Hospice, Long Term Care

Covered services

Providers should bill using their provider type 65 to receive room and board reimbursement for those hospice recipients residing in a nursing facility. Medicaid provides coverage for room and board in a nursing facility pursuant to the Nevada Medicaid Services Manual Chapters 500 and 3200. Services unrelated to the terminal illness billed by non-hospice providers may be covered subject to the specific program's limitations.

Non-covered services

No reimbursement is provided for curative services for adults.

Prior authorization requirements

Effective with dates of service on or after March 1, 2017, prior authorization is required for Hospice services. The hospice agency will not be reimbursed for hospice services unless all signed paperwork has been submitted to Nevada Medicaid and prior authorization has been obtained. It is the responsibility of the hospice provider to ensure that prior authorization is obtained for services unrelated to the hospice benefit.

Authorization requests for admission to Hospice Services must be submitted as soon as possible, but not more than eight business days following admission. Please note if the authorization request is submitted after admission, the Hospice provider is assuming responsibility for program costs if the authorization request is denied. Prior authorization only approves the existence of medical necessity, not recipient eligibility. Prior authorization for medical necessity is not required for dual eligible (Medicare/Medicaid eligible) recipients.

Hospice forms FA-92 or FA-93, and FA-94 must be submitted with FA-95 (the prior authorization request). For extended hospice services past 12 months, FA-96 must be submitted with FA-95. See page 2 of this billing guide for information regarding Hospice forms. To request PA and upload required documents, please use the Provider Web Portal. Faxes are no longer accepted.

Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Special billing instructions

All hospice claims are to be billed on a monthly basis. All claims should be submitted to Nevada Medicaid during the first week of the month following the month of service.

The National Provider Identifier (NPI) of the nursing facility from which the recipient was transferred, if applicable, must be provided in Loop 2310B NM109 of the 837I electronic transaction.

Do not include the prior authorization (PA) number on the claim. Retain the PA number for your records.

Ordering, Prescribing or Referring (OPR) Provider Requirements

The Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services (CMS) require all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (§455.410 Enrollment and Screening of Providers). The Affordable Care Act (ACA) requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid. Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as OPR providers.

For any services or supplies that are ordered, prescribed or referred, the National Provider Identifier (NPI) of the Nevada Medicaid-enrolled Ordering, Prescribing or Referring (OPR) provider must be included on Nevada Medicaid/Nevada Check

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Up claims or those claims will be denied. To prevent claim denials for this reason, please confirm that the OPR provider is enrolled with Nevada Medicaid; this can be done on the Provider Web Portal by using the Search Providers feature: https://www.medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx

Reminders for providers who submit institutional claims:

- If your provider type requires the attending physician to be listed on the Institutional claim, that attending physician must be enrolled with Nevada Medicaid.
- If the service was ordered, prescribed or referred by another provider, the NPI of the OPR provider is required to be listed on the claim form. The OPR provider must be enrolled in Nevada Medicaid.
- If the attending physician is the same as the OPR provider, leave the OPR field blank.
- The attending and OPR NPI must be for an individual provider (not an organization or group).
- For detailed claim completion information, refer to the 837I FFS Companion Guide located at: https://www.medicaid.nv.gov/providers/edi.aspx and the Electronic Verification System (EVS) User Manual Chapter 3 located at: https://www.medicaid.nv.gov/providers/evsusermanual.aspx

Notes

All hospice-enrolled recipients must have a Pre-Admission Screening and Resident Review (PASRR) and a Level of Care (LOC) screening prior to admission to a nursing facility.

All required documentation must be received in order for the Division of Health Care Financing and Policy (DHCFP) to issue a Billing Authorization Letter to the provider. See the Nevada Medicaid Services Manual, Chapter 3200 for documentation requirements.

A hospice physician or nurse practitioner (NP) must have a face-to-face encounter with the recipient to determine continued eligibility prior to the 180th day of recertification, and prior to each subsequent recertification. The face-to-face encounter must occur no more than 30 calendar days prior to the third benefit period recertification and no more than 30 calendar days prior to every subsequent recertification. The face-to-face encounters are used to gather clinical findings to determine continued eligibility for hospice services.

Nevada Check Up recipients are not disenrolled from a Managed Care Organization (MCO) when they receive hospice services. Although Nevada Check Up recipients receiving hospice care remain enrolled with the MCO, claims for hospice revenue codes are submitted to fee-for-service. The only claims submitted to the MCO are services not related to hospice revenue codes. It is the responsibility of the MCO to provide reimbursement to the provider for all ancillary services. For additional information, refer to MSM Chapter 3600 Managed Care Organization.

Hospice Forms

Forms have been created for standardization and uniformity of the Hospice Program. All fields on the forms are required to be filled in and the physician signature must be included. Nevada Medicaid Hospice forms without the physician signature will not be accepted.

- Nevada Medicaid Hospice Program Action Form (**FA-91**) (for hospice discharge, change of hospice provider or revocation of hospice services)
- Nevada Medicaid Hospice Program Election Notice - Adults (**FA-92**) or Nevada Medicaid Hospice Program Election Notice - Pediatrics (**FA-93**)
- Nevada Medicaid Hospice Program Physician Certification of Terminal Illness (**FA-94**)
- Hospice Prior Authorization Request (**FA-95**)
- Nevada Medicaid Hospice Extended Care Physician Review Form **(FA-96)**

These forms are available under “Hospice Forms” on the Providers Forms webpage.