

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 12/01/05
Section: Hospice	Section: 14.03	
Subject: Physician Certification/Plan of Care	Pages: 1	Cross Reference:

Physician certification/plan of care requirement include the following:

A written certification statement signed by the medical director of the hospice AND the beneficiary's attending physician. The certification must include the statement that the individual's medical prognosis is less than six (6) months if the terminal illness runs its normal course, and that hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions as determined by the hospice medical director or attending physician. The hospice must also retain the certification statement in the beneficiary's case record.

- A written certification statement signed by the medical director of the hospice AND the beneficiary's attending physician. The certification must include the statement that the ~~individual's~~ beneficiary's medical prognosis is less than six (6) months if the terminal illness runs its normal course, and that hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions as determined by the hospice medical director or attending physician. The hospice must ~~also~~ retain the certification statement in the beneficiary's case record.

~~A written plan of care that is developed and signed by all members of the interdisciplinary team prior to services being provided. The members of the basic interdisciplinary group will include a minimum of the beneficiary's attending physician, the hospice medical director and a registered nurse. The hospice must also retain the plan of care in the beneficiary's case record.~~

- A written plan of care developed and signed by all members of the interdisciplinary team. At a minimum, the members of the basic interdisciplinary group must include the beneficiary's attending physician, the hospice medical director and a registered nurse. The hospice must retain the plan of care in the beneficiary's case record.

~~Any supporting documentation that identifies the beneficiary's terminal illness, (i.e.: history and physical or copies of hospital admit or discharge summaries)~~

- All supporting documentation related to the beneficiary's terminal illness, (i.e.: history and physical or copies of hospital admit or discharge summaries)
- The Hospice Election Form must be signed and dated by the beneficiary or their representative and by the hospice provider. The hospice must retain the form in the beneficiary's case record.

~~The original DOM-1165 (Mississippi Medicaid Hospice Form) signed and dated by the beneficiary or their representative and by the hospice provider. The hospice must also retain a copy of this form in the beneficiary's case record.~~

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 12/01/05
Provider Policy Manual	Current:	
Section: Hospice	Section: 14.04	
	Pages: 1	
Subject: Election Procedures	Cross Reference: Section 14.03 Physician Certification/ Plan of Care 14.03	

If an individual When a beneficiary elects to receive hospice care, he/she must sign and file an election statement with a particular hospice Election Statement with the hospice. Beneficiaries must sign a Hospice form, DOM-1165, to have Medicaid payments made. The signed Election allows Medicaid to make payments for hospice care in lieu of payments made for treatment of the condition for which hospice care is sought, except for payments made for the service of any attending physician who is not connected with the hospice. The original DOM-1165 must be retained in the patient's medical record in the office of the hospice provider. The hospice must retain the original copies of the Election Statement and the DOM-1165 Enrollment form in the beneficiary's case record. A copy of the DOM-1165 Enrollment form must be mailed to the Division of Medicaid's fiscal agent at the address listed on the top of the form.

A hospice enrollment form may also Hospice enrollment may be filed by a beneficiary's representative acting pursuant to state law. With respect to an individual granted the power of attorney for the beneficiary, state law determines the extent to which the individual may act on the beneficiary's behalf. State law determines the extent to which an individual with power of attorney may act on the beneficiary's behalf.

An election to receive hospice care is considered to continue through the initial election period and continuous from the initial election period through each subsequent election period without a break in care as long as the individual beneficiary remains under the care of the hospice program, does not revoke the election, and is properly certified by DOM following policy as outlined in Section 14.03 and continues to meet Medicaid eligibility requirements.

Division of Medicaid State of Mississippi Provider Policy Manual	New:	Date:
	Revised: X	Date: 12/01/05
	Current:	
Section: Hospice	Section: 14.06	
	Pages: 7	
Subject: Election, Revocation, and Change of Hospice	Cross Reference: Section 14.03 Section 14.07	
	Physician Certification/Plan of Care 14.03	
	Dually Eligible Beneficiaries 14.07	

Election Election and Enrollment

The DOM-1165 election form includes the following items of information:

The Election Statement form includes the following:

- ~~Identification-~~ Name of the particular hospice that will provide care to the ~~individual~~ beneficiary;
- The ~~individual's~~ beneficiary's or representative's written acknowledgment that he/she has been given a full understanding of hospice care;
- The ~~individual's~~ beneficiary's or representative's written acknowledgment that he/she understands the listed Medicaid services that are waived by the election. If an ~~individual~~ a beneficiary is eligible for Medicare as well as Medicaid, the hospice benefit, and each period therein, must be elected and revoked simultaneously under both programs;
- The hospice benefit period in which the beneficiary is enrolling (periods must be used in order), and
- The signature of the ~~individual~~ hospice beneficiary or representative;
- The signature of the hospice provider representative.

Revocation

~~An individual~~ The beneficiary or representative may revoke the election of hospice care at any time by filing a DOM-1166 form ~~disenrolling to disenroll~~ from the current benefit period of hospice care. The form must reflect the effective date of the revocation of the hospice election. Disenrollment from hospice is required for the following, which may include, but is not limited to:

- Death
- Hospitalization unrelated to terminal illness;
- Seeking treatment other than palliative in nature; or
- No longer meets program requirements.

This disenrollment form must be completed, signed and dated and filed in the patient's medical record in the office of the hospice provider within 48 hours of the disenrollment, or the hospice will be responsible for any or all charges incurred by the beneficiary. The ~~individual~~ beneficiary forfeits coverage for any remaining days in that election period. ~~An individual~~ The beneficiary may not designate an effective date earlier than the date that the revocation was made.

Upon revoking the election of Medicaid coverage of hospice care for a particular election period, an individual the beneficiary resumes Medicaid coverage of the benefits waived when hospice care was elected. ~~An individual~~ The beneficiary may at any time elect to receive hospice services for any other hospice election periods for which he/she is eligible.

Change Of Hospice Change to Hospice Designation

~~An individual~~ The beneficiary may change, once in each election period, the designation of the particular hospice care. The A change of in the designated hospice is not considered a revocation of the election, and does not require a DOM-1166 hospice disenrollment form or a new hospice election statement form.

To change the designation of the hospice programs provider, ~~the individual~~ beneficiary must file a signed statement with the hospice from which he/she has received care and with the newly designated hospice. The hospice providers must file the statement in the beneficiary's medical record. The signed statement must include the following information:

- ~~• The name of the hospice from which the individual has received care;~~ The name of the current hospice provider from whom the beneficiary has been receiving care;
- ~~• The name of the hospice from which he/she plans to receive care; and~~ The name of the new hospice provider from whom the beneficiary plans to receive care; and
- The date the change is effective.

It is the responsibility of the current hospice provider to provide a copy of the current Hospice Election Statement to the newly designated hospice provider, for file documentation purposes.

The newly designated hospice provider must complete the DOM-1165 Enrollment Form. When submitting this form to the DOM fiscal agent because of a hospice provider designation change within a current election period, a copy of the beneficiary's signed statement must be attached to the DOM-1165, since a hospice disenrollment form is not required.

~~This form must be filed in the patient's medical record in the office of the Hospice Provider.~~

A change of ownership of a hospice is not considered a change in the beneficiary's designation of a hospice and requires no action on the beneficiary's part.

Mississippi Medicaid Hospice Form



Instructions for Completing the Mississippi Medicaid Hospice Form:

- (1) Complete the individual's name **exactly** as it appears on his/her Medicaid card.
- (2) Complete the Medicaid number **exactly** as it appears on his/her Medicaid card.
- (3) Complete the individual's Social Security number **exactly** as it appears on his/her Medicaid card.
- (4) Complete the individual's Medicare number **exactly** as it appears on his/her Medicare card.
- (5) Complete the individual's date of birth.
- (6) Complete the individual's area code and phone number.
- (7) Complete the individual's street address.
- (8) Complete the individual's city, state, and zip code.
- (9) Complete the name of parent, legal guardian, or representative (if applicable).
- (10) Complete by checking the appropriate box for the hospice benefit period and fill in requested effective date of segment.
- (11) Complete the hospice's Medicaid provider name
- (12) Complete the hospice's Medicaid provider number.
- (13) Complete the name of the nursing facility where the beneficiary resides (if applicable).
- (14) Complete the nursing facility's Medicaid provider number (if applicable).
- (15) Complete the attending physician's name.
- (16) Complete the county where actual services will be rendered.
- (17) Complete the "group rate" code (refer to section 14.11 of the Hospice manual).
- (18) Have the provider's representative sign the form.
- (19) Have the provider's representative date the form.

Election Statement: Allow individual or representative time to read closely. Have individual or representative sign indicating Enrollment or Disenrollment into the hospice program. **The hospice provider's representative who is present must sign as the witness.**

Election Statement Form



The Mississippi Medicaid Hospice Care Services program has been explained to me. I have been given the opportunity to discuss the benefits, requirements, and limitations of this program and the terms of the election statement. I understand that by signing the election statement, I am waiving all rights to Medicaid for the duration of hospice care for the following services:

1. Hospice care provided by a hospice other than the hospice designated by me (unless provided under arrangements made by the designated hospice) and;
2. Any Medicaid services that are related to the treatment of the condition, or a condition, for which hospice care was elected or that are equivalent to hospice care with the following exception: services provided by my attending physician (if that physician is not employed by the designated hospice or receiving compensation from the hospice for those services).

I understand that I will be entitled to Medicaid hospice care coverage for the enrolled benefit segment as long as I am Medicaid eligible.

I understand that I may revoke the hospice benefit at any time by signing a statement to that effect, specifying the date when the revocation is to be effective and submitting the statement to the hospice prior to that date. I understand my rights to other Medicaid services will resume at that time, if I continue to be Medicaid eligible.

I understand that I may change the designated hospice provider without affecting the provision of my hospice benefits. To change the designation of hospice programs, I must disenroll with the hospice from which care has been received.

Beneficiary Name	Beneficiary Medicaid Number

Address (Street Address, City, State and Zip Code)

By signing this statement, I am electing the above named hospice to provide me with the services of the Medicaid hospice care program.

Beneficiary/Representative's Signature	Date

Provider Signature (Must be present)	Date

Provider Name	Provider Number

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Mississippi Medicaid Hospice**Enrollment Form**To be completed upon **enrollment**. Please print in ink or type. See instructions.

Mail a copy to:

ACS

Attention: File Maintenance

P. O. Box 23076

Jackson, MS 39225

**Beneficiary Information****Name (Last, First and Middle Initial)**

1.)

Medicaid #

2.)

Social Security #

3.)

Medicare ID#

4.)

Date of Birth

5.)

Home Phone Number

6.)

Street Address

7.)

City, State and Zip Code:

8.)

Parent/Legal Guardian or Representative and Relationship:

9.)

10.) Hospice Benefit Period:

First 90 Day Segment

Second 90 Day Segment

60 Day Period

Requested effective date of segment: _____

Provider Information**Hospice Provider Name**

11.)

Hospice Medicaid Provider #

12.)

Nursing Facility Where Beneficiary Resides (if applicable)

13.)

Nursing Facility Medicaid Provider # (if applicable)

14.)

Attending Physician's Name:

15.)

County Where Services Will Be Rendered:

16.)

Group Rate Code

17.)

Provider Signature

18.)

Date

19.)

**Mississippi Medicaid Hospice
Disenrollment Form**

To be completed upon disenrollment.



**Instruction for Completing the
Mississippi Medicaid Hospice Disenrollment Form:**

1. Enter the Beneficiary's name exactly as it appears on his/her Medicaid ID Card.
2. Enter the Beneficiary's Medicaid ID #
3. Enter the Hospice provider name.
4. Enter the Hospice Provider's Medicaid ID#
5. Enter the effective date of disenrollment.
6. Enter the county where services were rendered.
7. Enter the Beneficiary's Social Security Number.
8. Indicate the reason for disenrollment. If 6 (other), please explain.
9. Allow the beneficiary or representative time to read the form. Have the individual sign and date the form.
10. Have the provider's representative sign and date the form.

Mississippi Medicaid Hospice Disenrollment Form



To be completed upon **disenrollment**. Please print in ink or type. See instructions.

Mail a copy to:

ACS

Attention: File Maintenance

P. O. Box 23076

Jackson, MS 39225

Beneficiary Information

Name (Last, First and Middle Initial)

1.)

Beneficiary's Medicaid ID#

Hospice Provider's Name

2.)

3.)

Hospice Medicaid's Provider ID#

Effective Date of Disenrollment

4.)

5.)

County where services were rendered

Social Security Number

6.)

7.)

8.) Reason for Disenrollment:

1 Voluntary disenrollment

4 Seeking treatment other than palliative in nature

2 No longer meets hospice requirements

5 Death

3 Hospitalization unrelated to terminal illness

6 Other _____

THIS DISENROLLMENT FORM MUST BE COMPLETED, SIGNED, AND DATED AND FILED IN PATIENT'S MEDICAL RECORD IN THE OFFICE OF THE HOSPICE PROVIDER WITHIN 48 HOURS OF THE DISENROLLMENT, OR THE HOSPICE WILL BE RESPONSIBLE FOR ANY OR ALL CHARGES INCURRED BY THE BENEFICIARY.

The individual forfeits coverage for any remaining days in that election period. An individual may not designate an effective date earlier than the date that the revocation was made.

Upon revoking the election of Medicaid coverage of hospice care for this particular election, I understand that I resume Medicaid coverage of benefits waived when hospice care was elected, providing I remain eligible for Medicaid coverage. I also understand that I can re-elect hospice coverage for any other hospice benefits for which I am eligible.

Signature of Beneficiary/Representative

Date

Signature of Hospice Representative

Date

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 12/01/05
Section: Hospice	Section: 14.07	
Subject: Dually Eligible Beneficiaries	Pages: 1	Cross Reference:

Medicare is the primary coverage for dually eligible individuals; however, the hospice benefit is used simultaneously under both programs. The hospice benefit, and each period therein, is available only once in a lifetime for dually eligible individuals.

When enrolling a dually eligible individual, the DOM-1165 (Mississippi Medicaid Hospice Enrollment Form), along with a copy of the Medicare enrollment form, must be submitted to the Division of Medicaid must be retained in the patient's medical record in the office of the Hospice Provider. must be mailed to the Division of Medicaid's fiscal agent at the address listed at the top of the forms. The original forms must be retained in the patient's medical record in the office of the hospice provider.

When disenrolling a dually eligible individual, the DOM-1166 (Mississippi Medicaid Hospice Disenrollment Form), along with a copy of the Medicare disenrollment form, must be submitted to the Division of Medicaid must be retained in the patient's medical record in the office of the Hospice Provider. mailed to the Division of Medicaid's fiscal agent at the address listed at the top of the forms. The original forms must be retained in the patient's medical record in the office of the hospice provider.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 12/01/05
Section: Hospice	Section: 14.10	
Subject: Hospice Reimbursement	Pages: 4	Cross Reference:

With the exception of payment of attending physician services, Medicaid payment for hospice care is made at one of four predetermined rates for each day in which an individual is under the care of the hospice. The state's Medicaid rates are established once each year based on the national rates published annually for the Medicare hospice program and adjusted for the wage index of the **location where the hospice service is provided**. The four rates are prospective rates. The rate paid for any particular day varies depending on the level of care furnished to the individual.

Levels of Care

There are four levels of care into which each day of care is classified:

HOSPICE SERVICES	UB-92 REVENUE CODE
Routine Home Care	651
Continuous Home Care	652
Inpatient Respite Care	655
General Inpatient Care	656

NOTE: For nursing facility residents, Revenue Code 659, refer to: "Reimbursement for Nursing Facility Residents" in this section of the manual.

For each day that an individual is under the care of a hospice, Medicaid will pay the hospice an amount applicable to the type and intensity of the services furnished to the individual for that day. For continuous home care, a registered nurse must have provided a minimum of eight hours of direct nursing care to the beneficiary during that day regardless of any other services that may have been rendered.

- **Routine Home Care**

Medicaid will pay the hospice the routine home care rate for each day the beneficiary is under the care of the hospice. This rate is paid without regard to the volume or intensity of services provided on any given day if a beneficiary is a nursing facility resident.

- **Continuous Home Care**

Medicaid will pay the hospice at the continuous home care rate when continuous home care is provided which includes at least eight (8) hours of care rendered by a registered nurse during the day. Continuous home care will be paid by an hourly rate. A minimum of eight (8) hours must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate is paid for up to twenty-four (24) hours per day. **THIS RATE IS NOT PAYABLE FOR A RESIDENT OF A FREE-STANDING HOSPICE OR NURSING FACILITY.**

- **Inpatient Respite Care**

Medicaid will pay the hospice at the inpatient respite care rate for each day in which the beneficiary stays in an approved inpatient facility receiving respite care. Inpatient respite care is limited to a maximum of five (5) consecutive days at a time (count the date of admission, but not the date of discharge). Any consecutive days beyond five (5) will pay at the routine home care rate. **THIS RATE IS NOT PAYABLE FOR A RESIDENT OF A FREE-STANDING HOSPICE OR NURSING FACILITY.**

- **General Inpatient Care**

THE HOSPICE REIMBURSES THE FACILITY THAT PROVIDES THE INPATIENT CARE TO THEIR PATIENTS. Medicaid will pay the hospice at the general inpatient care rate for each day such care is consistent with the patient's plan of care. Respite and general inpatient care days are payable to the hospice.

Date of Discharge

~~For the date of discharge from an inpatient unit, Medicaid will pay the appropriate home care rate unless the beneficiary dies as an inpatient. When the beneficiary is discharged due to being deceased, as with any institutional discharge date, that date is not paid. Medicaid will not reimburse for the date of discharge or the date of death.~~

Limitation on Payments for Inpatient Care

Payments to a hospice for inpatient care is limited according to the number of days of inpatient care furnished to Medicaid beneficiaries. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent for the aggregate total number of days of hospice care provided to all Medicaid beneficiaries during the same period. Medicaid does not use inpatient days for beneficiaries afflicted with acquired immunodeficiency syndrome (AIDS) in calculating this inpatient care limitation. This limitation is applied once each year at the end of the hospice "cap period" (11/1-10/31). This limitation is calculated as follows:

1. The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicaid hospice care by 0.2.
2. If the total number of days of inpatient care furnished to Medicaid hospice beneficiaries is less than or equal to the maximum, no adjustment is necessary.
3. If the total number of days of inpatient care exceeds the maximum allowable number, subtract the sum of the routine home care rate, times the number of excess days from the sum of the average payment of all inpatient days times the number of excess days. The remainder must be refunded by the hospice.

Payment for Physician Services under Hospice

The basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the beneficiary's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice. The physician serving as the medical director and the physician member of the hospice interdisciplinary group generally performs these activities. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and

updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care.

Medicaid does not reimburse the hospice separately for hospice physician services, except for coinsurance payments that result from Medicare approved claims. Medicaid will pay the claims of attending physicians for direct patient care services to beneficiaries that elect the hospice option as long as such services are not routinely provided to the hospice's patients on a voluntary basis.

In determining which services are furnished on a voluntary basis and which services are not, a physician must treat Medicaid beneficiaries on the same basis as other patients in the hospice. For instance, a physician may not designate all physician services rendered to non-Medicaid patients as voluntary and at the same time seek payment from Medicaid for all physician services rendered to Medicaid beneficiaries.

NOTE: Unless the attending physician has an agreement with the hospice to service on a volunteer or contracted basis, the only services billed by the attending physician are the physician's personal professional services.

Reimbursement for Nursing Facility Residents

For purposes of the Medicaid hospice benefit, a nursing facility may be considered the residence of a beneficiary. A beneficiary residing in such a setting may elect the hospice benefit. In addition to the hospice reimbursement for services, the hospice may also request reimbursement for room and board of the beneficiary residing in a nursing facility. DOM reimburses room and board to the hospice at 95% of the nursing home's established Medicaid per diem. The hospice reimburses the facility for these services and Medicaid payments to the facility are discontinued.

If Medicaid is covering the beneficiary's stay in the nursing facility at the time the hospice option is elected under either the Medicare or Medicaid program, Medicaid will reimburse the hospice an additional per diem rate when filed under Revenue Code 659, Nursing Facility Resident, on the UB-92 claim form or appropriate ESC format. This revenue code may only be used in conjunction with Revenue Code 651 (routine home care) when the beneficiary is a nursing home resident and Medicaid eligible only. If the beneficiary is a dual eligible (Medicare and Medicaid) and Revenue Code 651 is being submitted to Medicare, Medicaid will reimburse the hospice provider a per diem rate under Revenue Code 659. The per diem rate is established annually for the period October 1st through September 30th for the following year at not less than the average Medicaid rate paid to a freestanding, privately owned nursing facility.

The nursing facility must still reflect the beneficiary as a resident. The hospice and the facility must have a written agreement under which the hospice is responsible for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual. In this context, the term "room and board" includes performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies.

The nursing facility where the beneficiary resides is responsible for completing a DOM-317 form when the beneficiary is admitted, transferred, discharged or expires in the facility.

The DOM - 317 form documents the most recent date of Medicaid eligibility and the amount of Medicaid income due from the beneficiary each month. Medicaid income is the amount of money the resident in the nursing facility must pay toward the cost of his/her care.

The hospice provider must submit claims to DOM for reimbursement of the room and board and other

hospice covered services. The beneficiary's Medicaid income will be deducted from the hospice provider's reimbursement. The hospice provider will be responsible for collecting the beneficiary's Medicaid income, for the hospice dates of service provided to the beneficiary while residing in the nursing facility.

It is the responsibility of the hospice and the nursing facility to coordinate billing and payment distribution for services provided to the Medicaid beneficiary.