Table of Contents

Home Health and Hospice Services

This chapter of the Idaho Medicaid Provider Handbook covers home health and hospice services as deemed appropriate by the Department of Health and Welfare.

Should the handbook ever appear to contradict relevant provisions of Idaho or federal regulations, the regulations prevail. Any paper or digital copy of these documents is considered out of date except the version appearing on Gainwell Technologies' Idaho Medicaid website. Sections of the Idaho Medicaid Provider Handbook applicable in specific situations are listed throughout the handbook for provider convenience. Handbook chapters which always apply include the following:

- General Billing Instructions;
- General Information and Requirements for Providers; and
- Glossary.

Handbooks can only be used properly in context. Providers must be familiar with the handbooks that affect them and their services. The numbering in handbooks is also important to make note of as subsections rely on the content of the sections above them.

Example

Section 1.2.3.a The Answer requires the reader to have also read Section 1, Section 1.2 and Section 1.2.3 to be able to properly apply Section 1.2.3.a.

References are included throughout the handbook for provider and staff convenience. Not all applicable references have been incorporated into the handbook. Not all references provided are equal in weight.

- **Case Law:** Includes references to court cases that established interpretations of law that states and providers would be required to follow.
- **CMS Guidance:** These references reflect various Centers for Medicare and Medicaid Services (CMS) publications that Idaho Medicaid reviewed in the formulation of policies. The publications themselves are not required to be followed for Idaho Medicaid services unless otherwise specified.
- **Federal Regulations:** These references are regulations from the federal level that affected policy development. Usually these include the Code of Federal Regulations, the Social Security Act and other statutes. Providers are required to follow these.
- **Idaho Medicaid Publications:** These are communications from Idaho Medicaid to providers that were required to be followed when published. These are included in the handbook for historical reference. The provider handbook supersedes other communications unless the documents are listed in the Rules, Policies, Procedures, and Waivers webpage under policies in the Medicaid Policies library in the Policies & Standards Library.
- **Idaho State Plan:** The State Plan is the agreement between the State of Idaho and the Centers for Medicare and Medicaid Services (CMS) on how the State will administer its medical assistance program. Unless otherwise stated, services can only be reimbursed when in compliance with the agreement.
- **Idaho Waivers:** A waiver is a deviation, or an expansion of benefits, of federal requirements approved by the Centers for Medicare and Medicaid Services. Waiver services can only be reimbursed as detailed in an approved waiver.
- **Professional Organizations:** These references reflect various publications of professional organizations that Idaho Medicaid reviewed in the formulation of policies. Providers may or may not be required to follow these references, depending on the

individual reference and its application to a provider's certification, licensure or scope of practice.

- **Scholarly Work:** These references are publications that Idaho Medicaid reviewed in the formulation of policies. The publications themselves are not required to be followed for Idaho Medicaid services.
- **State Regulations:** These references are regulations from the state level that affected policy development. They usually include statute and IDAPA. They are required to be followed.

Some citations may not be available on the internet. Copies of the documents may be requested with a public records request. Guidance for public records requests is available on the department's website.

1. Important Contact

The Directory, Idaho Medicaid Provider Handbook contains a comprehensive list of contacts. The following contacts are presented here for provider convenience.

1.1. Gainwell Technologies

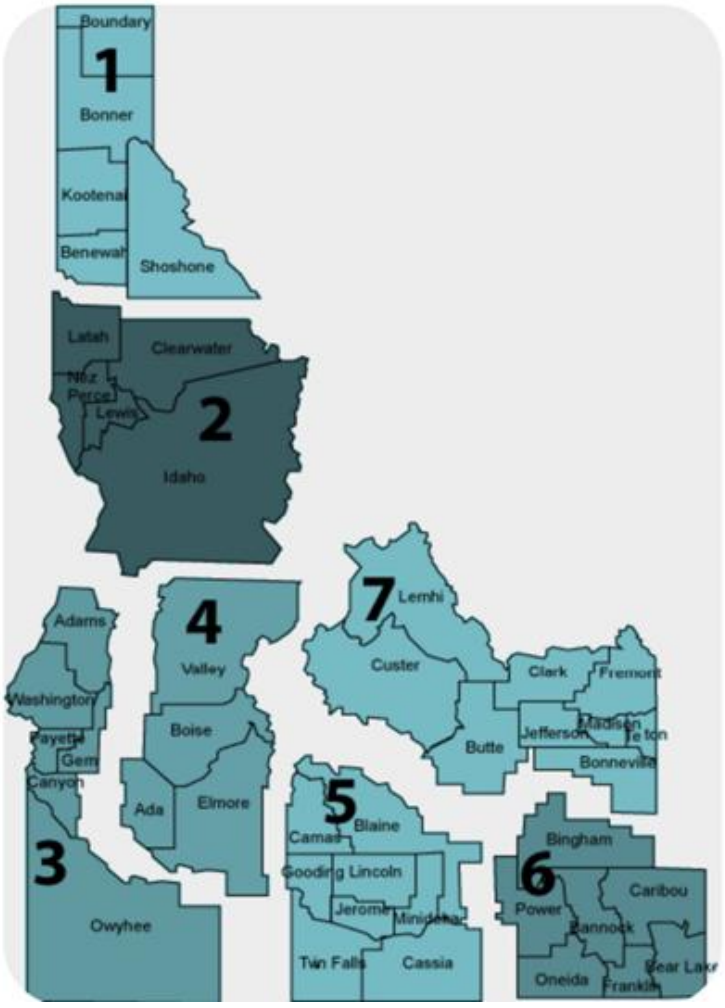
Gainwell Technologies is Idaho Medicaid's fiscal agent that handles all claims processing and customer service issues for participants not receiving services through a managed care plan.

Gainwell Technologies Contact Information
Gainwell Technologies Provider Services P.O. Box 70082 Boise, ID 83707 Phone: 1 (866) 686-4272 Fax: 1 (877) 661-0974 IDProviderServices@gainwelltechnologies.com The Medicaid Automated Call Service (MACS) is available 24 hours a day, seven days a week. Provider service representatives are available Monday through Friday, 7:00 A.M.-7:00 P.M. MT.
Provider Enrollment P.O. Box 70082 Boise, ID 83707 Phone: 1 (866) 686-4272 Fax: 1 (877) 517-2041 IDProviderEnrollment@gainwelltechnologies.com
Technical Services Phone: 1 (866) 686-4272 Fax: 1 (877) 517-2040 IDEDISupport@gainwelltechnologies.com

1.2. Provider Relations Consultants

Gainwell Technologies Provider Relations Consultants help keep providers up to date on billing changes required by program policy changes implemented by the Division of Medicaid. Provider Relations Consultants accomplish this by:

- Conducting provider workshops;
- Conducting live meetings for training;
- Visiting a provider's site to conduct training; and
- Assisting providers with electronic claims submission.



Region 1 and the state of Washington
1 (208) 202-5735
Region.1@gainwelltechnologies.com

Region 2 and the state of Montana
1 (208) 202-5736
Region.2@gainwelltechnologies.com

Region 3 and the state of Oregon
1 (208) 202-5816
Region.3@gainwelltechnologies.com

Region 4
1 (208) 202-5843
Region.4@gainwelltechnologies.com

Region 5 and the state of Nevada
1 (208) 202-5963
Region.5@gainwelltechnologies.com

Region 6 and the state of Utah
1 (208) 593-7759
Region.6@gainwelltechnologies.com

Region 7 and the state of Wyoming
1 (208) 609-5062
Region.7@gainwelltechnologies.com

Region 9 and other states (not bordering Idaho)
1 (208) 609-5115
Region.9@gainwelltechnologies.com

1.3. Medicaid

1.3.1. Bureau of Long Term Care

The Bureau of Long Term Care (BLTC) provides eligibility assessments for the Aged and Disabled (A&D) Waiver. BLTC also authorizes long-term care services for children and adults. BLTC can be contacted at:

Bureau of Long Term Care
PO Box 83720
Boise, ID 83720-0009
Phone: 1 (877) 799-4430
E-mail: BLTCCentral@dhw.idaho.gov

1.3.2. Medical Care Unit

The Medical Care Unit is Idaho Medicaid's team that reviews prior authorization (PA) requests for home health and hospice services.

Medical Care Unit
PO Box 83720
Boise, ID 83720-0009
Phone: 1 (866) 205-7403
Fax: 1 (877) 314-8779
E-mail:MedicalCareUnit@dhw.idaho.gov

The Medical Care Unit does not accept authorization requests via e-mail. The status of a PA request submitted to the Medical Care Unit may be checked online at the Gainwell Technologies portal under "Authorization Status", using your National Provider Identifier (NPI). If you have questions on a Denial, click on the Notes, which will explain the reason for the Denial. See the General Billing Instructions, Idaho Medicaid Provider Handbook for more information on billing and requesting prior authorized services.

1.4. Telligen, Inc.

Telligen, Inc. is Idaho Medicaid's quality improvement organization (QIO) that reviews Prior Authorization (PA) requests for durable medical equipment and supplies as listed on the Numerical Fee Schedule or when a PA would otherwise be indicated. They also conduct reviews of services.

Telligen, Inc.
670 E Riverpark Ln. Suite 120
Boise, ID 83706
Phone: 1 (866) 538-9510
E-mail: idmedicaidsupport@telligen.com

See the QIO Provider Manual for a listing of diagnoses and procedures that require PA and details regarding review processes. All PA requests and medical record updates for post payment medical necessity and DRG validation reviews must use the provider portal.

The status of a PA request submitted to Telligen, Inc. may be checked online via the Telligen Qualitrac portal or the Gainwell Technologies portal under "Authorization Status", using your National Provider Identifier (NPI). If you have questions on a Denial in the Gainwell Technologies portal, click on the Notes, which will explain the reason for the Denial. See the General Billing Instructions, Idaho Medicaid Provider Handbook for more information on billing and requesting prior authorized services.

2. Advanced Care Planning

Advanced care planning, or Advanced directives, is a covered service. Advance directives are documents appointing an agent and/or documenting the participant's decisions regarding their medical treatment should they lack the capability to communicate their wishes in the future. Planning may include Health Care Proxy, Durable Power of Attorney for Health Care, Living Will, or Medical Orders for Life-Sustaining Treatment. Home health and hospice service providers must explain to each participant their right to make decisions regarding their medical care. It is recommended the Idaho Physician Orders for Scope of Treatment (POST) Form be completed and placed at the care location, so the participant's end-of-life wishes are honored. The POST Form and other resources are available from the Idaho Secretary of State's Office's health care directive registry webpage.

See the Advance Directives section of the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more information including requirements and billing.

3. Home Health Services

Home health services include skilled nursing and at least one of the following services:

- Home Health Aide Services
- Medical Social Services
- Occupational Therapy
- Physical Therapy
- Speech-Language Pathology

Home health services also include audiology, and durable medical equipment and supplies.

3.1. References: Home Health Services

3.1.1. Federal Regulations

Home Health Services, 42 CFR §440.15 (1998). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-A/section-441.15.

Required Services for the Medically Needy, 42 CFR §440.220(a)(3) (1993). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-B/section-440.220.

3.1.2. State Regulations

"Services." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 242.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

3.2. Home Health: Provider Qualifications

Home health agencies must at a minimum offer skilled nursing, home health aides, and durable medical equipment and supplies. Home health agencies must be certified to participate in the Medicare Program. Services must be within the scope of practice, certification/licensure, and training of the provider rendering them. The provider must have a National Provider Identifier (NPI) to be eligible for enrollment. Enrollment as an Idaho Medicaid provider and entering into a provider agreement must be completed prior to providing services for Idaho Medicaid participants.

All employees of a home health agencies must receive a clearance from a background check through the Idaho Department of Health and Welfare.

Before a provider agreement can be entered into, the agency must have a surety bond of $50,000, 15% of the most recent annual total of Medicaid payments the provider received for home health services, or the most recent annual period's total overpayments, whichever is greater. A copy must be furnished to the department. An annual or continuous bond is acceptable. Changes in ownership do not affect the annual review or requirement for submitting a bond before entering into a provider agreement. New home health agencies do not use the 15% calculation. The bond must specify the home health agency as the principal, Medicaid as the obligee and the surety company. The department reserves the right to determine a surety company is ineligible to provide the necessary bond for good cause, which will be specified by public notification and effective date. Government operated home health agencies do not require a bond unless they have had uncollected overpayments. Government operated agencies have 60 days to furnish a bond if notified by Medicaid that they are not eligible for an exclusion.

The surety bond must guarantee that, upon written demand by Medicaid or its designee with sufficient evidence to establish liability under the bond, the Surety will timely pay Medicaid the amount, up to the stated amount of the bond. The bond must include the Surety is liable for uncollected overpayments and amounts if the agency doesn't renew or meet their bond requirements. Liability to Medicaid cannot be revoked or limited by:

- Any action of the home health agency or the surety to limit the scope or term the bond.
- The Surety no longer meeting requirements and becoming unauthorized.
- Termination of the home health agency's provider agreement.
- Any action by the Medicaid agency to suspend, offset, or otherwise recover payments.
- Any action by the home health agency to:
    - Cease operation.
    - Sell or transfer any assets or ownership;
    - File for bankruptcy.
    - Failure to pay the surety.
- Any fraud, misrepresentation, or negligence by the agency in obtaining the surety bond or by the Surety in issuing the bond, except that any fraud, misrepresentation, or negligence by the agency in identifying to the Surety the amount of Medicaid payments upon which the amount of the surety bond is determined shall not cause the Surety's liability to the Medicaid agency to exceed the amount of the bond.

Liability can be revoked if the agency obtains a new acceptable bond, or the Surety informs Medicaid within 10 days of notice from the home health agency that the bond is being terminated or limited, or no later than 60 days before the effective date of the Surety terminating the bond. If a new bond is obtained, the agency has 60 days to submit it to Medicaid.

Medicaid must deny or cancel the agency's provider agreement, if these requirements are not met. Medicaid can request proof of compliance at any time. Appeal rights are available for actions involving sureties. See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information about appeals.

Home health agencies must have an Electronic Visit Verification (EVV) system compatible with the state's EVV aggregator, Sandata, for all home health services that require an in-home visit. See the EVV section in the General Billing Instructions, Idaho Medicaid Provider Handbook for more information about EVV requirements.

All provider handbook and applicable state and federal regulations must be followed to maintain eligibility for reimbursement. See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

3.2.1. References: Home Health – Provider Qualifications

(a) CMS Guidance

Medicaid Electronic Visit Verification (EVV) Guidance, Centers for Medicare and Medicaid Services, Department of Health and Human Services, https://www.medicaid.gov/medicaid/home-community-based-services/guidance/electronic-visit-verification-evv/index.html.

(b) Federal Regulations

21st Century Cures Act. Section 12006(a). "Electronic Visit Verification System Required for Personal Care Services and Home Health Care Services Under Medicaid". https://www.congress.gov/bill/114th-congress/house-bill/34/text.

Home Health Agency Requirements for Surety Bonds; Prohibition on FFP, 42 CFR §441.16 (1998). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-A/section-441.16.

Home Health Services, 42 CFR §440.70(d) (2020). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.70.

"Payment to States" Social Security Act, Sec. 1903(i)(18) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1903.htm.

(c) Idaho Medicaid Publications

State of Idaho, Electronic Visit Verification (EVV) Website. https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/electronic-visit-verification-evv.

(d) State Regulations

"Conditions for Payment." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 025. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Definitions, Idaho Code 39-1301 (2025). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title39/T39CH13/SECT39-1301.

"Home Health: Provider Qualifications and Duties." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 624. Department of Administration, State of Idaho, . https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individual Providers – Requirements." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 007.10. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Agreements." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 022. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Application Process." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 021. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Therapy Services: Coverage and Limitations." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 252. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

3.3. Home Health: Participant Eligibility

Home health services must be medically necessary for the participant to receive services in their place of residence or where normal life activities take place. Participants are eligible even if they don't need institutional care, nursing or therapy services, or aren't homebound.

A face-to-face visit with a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant is required to establish coverage. The visit must be primarily for the condition requiring home health services. The visit can be conducted via virtual care services so long as it meets all requirements for telehealth services found in the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook. The ordering provider does not have to be the provider that performed the face-to-face visit but must document when the visit occurred, and the name and credentials of the professional that conducted the encounter. The face-to-face visit must occur either 90 days before, or within 30 days after home health services begin.

Not all participants are eligible for all services. Home health isn't covered in a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID) or any setting where Medicaid covers inpatient services including room and board. Services can be provided in an ICF/IID when otherwise not provided by the facility. Services are available based on the participant's enrollment eligibility. Incarcerated individuals or otherwise ineligible non-citizens with Medicaid coverage are not eligible for these services.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

3.3.1. References: Home Health — Participant Eligibility

(a) Case Law

Detsel v. Sullivan, 895 F.2d 58 (2d Cir.1990).

Skubel v. Fuoroli, 113 F.3d 330 (2d. Cir. 1997).

(b) CMS Guidance

"Face to Face Encounter with Patient Required Before Physicians May Certify Eligibility for Home Health Services or Durable Medical Equipment Under Medicare." H.R. 3590, "The Patient Protection and Affordable Care Act," Sec. 6407 (2010). Government Printing Office, https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf.

State Medicaid Director Letter Olmstead Update No: 3 (2000). The Health Care Finance Administration, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd072500b.pdf.

(c) Federal Regulations

Comparability of Services for Groups, 42 CFR §440.240(b) (1981). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-B/section-440.240.

Home Health Services, 42 CFR §440.70 (2020). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.70.

Home Health Services, 42 CFR §441.15(c) (1998). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-A/section-441.15.

Persons to Whom Services will be Provided, 42 CFR §136.12 (2002). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

"State Plans for Medical Assistance" Social Security Act, Sec. 1902(a)(10)(D) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

Sufficiency of Amount, Duration, and Scope, 42 CFR §440.230 (2024). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-B/section-440.230.

(d) State Regulations

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Settings." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 242.02. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

3.4. Home Health: Covered Services and Limitations

Home health services include skilled nursing and at least one of the following services provided where the participant's normal life activities take place.

- Home Health Aide Services
- Medical Social Services
- Occupational Therapy
- Physical Therapy
- Speech-Language Pathology

Home health services also include audiology, and Durable Medical Equipment and Supplies. Services provided must follow the requirements of the service's chapter of the provider handbook. Where home health and the service's requirements conflict, the more restrictive requirement prevails.

All home health services must be medically necessary and on the Orders of a physician, nurse practitioner, clinical nurse specialist or physician assistant as part of a home health Plan of Care. Medicaid requires all Medicare conditions of eligibility including, but not limited to, the Outcome and Assessment Information Set (OASIS) documentation be followed.

Services are typically provided in the participant's residence but can be provided anywhere normal life activities take place. Services are prohibited from being provided in a hospital, nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID) (unless the ICF/IID is not required to provide that service), or any other place with inpatient services including room and board.

Home health services are limited to a total of 100 medically necessary visits per calendar year. A visit consists of all services that occur on a date of service. The delivery of durable medical equipment and supplies alone does not constitute a visit. Additional visits require prior authorization from the Medical Care Unit. See the Home Health: Prior Authorization section for more information.

3.4.1. References: Home Health — Covered Services and Limitations

(a) Case Law

Detsel v. Sullivan, 895 F.2d 58 (2d Cir.1990).

Skubel v. Fuoroli, 113 F.3d 330 (2d. Cir. 1997).

(b) CMS Guidance

State Medicaid Director Letter Olmstead Update No: 3 (2000). The Health Care Finance Administration, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd072500b.pdf.

(c) Federal Regulations

"Definitions." Social Security Act, Sec. 1905(a)(7) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

Home Health Services, 42 CFR §440.70 (2020). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.70.

Home Health Services, 42 CFR §441.15 (1998). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-A/section-441.15.

(d) State Plan

Basic Alternative Benefit Plan. Division of Medicaid, Department of Health and Welfare, State of Idaho, http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/BasicBenchmark.pdf.

(e) State Regulations

"Home Health: Coverage and Limitations." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 242. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/current/16/160326.pdf.

"Home Health Services: Procedural Requirements." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 243 Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(3)(f) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/current/16/160326.pdf.

Rulemaking Authority, Idaho Code 56-264 (2012). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-264.

"Therapy Services: Procedural Requirements." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 253. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/current/16/160326.pdf.

3.4.2. Durable Medical Equipment and Supplies

Home health agencies are responsible for providing durable medical equipment and supplies (DME and DMS) to participants under a home health plan of care. DME and DMS must be medically necessary and suitable for use in the home but may be provided for use anywhere normal life activities take place. A physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant must provide Orders for DME and DMS and reevaluate their necessity in the Plan of Care annually. DME and DMS must have a face-to-face visit within the six months preceding delivery. Home Health Agencies must adhere to the Durable Medical Equipment, Prosthetics, Orthotics and Supplies, Idaho Medicaid Provider Handbook for any dispensed DME or DMS.

The Department of Health and Welfare may arrange purchase agreements with providers to purchase DME when the rental charges total more than the purchase price of the equipment. All such purchases will be handled separately from the home health program as medical vendor transactions.

Claims for DME and DMS must be billed with the correct revenue code and CPT®/HCPCS, one combination per claim line. Routine supplies are included in the cost of the home health visit and are not separately reimbursable. A routine supply is generally used in small supplies during most home health visits and aren't included in the plan of care. The items are part of the staff's supplies and aren't designated for an individual participant. Routine supplies usually include, but are not limited to:

- Swabs, alcohol preps, and skin prep pads;
- Tape removal pads;
- Cotton balls;
- Adhesive and paper tape;
- Nonsterile applicators;
- 4 x 4 gauze dressings;
- Nonsterile gloves;
- Aprons;
- Masks;
- Gowns;
- Specimen containers;
- Thermometers; and
- Tongue depressors.

(a) References: Durable Medical Equipment and Supplies

(i) Federal Regulations

Home Health Services, 42 CFR §440.70 (2020). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.70.

(ii) State Regulations

"Home Health Services: Coverage and Limitations." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 242. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(5)(a)(x) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

3.4.3. Influenza Vaccinations

All routine injections are included in the reimbursement for home health agency scheduled nursing visits. An exception is the administration of the influenza vaccine. The department will reimburse the agency for injection administration costs if no other home health visit is billed on the same day as the vaccination. A description in the remarks section of the claim form must indicate that influenza vaccine was administered.

(a) References: Influenza Vaccinations

(i) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(5)(a)(ii) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

3.5. Home Health: Prior Authorization

If the participant is 21 years of age or older or requires skilled nursing or home health aide visits over the 100-visit limit, the agency must upload documentation to the Telligen, Inc. Qualitrac portal for prior authorization. Approval will be determined on a case-by-case basis. The following documentation is required to determine the need for additional visits:

- Completed Home Health Prior Authorization Request Form;
- Current physician's order;
- Current signed Home Health Certification and Plan of Care;
- Last 30 days' visit notes;
- Current history and physical;
- Hospital discharge/admission orders and paperwork; and
- Any other documentation that will support medical necessity or is needed for manually priced items.

If the participant is under 21 years of age or requires occupational or physical therapy, or speech language pathology visits over the 100-visit limit, the agency must upload documentation to the Telligen, Inc. Qualitrac portal for prior authorization. Approval will be determined on a case-by-case basis. If the participant is discharged or terminates services after the prior authorization is approved, the agency must timely inform Telligen, Inc. by phone or e-mail the last service date. The following documentation is required to determine the need for additional visits:

- Completed Home Health Prior Authorization Request Form;
- Current physician's order starting from date of 100th visit through December 31st;
- Current signed Home Health Certification and Plan of Care;
- Last 30 days' visit notes;

Any other documentation that will support medical necessity.

Telligen, Inc. only accepts prior authorization requests, medical record updates for post payment medical necessity, and All Patient Refined (APR) Diagnosis Related Group (DRG) validation reviews through its online Qualitrac portal. For specific instructions on how to submit these requests, see Telligen's Provider Manual at Idmedicaid.telligen.com. See the General Billing Instructions, Idaho Medicaid Provider Handbook for additional information on billing and requesting prior authorized services and manually priced items.

3.6. Additional Documentation

Providers must follow the requirements of the Documentation: General section in addition to the ones presented here.

3.6.1. Orders

All home health services must be ordered by a physician, nurse practitioner, clinical nurse specialist or physician assistant as part of a home health Plan of Care. Home health orders must include the provider's National Provider Identifier (NPI), the services or items to be provided, the frequency, and, where applicable, the expected duration of time for which services will be needed. Services and durable medical equipment and supplies (DME and DMS) can have additional requirements in their specific provider handbook chapters. Services required for extended periods must be reordered every 60 days except DME and DMS, which must be reordered annually.

(a) References: Orders

(i) Federal Regulations

Home Health Services, 42 CFR §440.70(a)(2) (2020). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.70.

(ii) State Regulations

"Orders." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 243.01 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

3.6.2. Plan of Care

All home health services must have an individualized home health plan of care before beginning treatment. The participant's plan of care must be reviewed, signed and dated by the attending physician, nurse practitioner, clinical nurse specialist or physician assistant, who established the plan, every 60 days for services and annually for durable medical equipment and supplies. The home health agency must maintain a copy in their records and provide a copy to the participant. The plan must include at a minimum:

- All pertinent diagnoses;
- The participant's mental status;
- The services, equipment and supplies required;
- The frequency of visits;
- Functional limitations;
- Ability to perform activities of daily living;
- Activities permitted;
- Nutritional requirements;
- Medication and treatment orders;
- Any safety measures implemented to prevent injury;
- Any environmental factors that may impact the home health agency's ability to provide safe and effective care;
- The participant's support system's ability to provide care;
- The participant and support system's teaching needs;
- A plan for discharge; and
- Any other appropriate items.

(a) References: Plan of Care

(i) Federal Regulations

"Conditions of and Limitations on Payment for Services" Social Security Act, Sec. 1814(a)(7) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title18/1814.htm.

Home Health Services, 42 CFR §440.70 (2020). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-440/subpart-A/section-440.70.

(ii) State Regulations

"Home Health Plan of Care." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 243.02 Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

3.7. Home Health: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. Idaho Medicaid reimburses home health services on a per visit basis, which includes the cost of mileage. Interim payment amounts are found on the Home Health Fee Schedule. Interim payment is based on the lesser of the Medicaid cost caps established by Idaho Medicaid on a state fiscal year basis or billed amount. Interim payments are made for:

- Skilled nurse visit;
- Home health aide;
- Occupational therapy;
- Physical therapy; and
- Speech-language pathology services.

Finalized payments are based on the provider's usual and customary fees for services and paid up to the reasonable cost as determined by a finalized Medicare cost report or the Medicaid percentile cap. The Medicaid percentile cap is revised annually on July 1st. Rates are determined by data from the most recent finalized Medicare cost reports 30 days prior to the effective date. Home health providers are subject to the Overpayments and Underpayments section of the *General Billing Instructions*, Idaho Medicaid Provider Handbook.

Durable medical equipment and supplies (DME and DMS) are paid up to the Medicaid allowed amount per the Durable Medical Equipment, Prosthetics, Orthotics and Supplies, Idaho Medicaid Provider Handbook, and the Numerical Fee Schedule.

Participants with Medicare eligibility will have all services paid for by Medicare. The department will cover any remaining coinsurance and deductible.

Reimbursement for therapy services is not reduced when provided by an assistant and does not require the CO, CQ or HM modifiers.

Payment for the initial nursing evaluation visit depends upon the participant's need for home health services. The provider should bill according to the following requirements:

- If the participant needs further home health services, bill the evaluation visit as a skilled nursing visit; or
- If the participant does not require home health services, the visit must be charged to the agency administration cost center.

All claims that aren't for DME and DMS are subject to Electronic Visit Verification (EVV) and may pend up to 10 days before processing. EVV requires all data elements be submitted to the state's aggregator before claims are billed. All home health services, including DME and DMS must be billed by the home health provider on the UB-04 claim form using the appropriate revenue and type of bill codes. See the Home Health Billing Appendix for more information on allowed revenue codes and bill types. It's important to bill all services on the same date of service in a single claim when possible. If multiple claims for the same date of service are submitted, the claim processing system counts each one separately against the 100 visit limitation.

See the *General Billing Instructions*, Idaho Medicaid Provider Handbook regarding billing, prior authorization, and requirements for billing all other third party resources before submitting claims to Medicaid. See the Participant Financial Responsibility section of the *General*

Information and Requirements for Providers, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable including co-payments.

3.7.1. References: Home Health — Reimbursement

(a) State Regulations

"Burden of Proof." IDAPA 16.05.03, *"Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Electronic Visit Verification (EVV)." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 244. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec.030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Home Health Agencies." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 255.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Home Health Services: Provider Reimbursement." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 246. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, *"Office of Administrative Hearings,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2020). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

"Services Requiring EVV." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 054. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4. Hospice Services

Hospice provides a holistic care concept designed to keep the participant comfortable, free of pain, and in the least restrictive environment possible by providing services that are reasonable and necessary for the palliation and management of a terminal illness, while honoring the individual's end-of-life care decisions.

Essential to the hospice benefit is that the participant or their representative understands the nature of hospice care and philosophy. The hospice interdisciplinary team must coordinate and manage all care received by the participant. The participant and caregiver are expected to communicate with hospice personnel regarding needs or wishes related to emergent care for hospice or non-hospice diagnoses, to ensure coordination of care and updates to the Plan of Care as needed. For example, teaching interventions to deal with changes of status and crisis management to prevent unnecessary emergent transportation and medical services which are not a part of the participant's end-of-life choices.

4.1. References: Hospice Services

4.1.1. Federal Regulations

Definitions, 42 CFR §418.3 (2021). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-A/section-418.3.

"Definitions" Social Security Act, Sec. 1905(a)(18) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"Definitions" Social Security Act, Sec. 1905(o) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"State Plans for Medical Assistance" Social Security Act, Sec. 1902(a)(10) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

4.2. Hospice: Provider Qualifications

A hospice agency is a public or private organization primarily engaged in providing care to terminally ill participants. Hospice agencies must be licensed in Idaho or certified to participate in the Medicare Program. Services must be within the scope of practice, certification/licensure, and training of the provider rendering them. The agency must employ at least one physician, one registered nurse and a social worker. The provider must have a National Provider Identifier (NPI) to be eligible for enrollment. Enrollment as an Idaho Medicaid provider and entering into a provider agreement must be completed prior to providing services for Idaho Medicaid participants.

Hospice agencies are considered high-risk providers. All employees and volunteers of a hospice agency must receive a clearance from a background check through the Idaho Department of Health and Welfare. Providers must submit a list of physicians, including volunteer physicians, employed by the hospice in their provider application and update any changes to this list with the department. For the purpose of hospice, the attending physician is a doctor of medicine or osteopathy that is identified by the participant during the hospice election as having the most significant role in their medical care.

All provider handbook and applicable state and federal regulations must be followed to maintain eligibility for reimbursement. See *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

4.2.1. References: Hospice — Provider Qualifications

(a) Federal Regulations

Criminal Background Checks, 42 CFR §455.434 (2011). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-E/section-455.434.

Definitions, 42 CFR §418.3 (2021). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-A/section-418.3.

(b) State Regulations

"Conditions for Payment." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 025. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Deemed Status of Hospice Agency and Its Hospice Home--No Idaho License or Certification Required, Idaho Code 39-1309 (2025). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title39/T39CH13/SECT39-1309.

Definitions, Idaho Code 39-1301 (2025). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title39/T39CH13/SECT39-1301.

"Hospice Agency." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 651.03. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Hospice Care; Hospice Program" Social Security Act, Sec. 1861(dd) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title18/1861.htm.

"Hospice: Provider Qualifications and Duties." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 655. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Individual Provider Requirements." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 020. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 007.10. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Agreements." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 022. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Provider Application Process." IDAPA 16.03.26, *"Medicaid Plan Benefits,"* Sec. 021. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.2.2. Hospice Aide

Hospice aides are assigned to a specific patient by a registered nurse (RN) of the interdisciplinary group, and provided written patient care instructions for services found in the plan of care that are within the state's allowed scope of practice and training. The aide's regular duties include:

- Hands on personal care;
- Simple procedures of therapy and nursing services;
- Assistance with ambulation or exercises;
- Assistance in administering self-administered medications; and
- Reporting changes in medical, nursing, rehabilitative and social needs to the RN.

Hospice aides are also eligible to provide Personal Care Services and Homemaker services.

Hospice aides must receive their certified nurse aide (CNA) certification and complete a training program and competency evaluation. Home health aides that haven't provided services in the past 24 months must complete a new training program and competency evaluation. The program must include 75 hours of classroom and supervised practical training. Practical training must be supervised by a RN, or licensed practical nurse (LPN) under the supervision of an RN. The aide must complete 16 hours of classroom work before performing 16 hours of practical work. Aides must receive 12 hours of ongoing education in a year Training must be provided by a RN with two years of experience, one of which must be in homecare; or a person supervised by an RN. Training must include:

- Communication skills to report clinical information;
- Observation and documentation of patient status and services furnished;
- Collecting temperature, pulse and respiratory data;
- Basic infection control procedures;
- Basic elements of bodily functions requiring reporting to a supervisor;
- Maintenance of a clean, safe and healthy environment;
- Recognizing emergencies and knowing emergency procedures;
- The physical, emotional and developmental needs of the patient and techniques to address;
- Respect for the patient, their property and privacy;
- Appropriate techniques for personal hygiene and grooming tasks, including:
    - Bed bath.
    - Sponge, tub, and shower bath.
    - Hair shampoo.
    - Nail and skin care.
    - Oral hygiene.
    - Toileting and elimination.
- Safe transfer and ambulation;
- Normal range of motion and positioning;
- Adequate nutrition and fluid intake; and
- Any other services designated by the hospice.

Competency evaluations can be performed by any organization except a home health agency that has within the past two years:

- Was out of compliance with home health aide requirements;
- Had unqualified persons provide home health aide services;
- Was the subject of an extended survey or determined to have provided substandard care;
- Received $5,000 or more in sanctions;

- Had compliance findings that endangered the health and safety of the patient and had temporary management appointed to oversee the agency;
- Had Medicare payments suspended;
- Found negligent by CMS or the State under law:
- Had its participation in Medicare terminated;
- Closed by CMS or the State or had its patients transferred by the State.

An annual assessment by an RN with in-person observation of the aide must occur annually regardless of deficiencies. Ongoing supervision requires an RN make an onsite visit at least every 14 days to assess the quality of care and services and ensure they meet the patient's needs. The aide does not need to be present for the biweekly visits. If a concern is noted, the aide must be observed in person and any deficiencies evaluated for competency. Assessments must include demonstrations of satisfactorily performing outcome criteria including, but not limited to:

- Following the plan of care for assigned tasks;
- Interpersonal relationships with the patient and family;
- Competency with assignments;
- Compliance with infection control; and
- Reporting on changes in patient's condition.

(a) References: Hospice Aide

(i) Federal Regulations

Condition of Participation: Hospice Aide and Homemaker Services, 42 CFR §418.76 (2021). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C/subject-group-ECFR74797288a614803/section-418.76.

4.2.3. Homemaker

Homemaker services include assistance in maintaining a safe and healthy environment and services to enable the individual to carry out the treatment plan. Homemakers must have successfully completed hospice orientation on addressing the needs and concerns of patients and families coping with a terminal illness. A Hospice Aide meets the requirements to be a homemaker. Homemakers must be supervised by, and receive instructions from, a member of the interdisciplinary group. Homemakers must report all concerns to the member coordinating their services.

(a) References: Homemaker

(i) Federal Regulations

Condition of Participation: Hospice Aide and Homemaker Services, 42 CFR §418.76 (2021). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C/subject-group-ECFR74797288a614803/section-418.76.

4.2.4. Personal Care Services

Personal care services may be provided by the hospice agency under the plan of care. Services must be coordinated with any other personal care services received to ensure there is no duplication of service. See the Personal Care Services section of the Home and Community-Based Services (HCBS) and Long-Term Support Services (LTSS), Idaho Medicaid Provider Handbook for service requirements.

(a) References: Personal Care Services

(i) Federal Regulations

Condition of Participation: Hospice Aide and Homemaker Services, 42 CFR §418.76 (2021). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C/subject-group-ECFR74797288a614803/section-418.76.

4.2.5. Skilled Nursing Facilities

A Medicare-certified skilled nursing facility (SNF) is eligible to provide hospice services for pain control, symptom management and respite purposes. A member of the interdisciplinary group responsible for the participant must provide coordination of hospice care between the SNF and agency. They must communicate with the involved health care providers to ensure quality of care.

The hospice must provide the SNF:

- The most recent plan of care;
- The hospice election form and any advance directives specific to the participant;
- The names and contact information for the hospice personnel responsible for the participant's care;
- The physician certification and recertification of the terminal illness;
- Directions of accessing the hospice's 24-hour on-call system;
- Medication for hospice care; and
- Any physician or attending physician orders.

The SNF must provide 24-hour nursing care. The facility must be capable of meeting all the patient's nursing needs and furnish them in accordance with the plan of care. The patient must be kept comfortable, clean, well-groomed, and protected from accidents, injury, and infection. If any patients are receiving general inpatient care on the floor, there must be a registered nurse (RN) on duty who provides direct care.

The SNF must provide physical space for private patient and family visiting, or bereavement after the patient's death. Accommodations for family members to remain with the patient throughout the night must also be available. Visitors must be allowed at any hour, including infant and children visitors.

A plan of care must be developed between the hospice and SNF that delineates the responsibility for each service. The plan of care and any changes must be made with the review of the patient, Hospice agency and SNF representatives. The hospice agency must approve the plan before implementation.

A written agreement must be developed by the hospice agency that explains the hospice provider's professional management responsibilities for the individual's hospice care and the facility's agreement to provide room and board to the individual. The facility's responsibilities under room and board includes all assistance in the activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies. The level of hospice care must be at the same as if provided in the home.

The agreement must include the method and documentation of communication between the two providers. Communication is required in the event of a significant change in the patient's physical, mental or social state, there's a need to alter the plan of care due to complications, the patient needs to be transferred, or the patient dies. In the event of a transfer, the hospice retains responsibility for the terminal illness and related conditions. There must be an agreement on the responsibility of bereavement services for SNF staff.

The hospice must provide the plan of care to the facility and an acknowledgement from the participant of their agreement to palliative care. The agreement must enforce the hospice agency's responsibility for providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary and bereavement); social work; provision of

medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. The hospice may utilize facility staff to meet their responsibilities but only at the level of assistance that would be requested of a family member.

A provision in the agreement must state that the hospice will report all alleged violations of mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the SNF/NF administrator within 24 hours of the hospice becoming aware of the alleged violation.

The facility must agree to provide inpatient records to the hospice agency. There must be an agreed upon point of contact from the facility that is responsible for implementation of the agreement. The hospice retains responsibility for ensuring personnel providing care to the patient are trained appropriately to their condition, in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements. Finally, the agreement must include a method for determining compliance.

(a) References: Skilled Nursing Facilities

(i) Federal Regulations

Condition of Participation: Hospices that Provide Hospice Care to Residents of a SNF/NF or ICF/IID, 42 CFR §418.112 (2019). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-D/section-418.112.

Condition of Participation: Hospices that Provide Inpatient Care Directly, 42 CFR §418.110 (2016). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-D/section-418.110.

Condition of Participation: Short-term Inpatient Care, 42 CFR §418.108 (2016). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-D/section-418.108.

"Definitions" Social Security Act, Sec. 1905(o) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

4.3. Hospice: Participant Eligibility

Hospice services are a benefit of Idaho Medicaid's enhanced plan. The participant must meet medical necessity criteria according to the CMS Local Coverage Determination (LCD) L34538, Hospice Determining Terminal Status to be eligible for hospice services. Only participants with Medicaid Enhanced Plans are eligible for services. Participants residing in a certified family home (CFH), intermediate care facilities for individuals with intellectual disabilities (ICF/IID), residential assisted living facility (RALF), or skilled nursing facility (SNF) are eligible if they meet the criteria.

There must be a physician certification that the participant's life expectancy is six months or less is no more than two days after the participant elects or re-elects to receive hospice services. The certifying physician must be the hospice medical director or a physician member of a hospice interdisciplinary group and the participant's attending physician, if applicable. Medicaid must be notified if the attending physician is not a hospice employee. The department may request another physician's opinion to confirm the diagnosis. The physician certification must be from within the last six months for election of hospice services.

The participant or their legal representative must elect to receive hospice services by completing a formal document that selects the hospice, establishes an effective date and is signed and dated by the participant or their representative. The acknowledgement must include an understanding of the palliative nature of hospice, and that rehabilitative services, such as community-based rehabilitation, will no longer be covered. Participants under 21 retain eligibility for curative services and Medicaid benefits. The participant cannot request an effective date before the date of their election. Participants who elect less than eight monthly election periods within a benefit period may request additional election periods when:

- Available hospice did not exceed 210 days in a benefit period due to loss of financial eligibility;
- Agencies were not changed excessively;
- More than eight election periods were not revoked.

A participant can revoke services at any time. A revocation requires filing of a signed statement with the hospice by the participant that includes revocation of Medicaid hospice coverage effective the date signed. The hospice provider may not coerce or prevent a participant's termination of election. Medicaid coverage will be reinstated the date hospice election is revoked.

A participant can change hospice agencies at any time by filing a statement with the current hospice and new hospice agencies. The statement must be signed and dated and include the names of both hospices and the date the change is effective. Changes in ownership do not constitute a change in agencies. Participants can only change hospices six times within a benefit period.

The hospice provider is required to notify the Medical Care Unit (MCU) of all hospice elections, recertifications, revocations, discharges, transfers or death for Medicaid participants regardless of other insurance coverage, including Medicare. The provider is required to notify the MCU within 15 working days by faxing the completed Hospice Notification Form. If the form is not received timely, Idaho Medicaid will not pay the claim. Factors outside the control of the hospice provider may create an occasional need for a retrospective review. These will be considered on a case-by-case basis (e.g., if the participant's Medicaid eligibility has been pending).

The MCU determines if the medical necessity criteria for hospice care are met based upon submitted documentation. If the participant is approved for the Hospice Medicaid Benefit, election and recertification dates are entered into the Medicaid system as a Hospice Alert. The notice of decision will be located in the provider portal and the participant will receive a decision letter in the mail. Hospice care will be approved retrospectively based upon eligibility date.

Election and recertification are completed every eight months regardless of other payers' requirements and timelines. Agencies may automatically renew the election period without a break in care as long as the participant does not revoke the election. Forms are available under DHW Forms on Gainwell Technologies' webpage for election, recertification and changes of status such as revocations, discharges, transfers and death. Forms must be submitted with the required documentation:

- The completed Idaho Medicaid Hospice Notification Form;
- The hospice agency's completed Interdisciplinary Plan of Care (POC), signed by the Hospice Medical Director;
- A certification which states that the individual's medical prognosis for life expectancy is six months or less and is signed by the Hospice Medical Director, or the physician in the hospice interdisciplinary group and the attending physician, if the participant has one;
- **Elections** require the form signed by the participant or legal representative;
- **Elections** require the participant's most recent history and physical performed by the attending physician regarding the condition qualifying for hospice. This requirement may also be met with a comprehensive physical assessment signed by the hospice Medical Director;
- **Recertifications** require documentation of compliance with CMS eligibility standards for the participant's specific hospice diagnosis (e.g., Local Coverage Determination (LCD) or Criteria Worksheet); and
- **Changes of Status** require the Termination of Care section be completed.

Participants on the Aged & Disabled (A&D) Waiver or Developmentally Disabilities (DD) Waiver may have waiver service levels adjusted if the participant elects hospice.

Not all participants are eligible for all services. Services are available based on the participant's enrollment eligibility. Incarcerated individuals or otherwise ineligible non-citizens with Medicaid coverage are not eligible for these services.

Before delivery of services, providers must check eligibility on the date of the service to validate coverage. Providers must maintain documentation of the eligibility check. Eligibility can be checked by calling Idaho Medicaid Automated Customer Service (MACS) at 1 (866) 686-4272; or through the Trading Partner Account on Gainwell Technologies Idaho Medicaid website.

See the General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, for more detail on eligibility checks.

4.3.1. References: Hospice — Participant Eligibility

(a) Federal Regulations

Certification of Terminal Illness, 42 CFR §418.22 (2025). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-B/section-418.22.

"Conditions of and Limitations on Payment for Services" Social Security Act, Sec. 1814(a)(7) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title18/1814.htm.

Content of Certification, 42 CFR §418.22(b) (2025). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-B/section-418.22.

Definitions, 42 CFR §418.3 (2021). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-A/section-418.3.

"Definitions" Social Security Act, Sec. 1905(o) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

Election of Hospice Care, 42 CFR §418.24 (2024). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-B/section-418.24.

Persons to Whom Services will be Provided, 42 CFR §136.12 (2002). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-I/subchapter-M/part-136/subpart-B/section-136.12.

Timing of Certification, 42 CFR §418.22(a) (2025). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-B/section-418.22.

(b) State Regulations

Hospice: Definitions." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 651. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Hospice: Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 652. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Hospice: Procedural Requirements." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 654. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Participant Eligibility." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 025.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.4. Hospice: Covered Services and Limitations

Hospice services reasonable and necessary for the palliation and management of the terminal illness and related conditions are a covered benefit of Idaho Medicaid. The hospice agency is responsible for the overall management and coordination of the hospice Plan of Care including billing processes. It is the agency's responsibility to inform other providers the participant is on hospice. The hospice plan of care supersedes any other Medicaid provider plan of care. Rehabilitative services, such as community-based rehabilitation service, are not covered once hospice is elected. However, participants under age 21 are eligible for concurrent curative treatments and hospice. This means that children are not limited to palliative treatment only.

Core services must be provided by hospice employees except when it is necessary to contract such services during peak patient loads, staffing shortages from illness, other short-term temporary situations that interrupt patient care, temporary travel of the participant outside the hospice's service area, nursing services so infrequent that employment would be impractical and prohibitively expensive, or to obtain physician services. A hospice may contract another hospice enrolled with Medicaid to provide core services. Core services include:

- Physician services under the supervision of the Medical Director;
- Nursing services under the supervision of a registered nurse;
- Medical social services under the direction of a physician;
- Counseling services for the participant and family:
    - Bereavement counseling for the family up to a year after the death of the participant, includes residents of SNF and intermediate care facilities for individuals with intellectual disabilities (ICF/IID);
    - Dietary counseling; and
    - Spiritual counseling.

Other hospice services, which are the responsibility of the agency regardless of the service location, include:

- Nursing care provided by, or under the supervision of, a registered nurse (RN);
- Medical social services under the direction of a physician;
- Counseling services for the care of the participant or the acceptance of death;
- Home health aide and homemaker services;
- Occupational therapy, physical therapy, and speech-language pathology services;
- Medical equipment and supplies including:
    - Durable medical equipment and supplies related to the palliation or management of the patient's terminal illness; and
    - Self-help and personal comfort items related to the palliation or management of the patient's terminal illness; and
- Drugs and biologicals, as defined in Subsection 1861(t) of the Social Security Act, which are used primarily for the relief of pain and symptoms related to the patient's terminal illness.

Home health aide and homemaker services must be furnished by qualified aides under the supervision of an RN. Home health aides will provide personal care services and household services necessary to maintain a safe and sanitary environment in areas used by the participant. Homemaker services assist in maintenance of a safe and healthy environment.

Short-term inpatient care can be provided in a hospice inpatient unit or participating hospital or nursing facility with 24 hour nursing care that meets CMS standards for staff, and patient areas. The services must align with the plan of care. General inpatient care can be provided for necessary pain control or acute or chronic symptom management that cannot be provided

in other settings. Inpatient care is also covered for the participant's family or other caregivers to receive respite.

Certified family homes (CFH), ICF/IIDs, residential assisted living facilities (RALF), and skilled nursing facilities (SNF) with hospice participants must have a written agreement with the hospice agency to delineate management responsibilities for the participant's care.

- The ICF/IID facility has responsibility for room and board including all assistance in the activities of daily living (ADL), social activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies.
- The RALF room and board reimbursement is not the responsibility of the hospice agency.

4.4.1. References: Hospice – Covered Services and Limitations

(a) Federal Regulations

"Conditions of and Limitations on Payment for Services" Social Security Act, Sec. 1814(a)(7) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title18/1814.htm.

Condition of Participation: Core Services, 42 CFR §418.64 (2019). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-C/subject-group-ECFR35b48a647589673/section-418.64.

Condition of Participation: Drugs and Biologicals, Medical Supplies, and Durable Medical Equipment, 42 CFR §418.106 (2019). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-D/section-418.106.

Condition of Participation: Short-term Inpatient Care, 42 CFR §418.108 (2016). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-D/section-418.108.

Definitions, 42 CFR §418.3 (2021). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-A/section-418.3.

"Definitions" Social Security Act, Sec. 1905(o) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1905.htm.

"Definitions of Services, Institutions, Etc" Social Security Act, Sec. 1861(t) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title18/1861.htm.

"Hospice Care; Hospice Program" Social Security Act, Sec. 1861(dd) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title18/1861.htm.

"Scope of Benefits" Social Security Act, Sec. 1812(d) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title18/1812.htm.

(b) State Regulations

"Hospice." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 650. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(3)(g) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Types of Treatments and Procedures Not Covered." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 060.02.b. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.4.2. Routine Home Care

Idaho Medicaid hospice billing for routine home care uses Revenue Code 0651. Authorizations will be issued by the Medical Care Unit and manually priced:

- For the Day 1-60 higher payment rate.
- For the Day 61-240 reduced rate.
- For subsequent reduced rate periods when applicable.
- For the Service Intensity Add-on (SIA) in the last seven days of life. The provider will need to submit the dates and total increments for which the SIA applies.

The Hospice Notification Form must be faxed to the Medical Care Unit to request authorizations as described above. Participants with Medicare primary will not require authorizations related to Revenue Code 0651; Medicare will pay those claims according to Payment Reform.

(a) References: Routine Home Care

(i) Federal Regulations

"Payment Procedures for Hospice Care." 42 CFR §418.302 (2015), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-G/section-418.302.

(ii) Idaho Medicaid Publications

Hospice Rates, *Information Release MA15-08* (1/1/2016). Division of Medicaid, Department of Health and Welfare, State of Idaho.

(iii) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(3)(g) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.4.3. Personal Care Services

Medicaid may authorize personal care services (PCS) for some participants to prevent unnecessary institutional placement, to provide for the greatest degree of independence possible, to enhance quality of life, to encourage individual choice, and to maintain community integration. The hospice must coordinate its hospice aide and homemaker services with the PCS agency and the regional Medicaid Nurse Reviewer. Medicaid PCS services may not be substituted for the primary care required to be provided by the hospice provider. See the Personal Care Services section of the Home and Community-Based Services (HCBS) and Long-Term Support Services (LTSS), Idaho Medicaid Provider Handbook for more information.

(a) References: Personal Care Services

(i) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(3)(d)(iii) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.4.4. Physician Services

Hospice-based physician employee services are billed by the hospice provider on the UB-04 claim form using revenue code 0657 and the appropriate CPT® procedure codes. Notify the Medical Care Unit of any changes in physicians who are employees, contractors, or volunteers of the hospice agency.

Physicians who render hospice services who are not employees, contractors, or volunteers of the hospice agency, must bill Medicaid directly. The claim form should indicate that they have no affiliation with the hospice agency.

(a) References: Physician Services

(i) State Regulations

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(3)(g) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.4.5. Skilled Nursing Facility Room and Board

An authorization from Medicaid's Long-Term Care Unit is required for room and board in a skilled nursing facility or intermediate care facilities for individuals with intellectual disabilities (ICF/IID). Room and board payment includes assistance with activities of daily living (ADL), socializing activities, medication administration, maintaining cleanliness of resident rooms, and supervising and assisting use of durable medical equipment and prescribed therapies.

The Room and Board section of the Hospice Notification Form must be completed, noting the name of the facility and the date that hospice room and board payment responsibility begins. An eight month period is usually approved. It is very important to notify Medicaid if the hospice participant has been discharged from hospice, or revoked hospice care so the authorization end date can be modified.

(a) References: Skilled Nursing Facility Room and Board

(i) State Regulations

"Additional Amount for NF Residents." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 659.07. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

Medical Assistance Program – Services to be Provided, Idaho Code 56-255(3)(d)(i) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-255.

"Medical Necessity (Medically Necessary)." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 006.15. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.5. Prior Authorization

See the General Billing Instructions, Idaho Medicaid Provider Handbook for more information on billing and requesting prior authorized services.

4.6. Additional Documentation

Providers must follow the requirements of the Documentation: General section in addition to the ones presented here.

4.6.1. Plan of Care

A plan of care must be established and reviewed at least monthly and include all covered services and supplies. Only services and items consistent with the plan of care are covered. The initial plan of care must be written by a member of the basic interdisciplinary group who assess the participant's needs, after consulting with at least one other group member. One of the caregivers developing the plan of care must be a nurse or physician. Hospice services are not covered before the day the plan of care is established. The other two members of the basic interdisciplinary group must review the initial plan of care and provide input within two calendar days following the day of assessment.

(a) References: Plan of Care

(i) State Regulations

"Plan of Care." IDAPA 16.03.26, "Medicaid Plan Benefits," Sec. 454.06. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

4.7. Hospice: Reimbursement

Providers must be enrolled to receive reimbursement from Idaho Medicaid. Providers have the burden of proof to establish entitlement to payment. All hospice providers are paid through the use of prospective daily rates determined by the department except where specified. All services related to the terminal illness are included in the prospective rates paid. The hospice provider is responsible for all services bundled in the prospective rate regardless of whether they are supplied directly by the hospice provider or by a non-hospice provider.

Service reimbursement is based on the services provided and not the credentials of the person performing the service. Hospice services in the bundled reimbursement rate are the responsibility of the agency regardless of the service location, which include:

- Nursing care provided by, or under the supervision of, a registered nurse (RN);
- Medical social services under the direction of a physician;
- Counseling services for the care of the participant or the acceptance of death;
- Home health aide and homemaker services;
- Physical therapy, occupational therapy, and speech-language pathology services; and
- Medical equipment and supplies including:
    - Durable medical equipment and supplies related to the palliation or management of the patient's terminal illness; and
    - Self-help and personal comfort items related to the palliation or management of the patient's terminal illness; and
- Drugs and biologicals, as defined in Subsection 1861(t) of the Social Security Act, which are used primarily for the relief of pain and symptoms related to the patient's terminal illness.

Prospective rates are divided into routine home care, continuous home care, inpatient respite care, general inpatient care and service intensity add-ons for hospice care. Hospice reimbursement represents full payment to the provider for all costs of covered services, including administrative and general activities performed by physicians providing services for the hospice. Direct care by physicians working under the hospice is counted in the overall hospice cap and is reimbursed under the Numerical Fee Schedule. Laboratory and X-ray services are included in the hospice daily rate. Volunteer physician services are not reimbursed unless the physician is paid for their services. Physicians may not volunteer based on the participant's ability to pay. Independent physicians are paid as normal and outside the hospice benefit.

Routine home care rates are paid at a higher rate in the first 60 days of care despite the level of intensity. Regardless of the hospice providing services, when a participant leaves care and later returns, a new higher rate 60 day period only occurs if there has been a 60 day gap in service. If there has not been a sufficient gap, rates are paid at the lower rate.

Continuous home care is for crisis periods requiring continuous nursing care to achieve palliation and manage acute medical symptoms. Nursing service must be provided by an RN or licensed practical nurse (LPN) for at least half the total period of care. A minimum of eight hours of care must be provided during a 24-hour day beginning and ending at midnight and does not need to be continuous and uninterrupted. For every hour, or part of an hour of continuous care furnished, the hourly rate is paid to the hospice up to 24-hours per day.

General inpatient care is paid at a separate designated payment rate. No other rates are available during these days except for physician services. Home care rates are paid for the day of discharge unless the participant dies while inpatient. The date of death is paid at the inpatient rate. Inpatient rates are paid at Medicare hospice rates without decreases for

coinsurance amounts. Medicaid continues to cover inpatient care once the Medicare benefit is exhausted. Hospice agencies must continue to provide care until the participant revokes services or passes away.

Inpatient respite care has a designated rate for each day a participant resides in an approved inpatient facility receiving respite care. Payment is limited to a maximum of five days. The first day includes the admission date but the period does not include the discharge date in any monthly election period. Payment for the sixth and any subsequent days is made at a routine, continuous, or general inpatient rate.

A maximum number of allowable inpatient days is calculated by multiplying the total number of a provider's Medicaid hospice days by 20%. If the total is exceeded, payment is limited by calculating the ratio of maximum allowable inpatient days by the number of actual inpatient care days and multiplying the ratio by the total payment for inpatient care made. Excess inpatient care days are multiplied by the routine home care rate. The two amounts will be added and the sum compared to the interim inpatient hospice care payments made during the "cap period." Days determined to not be eligible for the inpatient rate will not be counted as inpatient days and paid at the home care rate.

It is a federal requirement that room and board "pass through" the hospice agency when a hospice participant resides in a skilled nursing facility, and Medicaid's Long-Term Care Unit has authorized a nursing facility payment. If a hospice participant resides in a skilled nursing facility or intermediate care facility with intellectual disabilities (ICF/IID), an authorization number is required so that the hospice provider can be paid by Medicaid for room and board (revenue code 658). Hospice agencies are reimbursed an additional per diem amount for participants in nursing facilities of 95% of the per diem interim nursing home daily or special rate for the nursing facility providing room and board to the hospice participant. These additions are not subject to payment caps. The hospice agency is then responsible to reimburse the facility for the room and board payment.

A payment for a service intensity add-on is made for visits by an RN or social worker during the last seven days of life. This is in addition to routine home care rates. The rate is determined by multiplying the continuous home care rate per 15-minutes by the number of units for combined daily visits and adjusted for geographic wage differences. Reimbursement is capped at 16 units per day. A social worker's time on the phone is not eligible for this reimbursement.

A reimbursement cap is calculated by aggregate payments to each hospice during a cap period. It is calculated by multiplying the number of participants on hospice care during the period by an amount adjusted for each cap year reflecting the percentage change in the medical care expenditure category of the Consumer Price Index for all urban consumers as published by the U.S. Bureau of Labor and Statistics. The number of participants must be reported to Medicaid within 30-days of the end of the cap year. If a participant was transferred to a non-certified hospice where no payment is made, the certified hospice may count the complete participant benefit period in their cap. A weighted average cap amount based on the number of days falling within each cap period is used to certify mid-month amounts. Adjustments are made to the cap based on which hospice is designated during the participant's election period. The number of days services are rendered are multiplied by the cap amount to adjust the overall cap. The share of the cap amount allowed by each hospice is based on the proportion of total covered days provided by each hospice in a cap period. The maximum number of allowable inpatient days for each hospice is multiplied by the cap amount for the cap period in which the participant first elected hospice. The participant must file an initial election during the period beginning September 28th of the previous year through

September 27th of the current cap year for it to count as an election during the current cap year. The inpatient limitation is deducted from the total reimbursement amount. The total in payments includes all services rendered in a cap year regardless of when the payment is made. Total payments are compared to the cap amount and providers must return any excess payments.

Claims for services rendered to participants receiving hospice services are pended for review by the department to determine whether the hospice agency or Medicaid is responsible for payment. Refer to the Provider Reimbursement Rates' HCBS and LTSS folder for the Hospice Fee Schedule rates. See the Hospice Billing Appendix for more information on allowed revenue codes and bill types. Those participants that have special rate pricing must bill revenue code 0658 and the appropriate CPT® procedure codes.

See the General Billing Instructions, Idaho Medicaid Provider Handbook regarding Medicaid policy on billing all other third party resources before submitting claims to Medicaid. Participants cannot be billed for any non-reimbursed amount except as allowed by the department such as in Participant Liability, and if the provider meets the requirements in the Participant Financial Responsibility section of the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook.

4.7.1. References: Hospice – Reimbursement

(a) Federal Regulations

"Payment Procedures for Hospice Care." 42 CFR §418.302 (2015), Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-G/section-418.302.

"State Plans for Medical Assistance" Social Security Act, Sec. 1902(a)(13)(B) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1902.htm.

(b) State Regulations

"Burden of Proof." IDAPA 16.05.03, *"Contested Case Proceedings and Declaratory Rulings,"* Sec. 133. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/2023%20Archive/16/160503.pdf.

"Burden of Proof (Rule 477)." IDAPA 62.01.01, *"Idaho Rules of Administrative Procedure,"* Sec. 477. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

"General Payment Procedures." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 030. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Hospice." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 650. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Hospice: Inpatient Payment Limitations." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 657. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Hospice: Physician Payments." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 658. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Hospice: Reimbursement." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 656. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Hospice: Reimbursement Cap." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 659. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

"Mandatory Application." IDAPA 62.01.01, *"Office of Administrative Hearings,"* Sec. 800.01. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/62/620101.pdf.

Provider Payment, Idaho Code 56-265 (2020). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/Title56/T56CH2/SECT56-265.

4.7.2. Participant Liability

Medicaid participants residing in a nursing facility or intermediate care facilities for individuals with intellectual disabilities (ICF/IID) must contribute toward the cost of room and board, when applicable and not otherwise exempt. The amount of each participant's monthly liability (the contribution toward the cost of care) will be determined under the same rules that are currently applied to all other Medicaid nursing facility residents. Medicaid hospice participants will be notified when they must pay a contribution. The hospice can request from the nursing facility the Authorization for Nursing Facility Payment form, which shows the participant's liability amount. See the Share of Cost section of the *General Information and Requirements for Providers*, Idaho Medicaid Provider Handbook for more information.

(a) References: Patient Liability

(i) Federal Regulations

Limitations on Premiums and Cost Sharing, 42 CFR §447.56(a)(1)(ix) (2024). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-A/subject-group-ECFRa3c17d28ea07411/section-447.56.

"State Option for Alternative Premiums and Cost Sharing" Social Security Act, Sec. 1916A(b)(3)(A)(iii) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1916A.htm.

"State Option for Alternative Premiums and Cost Sharing" Social Security Act, Sec. 1916A(b)(3)(B)(iv) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1916A.htm.

"Use of Enrollment Fees, Premiums, Deductions, Cost Sharing, and Similar Charges" Social Security Act, Sec. 1916(a)(2)(E) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1916.htm.

"Use of Enrollment Fees, Premiums, Deductions, Cost Sharing, and Similar Charges" Social Security Act, Sec. 1916(b)(2)(E) (1935). Social Security Administration, https://www.ssa.gov/OP_Home/ssact/title19/1916.htm.

(ii) State Regulations

"Hospice: Patient Liability." IDAPA 16.03.26, "*Medicaid Plan Benefits*," Sec. 660. Department of Administration, State of Idaho, https://adminrules.idaho.gov/rules/current/16/160326.pdf.

5. Documentation: General

All providers are required to generate records at the time the service is delivered and to maintain documentation that supports reimbursement for services. Individual services may have additional documentation requirements. General requirements for documentation and signatures can be found in General Information and Requirements for Providers, Idaho Medicaid Provider Handbook, including standard retention requirements. Records limited to checklists with attendance/appointments, procedure codes, and units of time are insufficient to meet this requirement. Documentation must be signed and dated by the person delivering the service with their name clearly printed.

Documentation must be made available immediately upon request by department personnel acting in their official capacity. Services delivered without adequate documentation are not eligible for reimbursement. Providers must only submit records for utilization management when requested by the department. Documentation sent unsolicited, or not for a service requiring prior authorization, will not be reviewed by the department. Unreviewed documentation does not constitute approval or authorization of a service.

5.1. References: Documentation: General

5.1.1. Federal Regulations

Disclosure of Information by Providers and Fiscal Agents, 42 CFR §455, Subpart B (2023). Government Printing Office, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/subpart-B.

5.1.2. State Regulations

Administrative Remedies, Idaho Code §56-209h(3) (2018). Idaho State Legislature, https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch2/sect56-20.

"Documentation of Services and Access to Records." *IDAPA 16.05.07,* "The Investigation and Enforcement of Fraud, Abuse, and Misconduct*,"* Sec. 101. Department of Administration, State of Idaho, https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/current/16/160507.pdf.

"Records." *IDAPA 16.03.26, "Medicaid Plan Benefits,"* Sec. 035. Department of Administration, State of Idaho https://proddfmmainsa.blob.core.windows.net/dfm-admin-website/rules/current/16/160326.pdf.

Appendix A. Home Health Billing Codes

a. Revenue Codes

Covered Revenue Codes		
Revenue Codes	**Description**	**Notes**
0270	Home Health Supplies	Requires a CPT®/HCPCS. Nutritional products are included.
0291	Rental Durable Medical Equipment	Requires a CPT®/HCPCS.
0421	Physical Therapy Visit	
0431	Occupational Therapy Visit	
0441	Speech- Language Pathology Visit	
0470	Audiology - General	
0471	Audiology - Diagnostic	
0472	Audiology - Treatment	
0551	Skilled Nurse Visit	Requires the skills of a Registered Nurse or Licensed Practical Nurse.
0571	Aide Visit	Services performed by trained nurse aides, licensed personnel or a home health aide.
0771	Drugs Requiring Special Coding	Requires a CPT®/HCPCS with National Drug Code (NDC). Refer to the Medical Services, Idaho Medicaid Provider Handbook, for reporting national drug codes for physician administered drugs.

b. Bill Types

Covered Home Health Bill Types	
Code	**Description**
0321	Home Health (Admit - Through - Discharge Claim) (Including Medicare Part A)
0322	Home Health (Interim - First Claim) (Including Medicare Part A)
0323	Home Health (Interim - Continuing Claim) (Including Medicare Part A)
0324	Home Health (Interim - Last Claim) (Including Medicare Part A)
0327	Home Health (Replacement of Prior Claim) (Including Medicare Part A)
0328	Home Health (Void or Cancellation of Prior Claim)

c. Patient Status Codes

Accepted Patient Status Codes (Field 17)	
Code	**Description**
01	Discharge to Home or self care
02	Transfer to Hospital
03	Transfer to Nursing Home
04	Transfer to Intermediate Care Facility
05	Discharged to Another Type of health care institution not defined elsewhere in this list

Accepted Patient Status Codes (Field 17)	
Code	**Description**
06	Discharge/Transfer to Home Under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care (Indicate in appropriate field the status or location of patient and time they left the facility)
07	Left Against Medical Advice
08	Discharged/Transferred to Home Under Care of a Home IV Provider
20	Death
30	Not Discharged, Still A Patient
40	Expired at Home
41	Expired in an Institution
42	Expired, Place Unknown
43	Discharged/transferred to a Federal Health Care Facility

d. Occurrence Codes

Accepted Occurrence Codes (Fields 31-34)	
Code	**Description**
01	Auto Accident
02	Auto Accident/No Fault
03	Accident/Tort
04	Accident/Employment Related
05	Other Accident
06	Crime Victim
24	Date Insurance Denied
25	Date Benefits Terminated by Primary Carrier
42	Date of Discharge
X0	Plan of Care on file

Appendix B. Hospice Billing Codes

a. Revenue Codes

Covered Hospice Revenue Codes		
Revenue Code	**Description**	**Notes**
0651	Routine Care	Daily care provided for general hospice care.
0652	Continuous Care	Care rendered during crisis conditions. Requires a minimum of eight (8) hours. Hours are counted from midnight to midnight. This procedure must be billed using units of time in fifteen (15) minute increments. Partial blocks can be billed in fifteen (15) minute increments. Services must be provided by a registered or licensed practical nurse.
0655	Inpatient Respite Care	Respite care is limited to five (5) days per election period (calendar month) for each participant in an approved inpatient facility. Respite care may only be rendered in a licensed freestanding hospice or a qualified nursing facility.
0656	General Inpatient Care (Non-Respite)	Participant care must be rendered in an approved inpatient hospital or freestanding hospice bed.
0657	Physician Care	Hospice-employed physician services must be billed with the appropriate CPT® procedure codes on each line for each service. When the physician billing for services is an employee of the hospice, the UB-04 claim form must be used with Revenue Code 0657.
0658	Room and Board Care	Room and Board reimbursement for a hospice participant only occurs when the participant has been approved for a level of care in a long-term care facility. Medicaid is always the primary payer of the hospice room and board charge. Per diems are paid for Medicaid or dually eligible hospice participants residing in a Medicare certified nursing facility. The reimbursement rate will be ninety-five percent (95%) percent of the nursing facility rate on file in which the hospice participant is a resident. The nine (9) digit Medicaid Nursing Home provider number must be submitted on the claim in field 80 of the UB-04 claim form or in the appropriate field of the electronic claim form. Any participant liability will be withheld from the total hospice payments. Prior Authorization is required.

b. Bill Types

Covered Hospice Bill Types	
Code	**Description**
0811	Hospice - Non-Hospital Based (Admit - Through - Discharge Claim)
0812	Hospice - Non-Hospital Based (Interim - First Claim)
0813	Hospice - Non-Hospital Based (Interim - Continuing Claim)
0814	Hospice - Non-Hospital Based (Interim - Last Claim)
0817	Hospice - Non-Hospital Based (Replacement of Prior Claim)
0818	Hospice - Non-Hospital Based (Void or Cancellation of Prior Claim)
0821	Hospice - Hospital Based (Admit - Through - Discharge Claim)
0822	Hospice - Hospital Based (Interim - First Claim)
0823	Hospice - Hospital Based (Interim - Continuing Claim)
0824	Hospice - Hospital Based (Interim - Last Claim)
0827	Hospice - Hospital Based (Replacement of Prior Claim)
0828	Hospice - Hospital Based (Void or Cancellation of Prior Claim)

c. Patient Status Codes

Accepted Patient Status Codes (Field 17)	
Code	**Description**
01	Discharge to Home or self care
20	Death
30	Not Discharged, Still A Patient

d. Occurrence Codes

Accepted Occurrence Codes (Fields 31-34)	
Code	**Description**
24	Date Insurance Denied
25	Date Benefits Terminated by Primary Carrier
42	Date of Discharge

Appendix C. Provider Handbook Modifications

This table lists the last three years of changes to this handbook as of the publication date. Changes to references or of a non-substantive technical nature are not captured.

Provider Handbook Modifications				
Version	**Section**	**Modification Description**	**Publish Date**	**SME**
17.0	All	Published version	03/11/2026	TQD
16.1	Handbook	Handbook was rewritten to reflect current policies and regulations.	03/11/2026	M Hurst W Deseron
16.0	All	Published version	08/16/2023	TQD
15.1	1.2.5. Prior Authorization (PA)	Renamed section Prior Authorization. Updated process.	08/02/2023	W Deseron E Garibovic