to bill Medicare for routine care services.
- For a Medicaid only recipient (meaning Non-Medicare) in the community, the hospice provider is on the Level of Care panel. Hospice bills Medicaid for every day the provider renders service at the appropriate care level (Revenue Code 651/Procedure Code T2042 or Revenue Code 651/Procedure Code T2042 for Routine Home Care **or** Revenue Code 652/Procedure Code T2042-SC for Continuous Home Care).
- For a Medicaid only recipient in a nursing facility, the recipient is on the Level of Care panel. Hospice bills Medicaid for the appropriate care level for every

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

day service is render + 95% Room & Board for the days Medicaid would have reimbursed if the nursing facility was billing Medicaid directly. (Revenue Code 659/Procedure Code T2046 or Revenue Code 659/Procedure Code T2046).

- For a Medicaid only recipient in the community or the Nursing Facility, the recipient is on the Level of Care panel. Hospice bills Medicaid for Routine Home Care and may also bill as a Service Intensity Add On (SIA) for a Registered Nurse RN or Social Worker up to 4 hours per day during the last 7 days of life of the recipient. (Revenue Code 651/Procedure Code G0299 Registered Nurse RN or Revenue Code 651/Procedure Code G0155 Social Worker).
- Hospice Providers will be required to span bill claims (up to one month) – billing only one detail line per claim.
- Hospice Providers should bill one procedure code for one unit/per day of service for all hospice procedure codes except *T2045 General Inpatient Care/per day,* which can be billed with *T2042 Routine Home Care/per day*. T2042 should be billed on a separate claim with overlapping dates of service.

This does not include *T2042-SC Continuous Care*. The Continuous Care billed amount must be calculated based upon the number of hours of care provided. The units will continue to be based upon the number of days.

NOTE:

For a straight Medicaid recipient, Medicaid will reimburse Hospice care for *Date of Death* or *Discharge* when the recipient is in a nursing facility, but will not reimburse for room and board.

When a recipient is discharged from Hospice and transfers to a nursing facility, Hospice should bill for the Date of Discharge and the nursing facility should bill for the next day. The nursing facility is paid for the admission date and the hospice provider is paid for the day of discharge. Hospice is responsible for reimbursing the nursing facility for the Room & Board for every day that the Hospice is on the Level of Care file as rendering services. The nursing facility should submit a new admission for the first day that the nursing facility would have billed the Agency for rendered services.

NOTE:

Reimbursement for disease specific drugs related to the recipient's terminal illness as well as drugs found on the Hospice Palliative Drug List (HPDL) are included in the per diem rates for hospice covered services and will not be reimbursed through the Medicaid Pharmacy Program. The HPDL is on the agency website *at* www.medicaid.alabama.gov.

With the exception of payment for physician services, Medicaid reimburses hospice care at one of four rates for each day in which a Medicaid recipient receives hospice care with the option of an intensity add on rate that may only be billed with routine home care rate. The payment amounts are determined within each of the following categories:

- Routine home care
- Continuous home care

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

- Inpatient respite care
- General inpatient care

Routine Home Care

The hospice receives reimbursement for routine home care for each day that the recipient receives hospice care at home but does not receive continuous home care. Medicaid pays this rate without regard to the volume or intensity of routine home care services provided on any given day.

Routine Home Care Service Intensity Add-On

The hospice receives reimbursement for service intensity add-on when a social worker or registered nurse (RN) makes a visit during routine home care in the last seven days of life. The SIA payment is in addition to the routine home care rate. This rate also applies to Medicaid recipients residing in the nursing facility.

Continuous Home Care

The hospice receives reimbursement for continuous home care when the recipient receives nonstop nursing care at home. Continuous home care is intended only for periods of crisis when skilled nursing care is needed on a continuous basis to manage the recipient's acute medical symptoms, and only as necessary to maintain the recipient at home. Continuous home care consists of a minimum of eight hours per day.

Inpatient Respite Care

The hospice receives reimbursement for inpatient respite care for each day that the recipient receives respite care. Patients admitted for this type of care do not need general inpatient care. Medicaid provides inpatient respite care only on an intermittent, non-routine, and occasional basis and will not reimburse for more than five consecutive days, including date of admission, but not date of discharge.

General Inpatient Care

The hospice receives reimbursement for general inpatient care for each day that the recipient occupies an approved inpatient facility for the purpose of pain control or acute or chronic symptom management.

NOTE:

Payment for total inpatient care days (general or respite) for Medicaid patients cannot exceed twenty percent of the combined total number of days of hospice care provided to all Medicaid recipients during each 12-month period of November 1 through October 31.

Reimbursement for Physician Services

The basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the beneficiary's terminal illness, including the administrative and general supervisory activities performed by physicians employed by or working under arrangements made with the hospice.

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

Group activities, which include participation in establishing plans of care, supervising care and services, periodically reviewing and updating plans of care, and establishing governing policies are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. Direct patient care services by physicians are reimbursed as follows:

- Physicians employed by or working under arrangements made with the hospice may bill for direct patient care services rendered.
- Services provided by the attending physician who is not employed by or receiving compensation from the hospice will be paid to that physician in accordance with the usual billing procedures for physicians. Refer to Chapter 28, Physician, for physician billing procedures.
- Services furnished voluntarily by physicians where the hospice has no payment liability are not reimbursable.

Nursing Facility Residents

Medicaid will not restrict hospice services based on a patient's place of residence. A nursing facility resident may elect to receive hospice benefits if he or she meets the requirements for hospice care under the Medicaid program.

If the resident elects to receive hospice benefits, the nursing facility submits discharge information per LTC Admission Notification Software.

A Medicaid hospice recipient residing at home who enters a nursing facility may continue to receive services under the hospice benefit. Any applicable resource liability amount and/or third party liability amount for a nursing facility resident need to be established and applied to the amount paid to the hospice by Medicaid for the nursing facility services. Nursing facility residents are required to use income to offset the cost of nursing facility care. Additionally, if a resident in a nursing facility elects, the hospice income will be applied to offset the cost of hospice care. The Medicaid district office will provide the hospice provider a copy of the Notice of Award or Notice of Change of Liability in order to inform the hospice of the claimant’s liability required amount to be paid from claimant’s income.

The Hospice Provider should use the Hospice Recipient Status Change Form 165B to report the following information to the Alabama Medicaid Agency, or its designee, for **dually eligible** institutionalized recipients:

- Initial nursing home admission
- Discharge from the nursing home to the hospital
- Discharge from the nursing home to the community
- Expiration in the nursing home
- Readmission to the nursing home from the hospital after an unrelated hospital stay

The Hospice Provider should use the Hospice Recipient Status Change Form 165B to report the following information to the Alabama Medicaid Agency, or its designee, for **Medicaid Only** institutionalized and/or recipients in the community:

- Discharge from the nursing home to the hospital
- Discharge from the nursing home to the community

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

- Discharge, revocation or death
- Expiration in the nursing home
- Readmission to the nursing home or the community from the hospital after an unrelated hospital stay

NOTE:

Medicaid pays the hospice 95% of the nursing home rate applicable for that year for the room and board that would have been paid to the nursing facility for that individual under the State Plan. Providers should submit to Medicaid for reimbursement 95% of the Medicaid per diem rate for the nursing home in which the recipient resides. For Nursing Home claims regarding patient days, Medicaid covers the day of admission, but not the day of discharge, or the date of death.

Medicare/Medicaid Eligibility

The Hospice Election and Physicians Certification Form 165 must be completed for all recipients who are Medicaid eligible. However, for dually eligible recipients who have Medicare Part A, Medicare will pay the daily hospice rate for the appropriate level of care – routine, continuous, inpatient respite, or general inpatient.

If the dually eligible hospice recipient with Part A Medicare resides in a nursing facility, Medicare pays the daily hospice rate as usual. Providers should submit to Medicaid for reimbursement 95% of the Medicaid per diem rate for the nursing home in which the recipient resides. The number of days of Medicare coverage must equal the number of days requested for nursing facility room and board. Any applicable resource liability amount and/or third party liability amount is deducted from the payment made to the Hospice provider for the facility services.

The Qualified Medicare Beneficiary (QMB) recipient who has **QMB-only** is not eligible for any Medicaid benefits, i.e., home health, hospice, medications, etc. A recipient who has **QMB+** does have full Medicaid benefits and would be eligible for home health, hospice, and medications.

Coinsurance amounts for drugs and biologicals or respite care may be billed to Medicaid as crossover claims for dually eligible recipients for whom Medicare is the primary payer.

Drugs and biologicals furnished by the hospital while the recipient is not an inpatient may be billed at 5 percent of the cost of the drug or biologicals, not to exceed $5.00 per prescription.

Home and Community-Based Services (HCBS) Waiver Services

Medicaid only recipients may receive non-duplicative HCBS waiver services in coordination with hospice services. The Plan of Care (POC) of a waiver recipient receiving hospice care should be coordinated between the hospice provider and the waiver provider to ensure continuity of care. The hospice provider and waiver case manager must have a conference regarding the POC before concurrent services can start. The conference must be documented in the recipient's record. Both the waiver and hospice care plans should document the concurrent services. Both providers are subject to retrospective reviews of hospice and HCBS waiver services. If duplication of services is found, Medicaid may recover improper payment.

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

Audits

The provider of hospice care may be asked to furnish the Medicaid Hospice Care Program with information regarding claims submitted to Medicaid. The provider of hospice care must permit access to all Medicaid records and facilities for the purpose of claims audit, program monitoring, and utilization review by duly authorized representatives of federal and state agencies.

The provider of hospice care must maintain complete and accurate medical and fiscal records that fully disclose the extent of the services and billings. The provider retains these records for the period of time required by state and federal laws.

Inpatient Respite Care

Medicaid pays coinsurance claims for inpatient respite care, drugs, and biologicals for dually eligible recipients. Medicaid pays 5 percent of the Medicare payment for a day of respite care. This payment will not exceed the inpatient hospital deductible applicable for the year in which the hospice co-insurance period began. Medicaid will not pay for more than five consecutive days.

Medicaid pays 5 percent of the cost of each palliative drug and biological prescription furnished by the hospice while the individual is not an inpatient. The cost may not exceed $5.00 for each prescription.

NOTE:
When filing coinsurance claims for inpatient respite care or for drugs and biologicals, the provider must complete the UB-04 claim form.

18.3 Medicaid Approval for Hospice Care

Providers must adhere to all state and federal specific timeframes and documentation requirements under the Medicaid Hospice Program.

Effective February 1, 2006, all hospice providers are subject to a 100% review of medical records containing documentation of admission; including hospice stays of six months or more. Hospice providers will no longer have the ability to submit dates of service to the LTC file for hospice admission or recertification.

Policies and Procedures for Hospice Admission and Recertification

- Applicants to Medicaid approved hospice providers must be certified, by their attending physician or hospice medical director, to have a terminal illness with a life expectancy of six months or less. The certification for terminal illness is substantiated by specific findings and other medical documentation including, but not limited to, medical records, labs, x-rays, pathology reports, etc.
- The hospice provider will be required to comply with all state and federal rules related to an individual's election of the hospice benefit.
- The hospice provider must establish a permanent medical record for each patient which documents eligibility for the Medicaid Hospice benefit based upon the medical criteria found in the Alabama Medicaid Agency Administrative Code Rule 560-X-51-.04. For cases with evidence of other co-morbidities and the evidence of rapid decline and for pediatric cases, medical necessity review will be conducted on a case-by-case basis.

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

- All hospice providers certifying patient initial admission, recertification or hospice stays for six months or more must submit medical documentation to the Alabama Medicaid Agency or its designee for review. When approved the Alabama Medicaid Agency or its designee will enter the dates of service through the LTC notification software.
- Hospice recipients who are in a nursing home with a third party insurance as the primary payer for hospice care, do not require a medical review to receive room and board payment by Medicaid. Hospice providers are required to submit to Medicaid or it's designee a Form 165B, proof of insurance coverage, and paid claims (such as an EOP) from the third party payer to be approved for room and board payment by Medicaid. The hospice provider will be added to the LTC file and should submit for reimbursement at 95% of the Medicaid per diem rate for the nursing home in which the recipient resides.
- When submitting records the LTC Gainwell Cover Sheet from the web portal must accompany the medical record. Hospice records for approval may be uploaded two different ways:
    - Medicaid Interactive Web Portal (preferred) https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20-Site/tabId/66/Default.aspx
    - Fax information in for processing (bar coded cover sheet required)

Documents must be in a Portable Document Format (PDF) for upload through the Medicaid web portal. If you do not currently have the ability to create PDF versions of medical records, you may perform an internet search and find free downloadable utilities that can be installed to create a PDF. For your convenience, a list of three PDF creation utilities that can be installed to create PDF documents at no charge.

- PrimoPDF – http://www.primopdf.com/
- Solid PDF Creator - http://www.freepdfcreator.org/
- PDF24 – http://pdf24-pdf-creator.en.softonic.com/

Once a PDF utility has been successfully downloaded and the PDF document created, providers should follow these steps to upload documentation for review:

1. Log on to Medical Interactive Web portal:

   https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure%20-Site/tabId/66/Default.aspx
2. Select Trade Files/Forms.

Forms Name field – select a form from the drop down list and click on "Search". The following is a list of forms available for selection,

   a. LTC – Hospice Records
   b. LTC – Records

3. Complete all fields (record ID field will auto populate). Required
4. Click on 'Browse' and select the required medical records documentation from your network drive or PC and select 'Submit'.
5. A message will be generated that states 'your form was submitted successfully' at the top of the page.

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

6. A barcode coversheet is generated and will be displayed.
7. Select the 'Print Friendly View' button to print the barcode coversheet or to save as a PDF. A copy of this barcode coversheet should be saved in the event additional documentation is required.

If a PDF document of the medical records cannot be created, information may also be faxed for review. A fax cover sheet will be required with each submission; providers should follow the instructions below to fax documentation:

1. Follow steps 1-7 documented above.
2. Fax the required medical records documentation with the barcode coversheet on top of the documentation to 334-215-7416.Include the bar coded cover sheet with each submission for the same recipient.
3. Do not fax double sided pages.
4. Do not fax multiple sets of records at the same time, each fax should be sent separately.

NOTE:

The bar code cover sheet is required for each fax submission for the same recipient. A fax submission cannot be processed without the bar coded cover sheet. DO NOT place anything on the bar code on the cover sheet or alter it any manner.

The Alabama Medicaid Agency or its designee's Nurse Reviewer will review the documentation to ensure the appropriateness of admission based on Medicaid's medical criteria for admission as defined in the Alabama Medicaid Agency Administrative Code Rule No. 560-X-51-.04.

- If there are no established criteria for the admitting hospice diagnosis, the Nurse Reviewer will perform a preliminary review of the documentation for terminality and the normal progression of the terminal disease. The Medicaid Agency's Medical Director will make the final determination of approval or denial of the admission and continued stay in the Hospice Program for those diagnoses which have no established medical criteria.
- A person who reaches a point of stability and is no longer considered terminally ill must not be recertified for hospice services. The individual must be discharged to traditional Medicaid benefits.
- Individuals seeking aggressive treatment shall not be certified for hospice services. "Aggressive treatment" means treatment that is intended to be life-prolonging or curative (rather than palliative) and would prevent the natural course of the terminal illness upon which they are seeking hospice services.
- When there is both medical and financial approval, the application dates will be entered through the LTC notification software by the Alabama Medicaid Agency or its designee.
- If the hospice provider submits documentation which appears to be incomplete (i.e. Medicaid Hospice Election Form 165 is missing or incomplete, etc.) the provider will receive a letter requesting the additional information. If the additional information is not received within 30 days the application will be denied.

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

- No hospice segment will be approved by the Alabama Medicaid Agency or its designee for greater than six months. If a recipient remains on hospice beyond six months, the provider must submit documentation which supports continued appropriateness for hospice including documentation of the continued progression of the disease. This information should be forwarded to the Alabama Medicaid Agency or its designee for review two weeks prior to the end of the six month certification period or the case will automatically close. If the documentation demonstrates progression of the terminal illness, then an additional six month certification period will be established and added to the LTC file by the Alabama Medicaid Agency or its designee.
- An approval or denial letter will be faxed or mailed to the provider upon completion of the review. The approval or denial letter notifies the provider of the dates added to the file and may be used for billing of hospice claims.
- All revocations, discharges, deaths and readmissions after an unrelated hospital stay should be faxed to the Alabama Medicaid Agency or its designee using the Hospice Recipient Status Change Form 165B. Readmissions should include the previous six month admission approval letter.

18.4 Cost Sharing (Copayment)

Copayment amount does not apply to services provided by a Hospice provider.

18.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Hospice providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a hard copy UB-04 claim form is required.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

18.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Hospice providers to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

18.5.2 Diagnosis Codes

The International *Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the
American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

18.5.3 Procedure Codes, Revenue Codes and Modifiers

Hospice providers are required to use HCPCS procedure codes for each service rendered. Failure to identify each service with a procedure code will result in denial of the service. The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Payment of hospice services is limited to the following codes:

Revenue Code	*Procedure Code*	*Description*
651	T2042 T2042 G0155 G0299	Routine home care, per days 1-60 Routine home care, per days 61+ Clinical Social Worker, SIA, last 7days of life Registered Nurse (RN), SIA, last 7 days of life
652	T2042-SC	Continuous home care, per day
655	T2044	Inpatient respite care, per day
656	T2045	General inpatient care, per day
659	T2046 T2046 T2046-SC T2046-SE	Nursing facility room and board, Routine care, per days 1-60 Nursing facility room and board, Routine care, per days 61+ Nursing facility room and board, Continuous care, per day Nursing facility room and board, per dually eligible recipient, per day

NOTE:

For Medicaid recipients with another insurance which pays for routine care in the nursing home, submit T2046. Document the other insurance paid amount for routine care in block 54 of the UB-04, along with the other insurance information in the appropriate blocks of the claim form.

18.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.

18.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:
When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

18.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

The Current Procedural Terminology (CPT) and Current Dental Terminology (CDT) codes descriptors, and other data are copyright © 2026 American Medical Association and © 2026 American Dental Association (or such other date publication of CPT and CDT). All rights reserved. Applicable FARS/DFARS apply.