Washington State Health Care Authority

Washington Apple Health (Medicaid)

Hospice Services Billing Guide

For Hospice Agencies, Hospice Care Centers, and Pediatric Palliative Care Providers

May 19, 2026

Washington State Health Care Authority

Disclaimer

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict arises between this document and a governing statute or Health Care Authority (HCA) rule, the governing statute or HCA rule applies.

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If the broken link is in the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **May 19, 2026**, and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this guide is governed by the rules found in Chapter 182-551 WAC.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

> Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by HCA.

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with HCA.

How can I get HCA Apple Health provider documents?

To access provider alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Health care privacy toolkit

The Washington Health Care Privacy Toolkit is a resource for providers required to comply with health care privacy laws.

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* This publication is a billing instruction.

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Where can I download HCA forms?

To download an HCA form, see HCA's **Forms & Publications** webpage. Type only the form number into the Search box (Example: 13-835).

Copyright disclosure

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
Definitions	Added a definition for "Brief period"	Correction. This term was inadvertently removed.in the prior publication.

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Resources Available

Topic	Contact Information
Who do I contact if I have questions regarding hospice or Pediatric Palliative Care (PPC) Case Management/Coordination policies or need information on notification requirements?	• Billing questions 800-562-3022 (customer service line for claims) • HCA - Clinical Quality and Care Transformation PO Box 45535 Olympia, WA 98504-5506
Who do I contact if I have questions regarding medications not related to the hospice diagnosis?	Pharmacy only providers 800-848-2842 All other providers 800-562-3022
How do I obtain HCA's Hospice program forms?	View and download the HCA/Medicaid Hospice Notification form, HCA 13-746, and the Pediatric Palliative Care (PPC) Referral and 5 - Day Notification form, HCA 13-752. See Where can I download HCA forms?
Where is the Hospice Services fee schedule?	See HCA's Hospice Fee Schedule
How do I obtain prior authorization or a limitation extension?	For prior authorization or limitation extension, providers may submit prior authorization requests online through direct data entry into ProviderOne. See HCA's prior authorization webpage for details. Providers may also fax requests to 866-668-1214 along with the following: • A completed, typed General Information for Authorization form, HCA 13-835. This request form must be the initial page when you submit your request. • A completed Hospice (including PPC) Authorization Request form, HCA 13-848, and all the documentation listed on this form and any other medical justification. See Where can I download HCA forms? For more information on requesting authorization, see HCA's ProviderOne Billing and Resource Guide.
How do I find out where my local Community Services Office (CSO) is located?	See Community Services Office

Topic	Contact Information
How do I find out where my local Home and Community Services (HCS) office is located?	See Home and Community Services

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to **chapter 182-500 WAC and WAC 182-551-1010** for a complete list of definitions for Washington Apple Health.

Acute – Having a rapid onset, severe symptoms, and short course; not chronic.

Bereavement counseling – Counseling services provided to a client's family or significant others following the client's death.

Brief period – Six days or less within a 30-consecutive-day period.

Certification statement – A document that states the client's eligibility for each election period and is:

- Created and filed by the Hospice agency for each HCA hospice client.
- Signed by the physician and/or hospice medical director.

Continuous home care – Services provided for a period of 8 or more hours in a day. It may include homemaker services and home health aide services but must be predominantly nursing care. It can be provided only during a period of **acute medical** *crisis* or the sudden loss of a caregiver who was providing skilled nursing care, and only as necessary to maintain the client at home. (HCA does not reimburse for continuous home care provided to a client in a nursing facility, hospice care center or hospital.)

Counseling – Services for the purpose of helping a client and those caring for them to adjust to the individual's approaching death. Other counseling (including dietary counseling) may be provided for the purpose of educating or training the client's family members or other caregivers on issues related to the care and needs of the client.

Developmental Disabilities Community Services (DDCS) - The division within the Home and Community Living Administration under the Washington state Department of Social and Health Services (DSHS) that assists children and adults with developmental delays or disabilities, cognitive impairment, chronic illness, and related functional disabilities.

DSHS – Department of Social and Health Services.

Election statement – A written document provided by the hospice agency that is signed by the client to initiate hospice services.

General inpatient (GIP) hospice care - Acute care that includes services administered to the client for acute pain and/or symptom management that cannot be done in other settings. In addition:

- The services must conform to the client's written plan of care (POC).
- This benefit is limited to brief periods of care delivered in HCA -approved:
  - Hospitals.
  - Nursing facilities.
  - Hospice care centers.

Home - See Residence.

Home and Community Living Administration (HCLA) - The administration within the Department of Social and Health Services (DSHS) that provides services for adults needing long-term services and supports.

Home health aide – A person registered or certified as a nursing assistant under chapter 18.88 RCW who, under the direction and supervision of a registered nurse or licensed therapist, assists in the delivery of nursing or therapy related activities, or both. (WAC 182-551-2010)

Home health aide services – Services provided by a home health aide only when a client has an acute, intermittent, short-term need for the services of a registered nurse, physical therapist, occupational therapist, or speech therapist who is employed by or under contract with a home health agency. These services are provided under the supervision of the previously identified authorized practitioners and include, but are not limited to:

- Ambulation and exercise
- Assistance with self-administered medications
- Reporting changes in a client's condition and needs
- Completing appropriate records

Homemaker – A person who provides assistance in personal care, maintenance of a safe and healthy environment, and services to enable a client's plan of care to be carried out.

> **Note**: For the purposes of this billing guide, requirements for hospice agencies also apply to hospice care centers.

Home and Community-Based Long-Term Services and Supports Program (HCB LTSS) - A waiver or state plan program providing personal care services to eligible individuals in the community. Examples include Community First Choice (CFC), Roads to Community Living (RCL), Medicaid Personal Care (MPC), New Freedom (NF), Residential Support Waiver, and DDCS Waiver.

Hospice daily rate - The dollar amount HCA will reimburse for each day of care.

Inpatient respite care - See **Respite Care**.

Intermittent – Stopping and starting again at intervals; pausing from time to time; periodic.

Life-limiting condition - A medical condition in children that most often results in death before adulthood.

Participation - The money a client owes before eligibility for Medicaid services.

Pediatric Palliative Care (PPC) - Palliative care for a child with a life-limiting condition.

Referring provider – A client's primary or general practitioner, or a physician or nurse practitioner who has consulted with the client's primary or general practitioner.

Respite care – Short-term, inpatient care provided only on an intermittent, non-routine, and occasional basis and not provided consecutively for periods of longer than six days in a 30-day period.

Routine home care – Intermittent care received by the client at the client's place of residence, with no restriction on length or frequency of visits, dependent on the client's needs.

About the Hospice Program

What is the hospice program?

HCA's hospice program is a 24-hour a day program that allows a terminally ill client to choose physical, pastoral, spiritual, and psychosocial comfort care and focus on quality of life. A hospice interdisciplinary team communicates with the client's non-hospice care providers to ensure the client's needs are met through the hospice plan of care (POC). Hospitalization is used only for acute symptom management.

A client, physician, or an authorized health care representative may initiate hospice care. The client's physician must provide certification that the client is terminally ill and certify that the client has a life expectancy of six months or less and is appropriate for hospice care. Hospice care is provided in the client's temporary or permanent place of residence.

Hospice care ends when:

- The client or an authorized health care representative revokes the hospice care.
- The hospice agency discharges the client.
- The client's physician determines hospice care is no longer appropriate.
- The client dies.

Hospice care includes the provision of emotional and spiritual comfort and bereavement support to the client's family member(s).

How does a hospice agency become approved to provide Medicaid services?

To become a Medicaid-approved hospice agency, HCA requires a hospice agency to provide documentation that it is Medicare, Title XVIII-certified by the Department of Health (DOH) as a hospice agency and meet the requirements in:

- **Chapter 182-551 WAC Subchapter I**, Hospice Services.
- **Chapter 182-502 WAC**, Administration of Medical Programs-Providers.
- **Title XVIII** Medicare Program.

To ensure quality of care for clients, HCA's clinical staff may conduct a hospice agency site visit.

How does a hospice care center become an approved provider with Medicaid?

To become an approved hospice care center with Medicaid, a hospice agency must provide all the following documentation confirming that the agency is:

- Medicare-certified by DOH as a hospice care center.
- Approved by Centers for Medicare and Medicaid Services (CMS) in an approval letter.
- Providing one or more levels of hospice care such as:
  - Routine home care.
  - Inpatient respite care.
  - General inpatient care (requires a registered nurse on duty 24 hours a day, seven days a week).

A hospice agency qualifies as an approved hospice care center with Medicaid when:

- All the requirements are met.
- HCA provides the hospice agency with written notification.

For more information, see the **Billers, providers and partners webpage**.

How are hospice election statements used?

A client or a client's authorized health care representative must sign an election statement to initiate or reinstate an election period for hospice care. Hospice coverage is available for two 90-day election periods followed by an unlimited number of 60-day election periods.

An election to receive hospice care continues through the initial election period and subsequent election periods without a break in care as long as the client:

- Remains in the care of a hospice agency.
- Does not revoke the election (see **What happens when a client leaves hospice care without notice**?).

See **Pediatric Palliative Care**.

When are face-to-face encounters required?

The referring provider must have a face-to-face encounter with every hospice client:

- Within 30 days of the 180th day recertification.
- Before each subsequent recertification to determine if the client continues to meet eligibility for hospice care. (In other words, a physician or ARNP certifies that the client's life expectancy is six months or less, that the client's condition continues to decline, and that the client continues to meet criteria for hospice level of care.)

Note: HCA does not pay for face-to-face encounters to recertify a hospice client.

The referring provider must attest that the face-to-face encounter took place.

The hospice agency must:

- Document in the client's medical file that a verbal certification was obtained.
- Follow-up a documented verbal certification with a written certification signed by the medical director of the hospice agency, or physician staff member of the hospice agency.
- Place a written certification of the client's terminal illness in the client's medical file:
  - Within two calendar days following the beginning of a subsequent election period.
  - Before billing HCA for the hospice services.

Hospice agencies **must** submit a written certification to HCA with the hospice claim related to the recertification. The written notification can be added to the claim after the claim has been received by HCA.

For instructions on how to add attachments to claims, see the **ProviderOne Billing and Resource Guide**.

Hospice Provider Requirements

Are election statements required in the client's hospice medical record?

Yes. The election statement must be filed in the client's hospice medical record within 2 calendar days following the day the hospice care begins. An election statement requires all of the following:

- Name and address of the hospice agency that will provide the care
- Documentation that the client is fully informed and understands hospice care and waiver of other Medicaid or Medicare services, or both
- Effective date of the election
- Signature of the client or the client's authorized health care representative

What is the hospice certification process?

The hospice certification process is as follows:

When a client elects to receive hospice care, HCA requires a hospice agency to:

- Obtain a signed written certification of the client's terminal illness.

-OR-

- Document in the client's medical file that a verbal certification was obtained and follow up with a documented verbal certification and a written certification signed by:
  - The medical director of the hospice agency or a physician staff member of the interdisciplinary team.
  - The client's attending physician (if the client has one).
- Place the signed written certification of the client's terminal illness into the client's medical file:
  - Within 60 days following the day the hospice care begins.
  - Before billing HCA for the hospice services.

> **Note**: The hospice certification must specify that the client's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.

- For subsequent election periods, HCA requires the hospice agency to:
- Obtain a signed, written certification statement of the client's terminal illness.
- Document in the client's medical file that a verbal certification was obtained and follow up with a documented verbal certification and written certification

signed by the medical director of the hospice agency or a physician member of the hospice agency.

- Place the written certification of the client's terminal illness in the client's medical file:
  - Within two calendar days following the beginning of a subsequent election period.
  - Before billing HCA for the hospice services.

When a client's hospice coverage ends within an election period (e.g., the client revokes hospice care), the remainder of that election period is forfeited. The client may reinstate the hospice benefit at any time by providing an election statement and meeting the certification process requirements.

> **Note**: The hospice agency must notify HCA Hospice program of the start-of-care date within five business days of the first day of hospice services for all clients for whom Medicaid payment will be claimed. This includes clients with third-party or Medicare coverage or both.

What are HCA's requirements for the hospice plan of care (POC)?

Hospice agencies must establish a written POC for a client that describes the hospice care to be provided. The POC must be in accordance with the Department of Health (DOH) requirements, as described in WAC 246-335-640, and meet the requirements in this billing guide.

A registered nurse or physician must conduct an initial physical assessment of a client and develop the POC with at least one other member of the hospice interdisciplinary team.

At least two other hospice interdisciplinary team members must review the POC no later than two business days after it is developed.

The POC must be reviewed and updated every two weeks by at least three members of the hospice interdisciplinary team that includes all of the following:

- A registered nurse
- A social worker
- One other hospice interdisciplinary team member

What are the requirements for the coordination of care?

A hospice agency must facilitate a client's continuity of care with non-hospice providers to ensure that medically necessary care is met - both related and not related to the terminal illness.

> **Note**: When the client is in a nursing facility and has elected hospice, the hospice provider is responsible for reporting changes of the hospice status or a change in living arrangement to the HCS or the CSO financial worker.

This includes:

- Determining if HCA has approved a request for prescribed medical equipment, such as a wheelchair. If the prescribed item is not delivered to the client before the client becomes covered by a hospice agency, HCA will rescind the approval (see WAC 182-543-9000).

> **Example**: A nursing facility orders a wheelchair for one of its clients. The client chose and authorized hospice care services. The wheelchair arrives after the client has begun the first 90-day election period. The hospice agency may pay for the wheelchair or provide the medically necessary equipment. HCA reimburses the hospice agency for the medical equipment through the appropriate hospice daily rate as described in WAC 182-551-1510.

> **Note**: It may be appropriate to rent equipment in some cases.

- Communicating with other Medicaid programs and documenting the services a client is receiving in order to prevent duplication of payment and to ensure continuity of care. Other programs include, but are not limited to, programs administered by DSHS' **Home and Community Living Administration** (HCLA).
- Documenting each contact with non-hospice providers.

> **Note**: Both the POC and service plan must show the specific duties and services each will provide to prevent duplication of services.

When a client resides in a nursing facility, the hospice agency must do the following:

- Coordinate the client's care with all providers, including pharmacies and medical vendors
- Coordinate the client's care with all providers, including pharmacies, other medical vendors, and any nursing facility that is providing room and board
- Provide the same level of hospice care the hospice agency provides to a client residing at home

Once a client chooses hospice care, hospice agency staff must notify and inform the client of the following:

- By choosing hospice care from a hospice agency, the client gives up the right to the following:
  - Covered Medicaid hospice services (e.g., adult day health) and supplies received at the same time from another hospice agency
  - Any covered Medicaid services and supplies received from any other provider as necessary for the palliation and management of the terminal illness and related medical conditions
- Services and supplies are not paid through the hospice daily rate if they are any of the following:
  - Proven to be clinically unrelated to the palliation and management of the client's terminal illness and related medical conditions
  - Not covered by the hospice daily rate
  - Provided under a **Title XIX Medicaid** program when the services are similar to the hospice care services
  - Not necessary for the palliation and management of the client's terminal illness and related medical conditions

A hospice agency must have written agreements with all contracted providers.

What happens when a client leaves hospice care without notice?

When a client chooses to leave hospice care or the client's authorized health care representative removes the client from hospice care and refuses hospice care without giving the hospice agency a revocation statement as required by **WAC 182-551-1360**, the hospice agency must do all of the following:

- Inform and notify in writing HCA's Hospice program within five business days of becoming aware of the client's or the authorized health care representative's decision
- Not bill HCA for the client's last day of hospice services
- Fax a completed copy of HCA's HCA/Medicaid Hospice Notification form, HCA 13-746, to HCA, hospice/PPC notification number at 360-725-1965 to notify that the client is discharged from the hospice program, see **Where can I download HCA forms**?
- Notify the client or the client's authorized health care representative that the client's discharge has been reported to HCA
- Document the effective date and details of the discharge in the client's hospice record

May a hospice agency discharge a client from hospice care?

A **hospice agency** may discharge a client from hospice care when the client is any of the following:

- No longer certified (decertified) for hospice care
- No longer appropriate for hospice care (see **About the Hospice Program**)
- Seeking treatment for the terminal illness outside the POC

At the time of a client's discharge, the hospice agency must do all of the following:

- Inform and notify in writing HCA's Hospice program within five business days of the reason for discharge
- Fax a completed copy of HCA's HCA/Medicaid Hospice Notification form, HCA 13-746, to HCA hospice/PPC notification number at 360-725-1965, See **Where can I download HCA forms**?
- Keep the discharge statement in the client's hospice record
- Provide the client with a copy of the discharge statement

May a client choose to end (revoke) hospice care?

A client or authorized health care representative may decide to stop hospice care at any time by signing a **revocation** statement.

The revocation statement documents the client's choice to stop Medicaid hospice care. The revocation statement must include all the following:

- The client's (or authorized health care representative's) signature
- The date the revocation was signed
- The actual date that the client decided to stop receiving hospice care

The hospice agency must keep an explanation supporting any difference in the signature and revocation dates in the client's hospice records.

When a client revokes hospice care, the hospice agency must do all the following:

- Inform and notify HCA's hospice program within five business days of becoming aware of the client's decision.
- Fax a completed copy of HCA's HCA/Medicaid Hospice Notification form, HCA 13-746, to HCA hospice/PPC notification number at 360-725-1965. See **Where can I download HCA forms**?
- Do not bill HCA for the client's last day of hospice services.
- Keep the revocation statement in the client's hospice record.
- Provide the client with a copy of the revocation statement as described in **WAC 182-551-1360**.

After a client revokes hospice care, the remaining days within the current election period are forfeited. The client may immediately enter the next consecutive election period. The client does not have to wait for the forfeited days to pass before entering the next consecutive election period.

What happens when the client dies?

When a client dies, the hospice agency must do the following:

- Inform and notify in writing HCA's Hospice program within five business days.
- Fax a completed copy of HCA's HCA/Medicaid Hospice Notification form, HCA 13-746, that documents the date of death to HCA hospice/PPC notification number at 360-725-1965. See **Where can I download HCA forms?**

What are the notification requirements for hospice agencies?

To ensure a hospice client receives quality of care, and to ensure HCA determines accurate coverage and reimbursement for services that are related to the client's terminal illness or related conditions, a hospice agency must meet certain notification requirements.

To be reimbursed for providing hospice services, the hospice agency must complete HCA/Medicaid Hospice Notification form, HCA 13-746, and forward the form to HCA's hospice program within five business days from when an HCA client begins the first day of hospice care or has a change in hospice status. Case managers must determine if clients will need Medicaid eligibility when electing hospice. If a person electing hospice applies for Medicaid, the HCA/Medicaid Hospice Notification form, HCA 13-746 must be submitted to determine the correct program.

The hospice agency must notify HCA's hospice program of all of the following:

- The name and address of the hospice agency
- The date of a client's first day of hospice care
- A change in a client's primary physician
- A client's revocation of the hospice benefit (home or institutional)
- The date a client leaves hospice without notice
- A client's discharge from hospice care
- A client's admittance to a nursing facility. (This does not apply to a client admitted for inpatient respite care or general inpatient care.)
- A client's admittance to or discharge from a nursing facility/hospice care center, except for General Inpatient (GIP) hospice care or respite

- A client who is eligible for or becomes eligible for Medicare or third-party liability insurance
- A client who dies

> **Note**: When a hospice agency does not notify HCA within five business days of the date of the client's first day of hospice care, HCA authorizes the hospice daily rate or nursing facility room and board reimbursement effective the fifth business day prior to the date of notification.

What are the notification requirements when a client transfers to another hospice agency?

Both the former hospice agency and the current hospice agency must provide HCA with all of the following:

- The client's name, the name of the former hospice agency serving the client, and the effective date of the client's discharge
- The name of the current hospice agency serving the client, the hospice agency's provider number, and the effective date of the client's admission

HCA does not require a hospice agency to notify HCA's Hospice program when a hospice client is admitted to a hospital for palliative care.

> **Note**: Failure to notify HCA properly of a client's discharge or revocation from hospice care could result in denial of payment for services provided by the hospice agency.
>
> **For example**: The client revokes hospice care. The hospice agency fails to notify HCA's Hospice program within five business days. The client or the client's family attempt to get a prescription filled at the pharmacy. The pharmacist does not fill the prescription because the client is on hospice. The client or family is then forced to go without, or pay for the prescription.

Should HCA be notified if Medicaid is not primary?

Yes, for clients who reside in a nursing facility or may be admitting to a nursing facility and who have not yet applied for claims for Medicaid payment.

Notify HCA's hospice program when there is a change in the client's hospice **election status**. If you need clarification or have questions, call HCA hospice program (see Resources Available).

Medicaid clients with third-party liability

If a client has third-party liability (excluding Medicare) that covers nursing services only, with no allowance for room and board, PA is not required before

providing services. Providers must separate services on to two different claims and include an explanation of benefit (EOB) for each claim: nursing services on one claim, room and board on another.

Is it required that clients be notified of their rights (Advance Directives)?

42 CFR, Subpart I

Yes. All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment.
- Make decisions concerning their own medical care.
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

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Hospice Client Eligibility

Who is eligible?

In order to elect to receive hospice care through HCA's hospice program, a client must have the physician's hospice certification and meet all of the following:

- Be eligible for one of the following Washington Apple Health programs with hospice as a covered benefit :
  - Alternative Benefits Plan (ABP)
  - Categorically needy (CN)
  - Medically needy (MN)
  - Alien emergency medical (AEM) (Cancer treatment and kidney disease programs only)
- The client's physician certifies the client has a life expectancy of six months or less, which is supported by medical records, including documentation that the client's condition is declining.
- The client or an authorized health care representative on the client's behalf elects to receive hospice care and agrees to the conditions of the **election statement** as described in **How are hospice election statements used**? and the **What is the hospice certification process**?
- The hospice agency must:
  - Meet the hospice agency requirements listed in **What are the notification requirements for hospice agencies**?
  - Notify HCA within five business days of the admission of all clients, including:
    - Medicaid-only clients.
    - Medicaid-Medicare dual eligible clients.
    - Medicaid clients with third-party insurance.
    - Medicaid-Medicare dual eligible clients with third-party insurance.
    - Alien Emergency Medical (AEM) clients currently enrolled in another program.

> **Note:** The hospice agency is responsible for verifying eligibility directly with the person or the person's Department of Social and Health Services (DSHS) Home and Community Services Office or Community Services Office.

- The hospice agency provides additional information for a diagnosis when HCA requests and determines, on a case-by-case basis, the information that is needed for further review.

- AEM clients that are currently enrolled in the cancer treatment or dialysis programs may receive hospice care. PA is required prior to admission.

Note: See the Program benefit packages and scope of service categories webpage for a list of benefit packages.

Note: For a description of a client's MAGI Family-Related MA program codes see Appendix E of the ProviderOne Billing and Resource Guide.

Access to hospice care

Hospice care is included in the benefit package for all clients who receive active coverage under one of the following programs:

- Alternative Benefits Plan (ABP)
- Categorically needy (CN)
- Medically needy (MN)

Clients under the Alien Emergency Medical program (ERSO) may be eligible for hospice care with prior authorization (PA).

A client who is not eligible for Apple Health coverage may qualify for coverage under a special hospice program once the Department of Social and Health Services (DSHS) is aware the client has elected hospice. DSHS must have a copy of the election notice on file with the Medicaid application to determine eligibility under this program.

A client who needs Apple Health coverage to pay for nursing facility room and board expenses (not covered by Medicare) must submit an Apple Health application to DSHS in order to get coverage for this benefit.

The hospice agency is responsible for verifying a client's eligibility with the client, the client's HCS office or CSO, or through ProviderOne as described in How do I verify a client's eligibility?

The hospice agency is responsible to assist the client with an application for Apple Health and coordinate benefits with nursing facilities and DSHS LTSS programs to ensure there is no duplication of payment.

How do I verify a client's eligibility?

Most Apple Health clients are enrolled in an HCA-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See HCA's Apple Health managed care page for further details.

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service HCA will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Apple Health**. For detailed instructions on verifying a patient's eligibility for Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in HCA's ProviderOne Billing and Resource Guide.

If the patient is eligible for Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the note box below.

Step 2. **Verify service coverage under the Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

Note: Patients who are not Apple Health clients may apply for health care coverage in one of the following ways:

- **Online**: Go to Washington Healthplanfinder - select the "Let's get started" button. For patients age 65 and older, or on Medicare, go to Washington Connections – select the "Apply Now" button.
- **Mobile app:** Download the **WAPlanfinder app** – select "sign in" or "create an account".
- **Phone**: Call the Washington Healthplanfinder Customer Support Center at 1-855-923-4633 or 855-627-9604 (TTY).
- **Paper**: By completing an *Application for Health Care Coverage (HCA 18-001P)* form. To download an HCA form, see HCA's Free or Low Cost Health Care, Forms & Publications webpage. Type only the form number into the Search box (Example: **18-001P**). For patients age 65 and older, or on Medicare, complete the *Washington Apple Health Application for Age, Blind, Disabled/Long-Term Services and Supports (HCA 18-005)* form.

- **In-person**: Local resources who, at no additional cost, can help you apply for health coverage. See the **Health Benefit Exchange Navigator.**

How should the hospice agency confirm the client's pending medical eligibility?

The ProviderOne system does not show information about clients whose eligibility is pending. To confirm if a client has applied for Apple Health, call the client's Home and Community Services (HCS) office or Community Services Office (CSO).

- The following are examples of questions the hospice agency may ask when confirming pending medical eligibility:
  - Has the application been received by the CSO/HCS office?
  - Does the CSO or HCS office need additional information before benefits can be approved or denied?
  - Has the application been processed? Is the client subject to a spenddown? (See HCA's **ProviderOne Billing and Resource Guide** for instructions on how to verify a client's eligibility.)

Note: The HCA/Medicaid Hospice Notification form, HCA 13-746 must be submitted within 5 business days of a client electing hospice services, regardless of a pending application. Case managers must determine if clients will need Medicaid eligibility when electing hospice. If a person electing hospice applies for Medicaid, the HCA/ Medicaid Hospice Notification form, HCA 13-746 must be submitted to determine the correct program. This helps prevent inappropriate denials and avoids duplication of services by the hospice agency and HCS.

Use one of the eligibility determination methods outlined in the **ProviderOne Billing and Resource Guide** to check on the client's medical eligibility.

Ask to receive confirmation of the client's eligibility status at the time the application is approved. If the client is **not** approved for a program which covers hospice services, ask for the case to be reviewed or considered for a different program.

Once the hospice agency receives confirmation of a client's eligibility, the hospice agency must resubmit HCA's *HCA/Medicaid Hospice Notification* form, HCA 13-746, by fax to: 360-725-1965.

Washington State Health Care Authority

What if your patient has not applied for Apple Health?

Patients who have not yet applied for Apple Health may do so in one of the following ways:

Client demographic	Application form number	Online applications	Phone contact	Fax number:
Parents, pregnant people, children under age 19 and adults under age 65 without Medicare	HCA 18-001*	Washington Apple Health Plan Finder In-person application assistance is also available. To get information about where to get help in your area, visit the Washington Apple Health Plan Finder website or call HCA's Customer Service Center for free at 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)	Call 1-855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)	N/A
Age 65+ Blind Disabled has medicare, who DOES need LTSS**	HCA 18-005* Mail to: DSHS Home & Community Services PO Box 45826 Olympia, WA 98504-5826	Washington Connection To locate a local HCS office, visit the DSHS HCLA resource webpage.	Contact your local HCS office	1-855-635-8305
Age 65+ Blind, disabled, medicare, who DOES NOT need LTSS**	HCA 18-005* Mail to: DSHS Community Services Division – Customer Service Center PO Box 11699 Tacoma, WA 98411-6699	Washington Connection To locate a local Community Services Office, visit the DSHS Find a Community Services Office webpage	Call 1-877-501-2233	1-888-338-7410

* These forms are available on HCA's Electing hospice services – DSHS agency and client webpage.

** Nursing facility care, in-home personal care, assisted living facility and adult family home programs

Are clients enrolled in an HCA-contracted managed care organization (MCO) eligible?

Yes. Most Apple Health clients are enrolled in one of HCA's contracted managed care organizations (MCOs). For these clients, managed care enrollment will be displayed on the client benefit inquiry screen in ProviderOne.

A client enrolled in one of HCA's contracted MCOs must receive all hospice services, including nursing facility room and board, directly through that MCO. The client's MCO is responsible for arranging and providing for all hospice services. Clients can contact their MCO by calling the telephone number provided on the client's Services Card. The MCO is responsible for payment of a client's approved hospice care until the client is discharged, as long as the client remains eligible for Apple Health.

A hospice agency must notify HCA within five business days when a client elects to receive hospice services. Fax a completed HCA/Medicaid Hospice Notification form, HCA 13-746, to 360-725-1965. See Where can I download HCA forms? **The hospice agency must comply with the managed care plan's policies and procedures to obtain authorization.**

> **Note**: A client's enrollment can change monthly. Providers who are not contracted with the MCO must receive approval from **both** the MCO and the client's primary care provider (PCP) prior to serving a managed care client.

Managed care enrollment

Most Apple Health clients are enrolled in an HCA-contracted MCO the same month they are determined eligible for managed care as a new or renewing client. Some clients may start their first month of eligibility in the FFS program because their qualification for MC enrollment is not established until the month following their Apple Health eligibility determination. **Exception:** Apple Health Expansion clients are enrolled in managed care and will not start their first month of eligibility in the FFS program. For more information, visit Apple Health Expansion. Providers must check eligibility to determine enrollment for the month of service.

New clients are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health managed care. Renewing clients are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Checking eligibility

Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to HCA's **Apply for or renew coverage webpage.**

Clients' options to change plans

Clients have a variety of options to change their plan:

- **Available to clients with a Washington Healthplanfinder account**:

  Go to Washington Healthplanfinder website.

- **Available to all Apple Health clients:**
  - Visit the ProviderOne Client Portal website:
  - Request a change online at ProviderOne Contact Us (this will generate an email to Apple Health Customer Service). Select the topic "Enroll/Change Health Plans."
  - Call Apple Health Customer Service at 1-800-562-3022. The automated system is available 24/7.

For online information, direct clients to HCA's Apple Health Managed Care webpage.

Clients who are not enrolled in an HCA-contracted managed care plan for physical health services

Some Apple Health clients do not meet the qualifications for managed care enrollment or have the option to enroll in fee-for-service. These clients are eligible for services under the fee-for-service program.

In this situation, each managed care organization (MCO) will have a Behavioral Health Services Only (BHSO) benefit available for Apple Health clients who are not in integrated managed care. The BHSO covers only behavioral health treatment for those clients. Eligible clients who are not enrolled in an integrated HCA-contracted managed care plan are automatically enrolled in a BHSO except for American Indian/Alaska Native clients. If the client receives Medicaid-covered services before being automatically enrolled in a BHSO, the fee-for-service program will reimburse providers for the covered services. Examples of populations that may be exempt from enrolling into a managed care plan are Medicare dual-eligible, American Indian/Alaska Native, Adoption Support and Foster Care Alumni.

Integrated managed care

Clients qualified for enrollment in an integrated managed care plan receive all physical health services, mental health services, and substance use disorder treatment through their HCA-contracted managed care organization (MCO).

Integrated Apple Health Foster Care (AHFC)

Children and young adults in the Foster Care, Adoption Support and Alumni programs who are enrolled in Coordinated Care's (CC) Apple Health Core Connections Foster Care program receive both medical and behavioral health services from CC.

Clients under this program are:

- Age 17 and younger who are in foster care (out of home placement)
- Age 20 and younger who are receiving adoption support
- Age 18-21 years old in extended foster care
- Age 18 to 26 years old who aged out of foster care on or after their 18th birthday (alumni)

These clients are identified in ProviderOne as "**Coordinated Care Healthy Options Foster Care**."

The Apple Health Customer Services team can answer general questions about this program. For specific questions about Adoption Support, Foster Care or Alumni clients, contact HCA's Foster Care and Adoption Support (FCAS) team at 1-800-562-3022, Ext. 15480.

Fee-for-service Apple Health Foster Care

Children and young adults in the fee-for-service Apple Health Foster Care, Adoption Support and Alumni programs receive behavioral health services through the regional Behavioral Health Services Organization (BHSO). For details, see HCA's Mental Health Services Billing Guide, under *How do providers identify the correct payer*?

American Indian/Alaska Native (AI/AN) Clients

American Indian/Alaska Native (AI/AN) clients have two options for Apple Health coverage:

- Apple Health Managed Care
- Apple Health coverage without a managed care plan (also referred to as fee-for-service [FFS])

If an AI/AN client does not choose a managed care plan, they will be automatically enrolled into Apple Health FFS for all their health care services, including comprehensive behavioral health services. See the Health Care Authority's (HCA) American Indian/Alaska Native webpage.

Are clients who are eligible for Medicare part A eligible for the hospice Medicaid daily rate?

No. A client who is also eligible for hospice under Medicare part A is not eligible for the hospice Medicaid daily rate through HCA's hospice program. HCA pays hospice nursing facility room and board if the client is admitted to a nursing facility or a hospice care center and is not receiving general inpatient care or inpatient respite care. (Also, see WAC 182-551-1530.)

Washington State Health Care Authority

Hospice Coverage

What is included in the hospice daily rate?

HCA reimburses a hospice agency for providing covered services through HCA's hospice daily rate. The hospice daily rate includes core services and supplies. These are subject to the conditions and limitations described in this billing guide.

For reimbursement of covered services, including core services and supplies that are included in the hospice daily rate, the service must be:

- Related to the client's hospice diagnosis.
- Identified by a client's hospice interdisciplinary team.
- Written in the client's plan of care (POC).
- Safe and meet the client's needs within the limits of the Hospice program.
- Available to the client by the hospice agency on a 24-hour basis.

> **Note**: Services are intermittent except during brief periods of acute symptom control. The client/family has 24-hour access to a registered nurse (RN)/physician.

The hospice daily rate includes the following core services that must either be:

- Provided by hospice agency staff

-OR-

- Contracted through a hospice agency, if necessary, to supplement hospice staff in order to meet the needs of a client during a period of peak patient loads or under extraordinary circumstances including:
  - Physician services related to administration of the POC.
  - Nursing care provided by:
    - A registered nurse (RN).
    - A licensed practical nurse (LPN) under the supervision of an RN.
  - Medical social services provided by a social worker under the direction of a physician.
  - Counseling services provided to a client and the client's family members or caregivers.

Covered services and supplies must be provided by a service organization or an individual provider when contracted through a hospice agency. To be reimbursed the hospice daily rate, a hospice agency must:

- Ensure all contracted staff meets the regulatory qualification requirements.
- Have a written agreement with the service organization or individual provider providing the services and supplies.
- Maintain professional, financial, and administrative responsibility.

> **Note**: Personal care is not a core service. A home health aide from a hospice agency that is needed under the client's plan of care (POC) is different than personal care from a caregiver. Record in the client's record what services the hospice agency is providing and what Long-Term Services and Supports (LTSS) or personal care services are being provided by others. Document the frequency and services of both to show non-duplication.

Subject to the limitations described in this guide, the following covered services and supplies, as described in **Hospice Reimbursement**, are included in the appropriate hospice daily rate:

- **A brief period of inpatient care**, for general or respite care provided in a Medicare-certified hospice care center, hospital, or nursing facility
- **Adult day health**
- **Communication** with non-hospice providers about care not related to the client's terminal illness to ensure the client's POC needs are met and not compromised
- **Coordination of care**, including coordination of medically necessary care not related to the client's terminal illness
- **Drugs, biologicals, and over-the-counter medications** used for the relief of pain and symptom control of a client's terminal illness and related conditions

> **Note**: The provider of the drugs and biologicals bills HCA separately for enteral/parenteral supplies only when there is a pre-existing diagnosis requiring enteral/parenteral support. This pre-existing diagnosis **must not** be related to the diagnosis that qualifies the client for hospice.

- **Hospice aide services** that are ordered by a client's physician and documented in the POC. (Hospice aide services are provided through the hospice agency to meet a client's extensive need due to the client's terminal illness.) These services must be provided by a qualified home health aide and are an extension of skilled nursing or therapy services. (See **42 CFR § 484.36**)
- **Interpreter services** as necessary for the POC

- **Durable medical equipment and related supplies, prosthetics, orthotics, medical supplies, related services, or related repairs and labor charges** that are medically necessary for the palliation and management of a client's terminal illness and related conditions
- **Medical transportation services, including ambulance** as required by POC related to the terminal illness (see WAC 182-546-5550)
- **Physical therapy, occupational therapy, and speech-language therapy** to manage symptoms or enable the client to safely perform activities of daily living (ADLs) and basic functional skills
- **Skilled nursing care**
- **Other services or supplies** that are documented as necessary for the palliation and management of the client's terminal illness and related conditions

The hospice agency is responsible for determining if a nursing facility has requested authorization for medical supplies or medical equipment, including wheelchairs, for a client who becomes eligible for the Hospice program. HCA does not pay separately for medical equipment or supplies that were previously authorized by HCA and delivered on or after the date HCA enrolls the client in hospice.

> **Note**: If the covered services listed above are not documented in the POC but are considered necessary by medical review for palliative care and are related to the hospice diagnosis, the hospice agency is responsible for payment.

What is not included in the hospice daily rate?

The following services are not included in the hospice daily rate:

- Dental care
- Eyeglasses
- Hearing aids
- Podiatry
- Chiropractic services
- Ambulance transportation, if not related to client's terminal illness
- Brokered transportation, if not related to the client's terminal illness
- Home and Community Based Long-Term Services and Supports (HCB LTSS) or Title XIX Personal Care Services

  For clients who have been assessed and approved for HCB LTSS by the local Home and Community Living Administration (HCLA) field office, payment for those services is made to authorized providers using HCLA program funding.

  For clients who have been assessed and approved for HCB LTSS by the local

Developmental Disabilities Community Services (DDCS) field office, payment for those services is made to authorized providers, using DDCS program funding.

- Any services **not** related to the terminal condition

If the above service(s) are covered under the client's Medicaid program, the provider of service must follow specific program criteria and bill HCA separately using the applicable fee schedule and billing guide.

Early periodic screening, diagnosis, and treatment (EPSDT) includes all services that are medically necessary to address health conditions for clients age 20 and younger. Providers may reference program-specific billing guides for services and equipment not covered by this billing guide and must follow the rules for the EPSDT program described in chapter 182-534 WAC. Published limits for services covered under EPSDT, if any, may be exceeded based on agency review of medical necessity described in WAC 182-501-0165.

Washington State Health Care Authority

General Authorization

Authorization is HCA's approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Prior Authorization (PA) and limitation extensions (LE) are forms of authorization**.

What is prior authorization (PA)?

Prior authorization (PA) is HCA or its designee's approval for certain medical services, equipment, or supplies, before the services are provided to clients. When PA is applicable, it is a precondition for provider reimbursement.

What is a limitation extension (LE)?

HCA limits the amount, frequency, or duration of certain services and reimburses up to the stated limit without requiring PA. HCA requires a provider to request PA for a limitation extension (LE) to exceed the stated limits.

See How do I obtain authorization?

HCA evaluates requests for LE under the provisions of WAC 182-501-0169.

How do I obtain authorization?

For PA or LE, providers may submit PA requests online through direct data entry into ProviderOne. See HCA's prior authorization webpage for details. Providers may also fax requests to 866-668-1214 along with the following:

- A completed, typed *General Information for Authorization* form, HCA 13-835. This request form must be the initial page when you submit your request.
- A completed *Hospice (including PPC) Authorization Request* form, HCA 13-848, and all the documentation listed on this form and any other medical justification.

See Where can I download HCA forms?

For more information on requesting authorization, see HCA's ProviderOne Billing and Resource Guide.

How do I request prior authorization (PA) for a noncovered service?

Providers may request PA for HCA to pay for a noncovered medical service or related equipment. This is called an exception to rule (ETR). HCA cannot approve an ETR if the exception violates state or federal law or federal regulation.

> **Note**: Authorization does not guarantee payment. HCA's authorization process applies only to medically necessary covered health care services and is subject to client eligibility and program limitations. Not all categories of eligibility receive all health care services. Example: Therapies are not covered under the Family Planning Only Program. All covered health care services are subject to retrospective utilization review to determine if the services provided were medically necessary and at the appropriate level of care. Requests for non-covered services are reviewed under the exception to rule policy. See WAC 182-501-0160.

For HCA to consider the request, ETR sufficient client-specific information, and documentation must be submitted to HCA to determine if:

- The client's clinical condition is so different from the majority that there is no equally effective, less costly covered service or equipment that meets the client's need(s).
- The requested service or equipment will result in lower overall costs of care for the client.

> **Note**: For more details, see Resources Available.

HCA evaluates and considers ETR requests on a case-by-case basis according to the information and documentation submitted by the provider. Within 15 business days of HCA's receipt of the request, HCA notifies the provider and the client, in writing, of HCA's decision to grant or deny the ETR.

> **Note**: Clients do not have a right to an administrative hearing on ETR decisions.

Do children who are hospice care clients have access to concurrent life prolonging and curative services?

Yes. In response to the Patient Protection and Affordable Care Act, clients age 20 and younger who are on hospice services also have access to curative services.

> **Note**: The legal authority for these clients' hospice **palliative** services is in Section 2302 of the Patient Protection and Affordable Care Act of 2010 and Section 1814(a)(7) of the Social Security Act; and for a client's **curative** services is Title XIX Medicaid and Title XXI Children's Health Insurance Program (CHIP) for treatment of the terminal condition.

Concurrent care treatment – life prolonging/curative treatment

Unless otherwise specified within this billing guide, concurrent - life prolonging/curative treatment, related services, or related medications requested for clients age 20 and younger are subject to HCA's specific program rules governing those services or medications.

A client age 20 and younger may voluntarily elect hospice care without waiving any rights to services that the client is entitled to under Title XIX Medicaid and Title XXI Children's Health Insurance Program (CHIP) that are related to the treatment of the client's condition for which a diagnosis of terminal illness has been made.

EPA #	Criteria
870001409	**Children 20 years old or younger** - enrolled in hospice with or without concurrent care treatment. Hospice agencies will remain and are responsible for symptom control related to the child's terminal illness. See WAC 182-551-1210 to see what is included in the hospice daily rate.

Note: If billing with EPA 870001409, the Hospice Indicator will not be listed on the client's file in ProviderOne.

Note: If a noncovered service is recommended based on the early and periodic screening, diagnosis, and treatment (EPSDT) program, HCA evaluates the request for medical necessity based on the definition in WAC 182-500-0070 and the process in WAC 182-501-0165.

If HCA denies a request for a covered service, refer to WAC 182-502-0160 that specifies when a provider or a client may be responsible to pay for a covered service.

Services that are the hospice agency's responsibility

The following services are to be provided by the hospice agency in accordance with current guidelines, while the client is receiving concurrent care:

- Hospice covered services as described in WAC 182-551-1210
- Services rendered for symptom management, including but not limited to:
  - Medications (e.g., pain management, nausea, vomiting, anxiety)
  - Equipment and related supplies

- Ancillary services, such as medical transportation (e.g., provider appointment, laboratory and other testing)

Hospice Coverage Table

What places of service are allowable?

The following is a chart explaining where hospice care may be performed:

Place of Service/Client Residence

Type of Service/Levels of Care	Client's Home (AFH, BH, AL)	Nursing Facility (NF)	Hospital	Hospice Care Center (HCC)
Level 1: Routine Home Care (RHC) (0651)	Yes Not in combination w/ any other code	Yes Not in combination w/ any other level of care	No	Yes Not in combination w/ any other level of care
Level 2: Continuous Home Care (CHC) (0652) Hourly nursing	Yes Not in combination w/ any other code	No	No	No
Level 3: Inpatient Respite (0655) Includes R/B	No	Yes For clients not residing in NF Not in combination w/ any other code	Yes Not in combination w/any other code	Yes For clients not residing in HCC Not in combination w/ any other code
Level 4: General Inpatient Care (GIP) (0656) Includes R/B	No	Yes Not in combination w/ any other code	Yes Not in combination w/ any other code	Yes Not in combination w/ any other code
Nursing Facility (NF) R/B (0115, 0125, 0135)	No	Yes Not in combination w/ 0655 or 0656	No	No
Hospice Care Center (HCC) (0145) R/B Admin day rate	No	No	No	Yes Not in combination w/ 0656 or 0655
Pediatric Palliative Care (PPC) (0659)	Yes Not for clients in a group home	No	No	No

Which hospice revenue codes are allowable?

Enter the following revenue codes and **service descriptions** in the appropriate form locators.

Revenue Code	Description of Code	Billing Provider Taxonomy
0115*	Hospice (Room and Board - Private)	251G00000X
0125*	Hospice (Room and Board - Semi-Private 2 Bed)	251G00000X
0135*	Hospice (Room and Board - Semi-Private 3-4 Beds)	251G00000X
0145	Hospice Care Center (Hospice Deluxe Room and Board)	315D00000X
0651	Level 1: Routine Home Care (Hospice Daily Rate)	251G00000X
0652	Level 2: Continuous Home Care	251G00000X
0655	Level 3: Inpatient Respite Care	251G00000X
0656	Level 4: General Inpatient Care	251G00000X

*For Revenue Codes 0115, 0125, and 0135, see the Nursing facility rates and reports webpage.

Note: For limitations, see Billing.

Note: For hospice, choose one of four levels of care. Only nursing facility or hospice care center room and board can be billed with level 1. Do not bill other codes with levels 2, 3, or 4. Do not bill any other code with 659.

Which pediatric palliative care (PPC) revenue codes are allowable?

Revenue Code	Description of Code
0659	**Other Hospice Services** (Pediatric Palliative Care (PPC) Case Management/Coordination will be reimbursed according to the fee schedule) See below for examples of use.
0659	PPC – RN (registered nurse)
0659	PPC – PT (physical therapy)
0659	PPC – OT (occupational therapy)
0659	PPC – ST (speech therapy)
0659	PPC – Case Management Time (Bill the date of service where each "two-hour time requirement" is met)

Which hospice services may be provided in the client's home?

Revenue Codes
0651, 0652, and 0659 are paid according to the client's place of residence. Non-CBSA* and out-of-state areas are paid as outlined **in All Other Areas.**

Counties	County Code
All Other Areas	50
Asotin	30300
Benton	28420
Chelan	48300
Clark	38900
Cowlitz	31020
Douglas	48300
Franklin	28420
King	42644
Kitsap	14740
Pierce	45104
Skagit	34580
Skamania	38900
Snohomish	42644
Spokane	44060
Thurston	36500
Whatcom	13380
Yakima	49420

* CBSA = Core Based Statistical Area

Which hospice services may be provided outside the client's home?

Revenue Codes
0655 and 0656 are paid according to the provider's place of business. Non-CBSA* and out-of-state areas are paid as outlined **in All Other Areas.**

Counties	County Code
All Other Areas	50
Asotin	30300
Benton	28420
Chelan	48300
Clark	38900
Cowlitz	31020
Douglas	48300
Franklin	28420
King	42644
Kitsap	14740
Pierce	45104
Skagit	34580
Skamania	38900
Snohomish	42644
Spokane	44060
Thurston	36500
Whatcom	13380
Yakima	49420

* CBSA = Core Based Statistical Area

Note: See **Hospice Reimbursement** for nursing facility and information about hospice care center reimbursement.

Hospice Reimbursement

How does HCA determine what rate to pay?

Note: Prior to submitting a claim to HCA, a hospice agency must file written certification in a client's hospice record. (See Are election statements required in the client's hospice medical record? and What is the hospice certification process?)

HCA pays for hospice care provided to clients in one of the following settings:

- A client's residence
- An HCA-approved nursing facility, hospital, or hospice care center

To be paid by HCA, the hospice agency must provide and/or coordinate HCA-covered hospice services including:

- Medicaid hospice services.
- Services that relate to the client's terminal illness any time during the hospice election.

Hospice agencies must bill HCA for their services using hospice-specific revenue codes (see What places of service are allowable?).

HCA pays hospice agencies for services (not room or board or both) at a daily rate calculated by one of the following methods:

- Payments for services delivered in a client's residence (routine and continuous home care) are based on the county location of the client's residence for that particular client.
- Payments for respite and general inpatient hospice care are based on the county location of the providing hospice agency.

HCA reduces hospice payments by two percent for providers who did not comply with the annual Medicare Hospice Quality Reporting Program.

- The payment reduction is effective for the fiscal reporting year in which the provider failed to submit data required for the annual Medicare Hospice Quality Reporting Program.
- The payment reduction applies to routine home care, including the service intensity add-on, continuous home care, inpatient respite care, and general inpatient care.
- The payment reduction does not apply to pediatric palliative care, the hospice care center daily rate, or the nursing facility room and board rate.

Note: The daily rate for authorized out-of-state hospice services is the same as that for in-state non-Metropolitan Statistical Area (MSA) hospice services.

How does HCA pay for the client's last day of hospice care?

See WAC 182-551-1510

What types of care does HCA pay for?

HCA pays for routine hospice care, continuous home care, respite care, or general inpatient care for the day of death.

What types of care does HCA not pay for?

- Room and board for the day of death
- Hospice agencies for the client's last day of hospice care when a client discharges, revokes, or transfers
- Hospice agencies or hospice care centers a nursing facility room and board payment for:
  - A client's last day of hospice care (e.g., client's discharge, revocation, or transfer)
  - The day of death

How does HCA reimburse for nursing facility charges?

For nursing facility room and board, including swing beds (See Swing bed rates), HCA pays hospice agencies that are not licensed as hospitals, at a daily rate as follows:

- Directly to the hospice agency at 95% of the nursing facility's current Medicaid daily rate in effect on the date the services were provided
- The hospice agency pays the nursing facility at a daily rate not greater than the nursing facility's current Medicaid daily rate
- Nursing facility charges are not covered for AEM clients. See WAC 182-507-0120

How does HCA reimburse for hospice care center (HCC) residents?

HCA pays an HCC a daily rate for room and board based on the average room and board rate for all nursing facilities in effect on the date the services were provided.

What is client participation?

Client participation is an amount calculated by the Department of Social and Health Services (DSHS) that the client must pay towards the cost of their Long-Term Service and Supports (LTSS) or hospice services. The following clients may be required to pay participation:

- Hospice clients who reside in a nursing facility
- Hospice clients who reside in a hospice care center
- Hospice clients who received LTSS Home and Community-based services
- Hospice clients who live at home and are eligible under the special hospice program and do not receive other long-term services and supports

If the client is assigned participation, the hospice agency is responsible for collecting the client's monthly participation amount stated in the notice of action (award) letter sent by DSHS to the client.

If the client is on a Home and Community Based LTSS program, and is required to pay participation, the LTSS provider, and not the hospice agency, is responsible for collecting the client's monthly participation amount and not the hospice agency.

> Do NOT use the participation amount in the **Total Claim Charge** when billing HCA. Bill HCA your usual and customary charge. See "How to indicate a client's participation amount on your claim" for instructions on how to indicate a client's participation amount on your claim.

Collecting and reporting the correct amount of the client's participation is the responsibility of the hospice agency.

- Report the client participation amount in the Value Code section using value code 31.
- Do not factor the client participation amount into the billed amount. Bill the full amount and report the participation amount using value code 31. ProviderOne will automatically subtract the client's participation amount.

The hospice agency collects the participation each month as directed by the notice of action (award letter) issued by DSHS. A hospice agency may contract with the nursing facility to collect the client's participation, the amount is reported using value code 31 as it is for all other hospice claims.

How does HCA reimburse for clients under a home and community-based long-term service and supports program (HCB LTSS)?

Home and Community Living Administration (HCLA) in DSHS pays the LTSS provider directly for personal care services provided to an eligible client and:

- The client's monthly participation amount (if any) is paid separately to the LTSS provider.
- Hospice agencies must bill HCA directly for hospice services, not the LTSS program.

When does HCA reimburse hospitals providing care to hospice clients?

HCA pays hospitals that provide inpatient care to clients in the hospice program when the medical condition is not related to their terminal illness. (See HCA's Inpatient Hospital Services Billing Guide or Outpatient Hospital Services Billing Guide.)

How does HCA reimburse for the following physician services?

Administrative and supervisory services

Administrative and general supervisory activities performed by physicians are **included** in the hospice daily rate. These physicians are either employees of the hospice agency or are working under arrangements made with the hospice agency. The physician serving as the medical director of the hospice agency and/or the physician member of the hospice interdisciplinary team would generally perform activities such as:

- Physician participation in the establishment of plans of care.
- The supervision of care and services.
- The periodic review and updating of plans of care.
- The establishment of governing policies.

Note: These activities cannot be billed separately.

Licensed health care services

Services not related to the hospice diagnosis provided by physicians, ARNPs, and PA-Cs not employed by the hospice agency

HCA pays providers who are attending physicians and not employed by the hospice agency, the usual and customary charge through the Physician-Related/Professional Services Fee Schedule:

HCA pays these providers:

- For direct physician care services provided to a hospice client.
- When the provided services are not related to the terminal illness.
- When the client's providers, including the hospice provider, coordinate the health care provided.

Professional services related to the hospice diagnosis

See HCA's Physician-Related/Professional Services Fee Schedule.

Who can bill for professional services?

HCA reimburses for professional services only when they are billed by one of the following:

- Primary physician
- Hospice agency (using Hospice Clinic National Provider Identifier (NPI))
- Consulting physicians or those providing backup care for the primary physician. (consulting physicians must be coordinated with the hospice agency)
- Radiologist/laboratory

When billing for the professional component, include **modifier 26** in *Modifiers* field on electronic professional claim, along with the appropriate procedure code. (See #1 or #2 below, as applicable.) Charges for the technical component of these services, such as lab and x-rays, are **included** in the hospice daily rate and may not be billed separately.

What provider number is required when billing HCA?

Bill HCA for all professional services in one of the following ways:

- When the primary physician performs the service, bill using their NPI number.

- OR-

- When a physician, other than the primary physician, performs the service, bill using the primary physician NPI number as the referring provider on the claim.

How does HCA reimburse for Medicaid-Medicare dual eligible clients?

HCA does not pay for any hospice care provided to a client covered by Medicare Part A (hospital insurance).

- HCA may pay for hospice care provided to a client:
  - Covered by Medicare Part B (medical insurance).
  - Not covered by Medicare Part A.

For hospice care provided to a Medicaid-Medicare dual eligible client, hospice agencies must bill:

- Medicare before billing HCA.
- HCA for hospice nursing facility room and board, using the nursing facility's NPI number in form locator 78 on the UB-04 claim form.

Billing for routine home care – revenue code 0651

Payments for RHC are based on a two-tiered payment methodology:

- Days one through 60 are paid at the base RHC rate.
- Days 61 and after are paid at a lower RHC rate.

When billing for RHC level of care, enter the appropriate procedure code and modifier. For the claim to process correctly, the revenue code, procedure code, and modifier must be submitted on each line billed.

Procedure Code and Modifier	Description of Code or Modifier
Q5001	Hospice care provided in client's home/residence
Q5002	Hospice care provided in assisted living facility
Q5003	Hospice care provided in non-skilled nursing facility
Q5010	Hospice home care provided in a hospice facility
TG	Complex/high tech level of care (for RHC days 1-60)
TF	Intermediate level of care (for RHC days 61+)

- If an RHC client discharges and readmits to hospice within 60 calendar days of that discharge, the prior hospice days will continue to follow the client and count toward the client's eligible days in determining whether the receiving hospice agency may bill at the base or lower RHC rate.
- If an RHC client discharges from a hospice agency for more than 60 calendar days, a readmit to the hospice agency will reset the client's hospice days.

End-of-life service intensity add-on payment

Hospice services are eligible for an end-of-life SIA payment when all the following criteria are met:

- The day on which the service is provided is an RHC level of care.
- The day on which the service is provided occurs during the last 7 days of life, and the client is discharged deceased.
- The service is provided by a Registered Nurse (RN) or Social Worker (SW) that day for at least 15 minutes and up to 4 hours total.
- The service is not provided by the SW via telephone.

When billing for an SIA payment, enter the appropriate revenue and procedure code. In order for the claim to process correctly, the revenue code and procedure code must be submitted on each line billed.

Revenue Code	Description of Code	Procedure Code	Description of Code
0551	Skilled Nursing	**G0299**	Direct skilled nursing services of an RN in a home health or hospice setting, each unit = 15 minutes
0561	Medical Social Service Visit	**G0155**	Services of SW in home health or hospice setting, each unit = 15 minutes

Note: For SIA payments, there is a maximum limit of 112 units per a client's lifetime.

Where is the fee schedule?

See HCA's Hospice Fee Schedule

Washington State Health Care Authority

Pediatric Palliative Care

How are pediatric palliative care (PPC) services provided?

PPC services are provided through a hospice agency. HCA's case management/coordination services for PPC provide the care coordination and skilled care services to clients who have life-limiting medical conditions. Family members and caregivers of clients eligible for pediatric palliative care services also may receive support through care coordination when the services are related to the client's medical needs.

How does a hospice agency become an approved PPC provider?

> **Note**: This section does not apply to providers who already are HCA-approved PPC providers.

To apply to become an HCA-approved PPC provider, a provider must:

- Be an approved hospice agency with Medicaid (see About the Hospice Program).
- Submit a letter to HCA's Hospice/PPC program (see Resources Available) requesting to become an HCA-approved provider of PPC and include a copy of the provider's policies and position descriptions with minimum qualifications specific to pediatric palliative care.

Provider requirements

WAC 182-550-1840

An eligible provider of PPC case management/coordination services must do **all** of the following:

- Meet the conditions in How does a hospice agency become approved to provide Medicaid services?
- Confirm that a client meets the eligibility criteria prior to providing PPC services.
- Obtain a written referral to HCA's PPC program manager from the client's physician.
- Determine and document in the client's medical record the medical necessity for the initial and ongoing care coordination of PPC services.

- Document in the client's medical record:
  - A palliative plan of care (POC) (a written document based on assessment of a client's individual needs that identifies services to meet those needs).
  - The medical necessity for those services to be provided in the client's residence.
  - Discharge planning.
- Provide medically necessary skilled interventions and psychosocial counseling services by qualified interdisciplinary hospice team members.
- Assign and make available a PPC case manager (nurse, therapist, or social worker) to implement care coordination with community-based providers to ensure clarity, effectiveness, and safety of the client's POC.
- Notify HCA's PPC program manager within five business days from the date of occurrence of the client's:
  - Date of enrollment in PPC.
  - Discharge from the hospice agency or PPC when the client:
    - No longer meets PPC criteria.
    - Is able to receive all care in the community.
    - Does not require any services for 60 days.
    - Discharges from PPC to enroll in HCA's Hospice program.
- Transfer to another hospice agency for pediatric palliative care services.
- Death.

Note: See Pediatric Palliative Care (PPC) Referral and 5-Day Notification form, HCA 13-752. See Where can I download HCA forms?

- Maintain the client's file which includes the POC, visit notes, and all the following:
  - The client's start of care date and dates of service
  - Discipline and services provided (in-home or place of service)
  - Case-management activity and documentation of hours of work
  - Specific documentation of the client's response to the palliative care and the client's and/or client's family's response to the effectiveness of the palliative care (e.g., the client might have required acute care or hospital emergency room visits without the pediatric palliative care services)
- Provide when requested by HCA's PPC program manager, a copy of the client's POC, visit notes, and any other documents listing the information identified above.

If HCA determines that the documentation in the POC or attachments to the POC does not meet the criteria for a client's PPC eligibility or does not justify the billed amount, any payment to the provider is subject to recoupment by HCA.

> **Note**: Therapy services may be provided in outpatient settings and billed with the client's Services Card. Outpatient therapy may not be appropriate for some children and may be best served in the home. The documentation on the Pediatric Palliative Care (PPC) Plan of Care (POC) would note the medical necessity.

Who is eligible for Pediatric Palliative Care (PPC) services?

To receive PPC case management/coordination services, a person must:

- Be age 20 or younger.
- Be covered by a benefit package that covers PPC case management/coordination services. See HCA's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.
- Have a life-limiting medical condition with a complex set of needs requiring case management and coordination of medical services due to **at least three** of the following six circumstances:
  - An immediate medical need during a time of crises
  - Coordination with family member(s) and providers required in more than one setting (i.e., school, home, and multiple medical offices or clinics)
  - A life-limiting medical condition that impacts cognitive, social, and physical development
  - A medical condition in which the family is unable to cope
  - A family member(s) or caregiver, or both, who needs additional knowledge or assistance with the client's medical needs
  - Therapeutic goals focused on quality of life, comfort, and family stability

> **Note**: See the Program Benefit Packages and Scope of Services table for an up-to-date listing of benefit packages.

> **Note:** Pediatric palliative care (PPC) case management/ coordination services allow, up to six pediatric palliative care contacts per client, per calendar month, without prior authorization, subject to WAC 182-551-1820 and WAC 182-501-0169.

Are clients enrolled in managed care eligible for PPC services?

Yes. When verifying eligibility using ProviderOne, if the client is enrolled in an HCA-managed care plan, managed care enrollment will be displayed on the client benefit inquiry screen. A client enrolled in one of the HCA-contracted managed care plans must receive all PPC services, including nursing facility room and board, directly through that plan. The client's managed care plan is responsible for arranging and providing for all PPC services for a client enrolled in a managed care plan. Clients can contact their managed care plan by calling the telephone number provided to them. HCA does not process or reimburse claims for managed care clients for services provided under the Apple Health contract.

> Note: To prevent billing denials, check the client's eligibility before scheduling services, and at the time of the service to make sure proper authorization or referral is obtained from the plan.
>
> See HCA's **ProviderOne Billing and Resource Guide** for instructions on how to verify a client's eligibility.

How many PPC services are covered?

HCA's PPC case management/coordination services cover up to six PPC contacts per client, per calendar month.

> **Note**: If more than six contacts are routinely needed, PPC may not be appropriate for the child.

If more than six contacts are medically necessary, prior authorization must be requested. See **How do I obtain authorization**?

What is included in a PPC contact?

A PPC contact includes:

- One visit with a registered nurse, social worker, or therapist with the client in the client's residence to address:
  - Pain and symptom management.
  - Psychosocial counseling.
  - Education/training.

> **Note**: For the purposes of this billing guide, HCA defines therapist as: a licensed physical therapist, occupational therapist, or speech and language therapist.

- Two hours or more per month of case management or coordination services to include any combination of the following:
  - Psychosocial counseling services (includes grief support provided to the client, client's family member(s), or client's caregiver prior to the client's death)
  - Establishing or implementing care conferences
  - Arranging, planning, coordinating, and evaluating community resources to meet the child's needs
  - Visits lasting 20 minutes or less (for example: visits to give injections, drop off supplies, or make appointments for other PPC-related services)
  - Visits not provided in the client's home

> **Note**: Two hours of case management equals one contact and one visit equals one contact. You can have six contacts with any combination. Unbilled case-management hours do not carry over to the next month.

When are PPC services not covered?

HCA does not pay for a PPC contact when a client is receiving **similar services** from **any** of the following:

- Home Health program
- Hospice program
- Private duty nursing*
- Disease case management program
- Any other HCA program that provides similar services

***Alert!** Private duty nursing is not covered unless the hospice agency requests an exception to rule by submitting for **prior authorization** and completing the Hospice (including PPC) Authorization Request form, HCA 13-848. See **Where can I download HCA forms**?

HCA does not pay for a PPC contact that includes providing counseling services to a client's family member or the client's caregiver for grief or bereavement for dates of service after a client's death.

Pediatric palliative care (PPC) revenue code

Revenue Code	Description of Code
0659	**Other Hospice Services** (Pediatric Palliative Care (PPC) Case Management/Coordination will be reimbursed according to the fee schedule.) See below for examples of use
0659	PPC – RN (registered nurse)
0659	PPC – PT (physical therapy)
0659	PPC – OT (occupational therapy)
0659	PPC – ST (speech therapy)
0659	PPC – Case-Management Time (Bill the date of service for each 2-hour time requirement that was met.)

How does HCA pay for PPC services?

HCA pays providers for PPC case management/coordination services per contact.

HCA adjusts the reimbursement rate for PPC contacts when the legislature grants a vendor rate change. New rates become effective as directed by the legislature and are effective until the next rate change. The reimbursement rate for authorized out-of-state PPC services is paid at the **All Other Areas** CBSA rate.

Washington State Health Care Authority

Billing

All claims must be submitted electronically to HCA, except under limited circumstances. For more information about this policy change, see Paperless Billing at HCA. For providers approved to bill paper claims, see HCA's Paper Claim Billing Resource.

What are the general billing requirements?

Providers must follow HCA's ProviderOne Billing and Resource Guide. These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments.
- When providers may bill a client.
- How to bill for services provided to primary care case management (PCCM) clients.
- How to bill for clients eligible for both Medicare and Medicaid.
- How to handle third-party liability claims.
- What standards to use for record keeping.

How are national provider identifier (NPI) numbers reported on hospice claims?

HCA has implemented a change in the process for reporting the nursing facility NPI number on a hospice claim for a client in a nursing facility.

Use the following claim forms to report the nursing facility NPI:

837 Institutional and institutional Direct Data Entry (DDE) – service facility NPI information:

- For the HIPAA 837 Institutional claim type the **Service Facility NPI** field is located within Loop 2310E, data element NM109.
- For the institutional DDE claim screen, the **Service Facility NPI** field is listed on the **Other Claim Info** tab at the top of the claim form. On the **Other Claim** page open the Miscellaneous Claim expander and enter the NPI number in the **Service Facility** box.

How do I bill claims electronically?

Instructions on how to bill Direct Data Entry (DDE) claims can be found on HCA's **Billers, providers, and partners webpage**, under **Learn how to use ProviderOne**, select **Webinars**.

For information about billing Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) claims, see the ProviderOne 5010 companion guides on the **HIPAA Electronic Data Interchange (EDI)** webpage.

The attending provider must be included on the claim, or the claim will be denied.

The following institutional claim instructions relate to hospice services:

Description	Field Required	Entry
Type of Facility	Yes	Choose 8-Special Facility
Bill Classification	Yes	These types of Bill Codes are to be used to correctly identify Washington State Medicaid Hospice Claims: 1S –Hospice (non-hospital-based) 2S – Hospice (hospital-based)
Value Code and Value Amount	Situational	Use this field to report a client's Participation amount. Enter code 31 (Patient Liability Amount) in the *Value Code* field and the client's total participation from the award letter in the *Value Amount* field.
Discharge Status	Yes	See the **National Uniform Billing Committee** (NUBC)

The following professional claim instructions relate to hospice services:

Name	Field Required	Entry
Claim Note	When applicable	If the client does not have Part A coverage, enter the statement "Client has Medicare Part B coverage only" in this field.

Code(s) only appropriate for Washington State Medicaid:

Name	Field Required	Code Number Entry	To Be Used For
Place of Service	Yes	12	Client's Residence
Place of Service	Yes	21	Inpatient Hospital
Place of Service	Yes	23	Emergency Room
Place of Service	Yes	24	Outpatient Hospital, Office or Ambulatory Surgery Center
Place of Service	Yes	31	Nursing Facility
Place of Service	Yes	34	Hospice Care Center
Place of Service	Yes	99	Other

*Units field is required. Entry code should be 1.

External cause codes (V00-Y99) are required to be submitted in groups of three for a claim to be processed. For questions email: **HIPAA-Help@hca.wa.gov**.