

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 06/01/05
Provider Policy Manual	Current:	09/01/07
Section: Hospice	Section: 14.01	
	Pages: 1	
Subject: Introduction	Cross Reference:	

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Hospice care is an optional benefit under the state's Medicaid program. Beneficiaries enrolled in Mississippi Medicaid's Home and Community Based Waiver programs may not receive hospice benefits simultaneously. A hospice may be a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. ~~A participating hospice must meet the Medicare conditions of participation for hospices and have a valid provider agreement with that agency.~~

To participate in the Mississippi Medicaid Program, a Hospice must:

- Meet the conditions of participation set forth in 42 CFR, Chapter IV Centers for Medicare & Medicaid Services, Department of Health and Human Services, Part 418, and
- Be licensed and certified for participation by the State survey agency, Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification (HFLC), and
- Enter into a provider agreement with the Mississippi Division of Medicaid (DOM).

~~A Hospice provider's Provider participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, he/she must accept the Medicaid payment as payment in full for those services covered by Medicaid. He/she The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then rebate refund Medicaid's payment to the beneficiary. Only services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary. DOM does not cover telephone contacts/consultations or missed/cancelled appointments, and providers may not bill beneficiaries for these services.~~

The Mississippi Medicaid program purchases needed personal health care services for beneficiaries as determined under the provisions of the Mississippi Medical Assistance Act. ~~Providers' charges for telephone contacts and broken appointments with Medicaid beneficiaries are not reimbursable under Medicaid program policies and are not billable to the beneficiary. The Division of Medicaid (DOM) DOM is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.~~

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 06/01/05 09/01/07
Section: Hospice	Section: 14.02 Pages: -4 2	
Subject: <u>Services Program Overview</u>	Cross Reference:	

Services

Hospice providers participating in the Medicare program that execute a provider agreement with DOM may be reimbursed for services provided to qualified Medicaid beneficiaries. Hospice provides **palliative** treatment such as: that may include the following:

- Nursing care
- Medical social services
- Physician services
- Counseling
- Short-term inpatient care
- Medical appliances and supplies
- Drugs and biologicals
- Home health aide/homemaker
- Non-restorative therapies
- Respite Care, excluding a resident in a nursing facility or free-standing hospice

For Mississippi Medicaid purposes, **palliative** is defined as the relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement. Through this emphasis on palliative rather than curative services, individuals beneficiaries have a choice whenever conventional approaches for medical treatment may no longer be appropriate. The medications prescribed for hospice beneficiaries must be palliative in nature and prescribed for an end of stage of life disease diagnosis. All palliative therapy, including medication used to treat the beneficiary's terminal illness, must be billed to the hospice provider, i.e., DOM reimburses for only those medications that are not directly related to the beneficiary's terminal illness and that are within the applicable DOM prescription service limits.

Plan of Care

~~The services~~ Services must be provided under a written plan of care (POC). The POC must be established and reviewed by the hospice's interdisciplinary team and it must be reviewed/ revised at each enrollment period. and updated as required by the beneficiary's condition. A new or updated plan of care, All plans of care (new and revised), along with supporting documentation that explains the beneficiary's condition (i.e., physician/nurse practitioner/physician assistant progress notes from MD and/or nursing notes that explain beneficiary's physical condition), must be retained in the patient's beneficiary's medical record in the office of the hospice provider. If the beneficiary is a resident in a nursing facility, the POC should be coordinated between the nursing facility provider and the hospice provider to ensure continuity of care.

Election Periods

The hospice benefit is divided into distinct periods as outlined in the Balanced Budget Act of 1997. Each period stands alone, and once used, is never again available. A period is used when the beneficiary enrolls in that period and subsequently disenrolls, or when the maximum number of days available in that period is used. The maximum number of days in each election period is as follows:

- 1st – 90 days
- 2nd – 90 days
- 3rd – 60 days - unlimited increments

~~For each benefit period, in order to~~ To be eligible to elect hospice care under Medicaid, an individual the beneficiary must be certified as being terminally ill with a life expectancy of six (6) months or less, and there must be a documented diagnosis consistent with a terminal stage of six (6) months or less. The beneficiary must be certified/re-certified for each benefit period. The individual beneficiary must acknowledge the terminal illness and elect to receive the palliative care of the hospice services rather than active treatment of the terminal condition.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 12/01/05 09/01/07
Section: Hospice	Section: 14.03 Pages: 1	
Subject: Physician Certification/Plan of Care	Cross Reference:	

Physician certification/plan of care requirements for Hospice include the following:

- A written certification statement signed by the medical director of the hospice **AND** the beneficiary's attending physician. The medical director of the hospice and the beneficiary's attending/certifying physician MUST be different physicians. To avoid possible conflict of interest, DOM does not allow the medical director to be the beneficiary's attending physician or the certifying physician. The certification must include the statement that the beneficiary's medical prognosis is ~~less than~~ six (6) months or less, ~~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 retain the certification statement in the beneficiary's case record.
- The physician signing the written certification statement can be held liable for causing false claims to be submitted. As noted above, the certification must include the statement that the beneficiary's medical prognosis is six (6) months or less. In addition, there must be a documented diagnosis consistent with a terminal stage of six (6) months or less. The hospice must retain the original certification statement 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.
- All supporting documentation related to the beneficiary's terminal illness, (i.e.: example: history and physical or copies of hospital admit or discharge summaries).
- ~~The A Hospice Election Form must be~~ that is signed and dated by the beneficiary or their beneficiary/legal representative and by the hospice provider. The hospice must retain the form in the beneficiary's case record.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 12/01/05 09/01/07
Section: Hospice Subject: Election Procedures	Section: 14.04 Pages: 1 Cross Reference: Physician Certification/Plan of care 14.03	

~~The beneficiary/legal representative must elect hospice care in order to receive it. When a beneficiary elects to receive hospice care, he/she~~ To elect hospice, the beneficiary/legal representative must sign and file an Election Statement with the hospice. The signed Election Statement 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. Exceptions may be found in Section 14.05 of this manual. ~~The hospice must retain the original copies~~ copy of the Election Statement and the DOM-1165 Enrollment form ~~forms~~ 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.~~

~~Hospice enrollment may be filed by a beneficiary's representative acting pursuant to state law. State law determines the extent to which an individual with power of attorney may act on the beneficiary's behalf.~~

~~An~~ The election to receive hospice care is considered continuous from the initial election period through each subsequent election period without a break in care as long as the beneficiary remains under the care of the hospice program, does not revoke the election, and continues to meet Medicaid eligibility requirements.

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 10/1/00
Provider Policy Manual	Current:	09/01/07
Section: Hospice	Section: 14.05	
	Pages: 1	
Subject: Waiver of Medicaid Services	Cross Reference:	

An individual The beneficiary must waive all rights to Medicaid payments for the duration of the election of hospice care for the following services:

- Hospice care provided by a hospice other than the hospice designated by the individual beneficiary/legal representative (unless provided under arrangements made by the designated hospice), **and**
- Any Medicaid services that are related to the treatment of the terminal condition or a related condition for which hospice care was elected or that are equivalent to hospice care except for these services:
 - Services provided ~~Provided~~ (either directly or under arrangement) by the designated hospice
 - Services provided ~~Provided~~ by the individual's beneficiary's attending physician, if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services; ~~or~~
 - Services provided ~~Provided~~ as room, board, and services by a nursing facility if the individual beneficiary is a resident at the time the hospice election is made and Medicaid was paying for that service

DOM applies an annual monetary cap to hospice services. The cap is adjusted annually and based on cap information supplied by the Centers for Medicare & Medicaid Services (CMS).

After When a hospice benefit period is completed, the annual cap has been reached, or the remaining days in that period are revoked, the beneficiary's waiver of all other Medicaid services ceases and all benefits under the Medicaid program, to the limits permitted, are again available.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 12/1/05 09/01/07
Section: Hospice	Section: 14.06 Pages: 7	
Subject: Election, Revocation, and Change of Hospice	Cross Reference: Physician Certification/Plan of Care 14.03 Dually Eligible Beneficiaries 14.07	

Election and Enrollment

The Election Statement form (DOM-1165) includes the following:

- Name The name of the particular hospice that will provide care to the beneficiary
- The ~~beneficiary's or representative's~~ beneficiary's/legal representative's written acknowledgment that he/she has been given a full understanding of hospice care
- The ~~beneficiary's or representative's~~ beneficiary's/legal representative's written acknowledgment that he/she understands the listed Medicaid services that are waived by the election ~~If 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 hospice ~~beneficiary or representative~~ beneficiary/legal representative
- The signature of the hospice provider representative

If 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. Refer to Section 14.07 in this manual.

Revocation

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

- Death
- Hospitalization unrelated to terminal illness
- Seeking Beneficiary is seeking treatment other than palliative in nature; ~~or~~
- ~~No~~ Beneficiary no longer meets program requirements

~~This disenrollment form~~ The Disenrollment Form (DOM-1166) must be completed, signed and dated, and filed in the patient's beneficiary's medical record, ~~in the office of the hospice provider and a copy transmitted to DOM's fiscal agent within forty-eight (48)~~ 48 hours of the disenrollment. Failure to comply will result in ~~or the hospice will be~~ being held responsible for any or all charges incurred by the beneficiary. The beneficiary forfeits coverage for any remaining days in that election period. The beneficiary may not designate an effective date earlier than the date that the revocation was made.

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

Change to In Hospice Designation

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

To change the designation of the hospice provider the beneficiary must file a signed statement with the current hospice from which he/she has received care and with the newly designated hospice. Each hospice provider must provide the other with a copy of the signed statement and both hospice providers must file the statement both statements in the beneficiary's medical record. The signed statement statements must include the following information:

- ~~—~~
- The name of the current hospice provider from whom the beneficiary has been receiving care
- 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 ~~The current hospice provider to~~ must 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.

The current hospice provider must complete the Disenrollment Form (DOM-1166) on the beneficiary's last date of service and the new hospice provider must complete the Enrollment Form (DOM-1165) on the next date of service. Both forms must be mailed to DOM's fiscal agent. The Election Statement must accompany the DOM-1165.

A change of ownership of a hospice Hospice change of ownership 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 legal 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 beneficiary/legal representative time to read closely. Have beneficiary/legal representative sign indicating Enrollment or Disenrollment in 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/Legal Representative's Signature	Date

Provider Signature (Must be present)	Date

Provider Name	Provider Number

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 #

Social Security #

2.)

3.)

Medicare ID#

Date of Birth

4.)

5.)

Home Phone Number

Street Address

6.)

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

Hospice Medicaid Provider #

11.)

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

Date

18.)

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/legal representative time to read the form. Have the beneficiary/legal representative 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, FILED IN PATIENT'S MEDICAL RECORD, AND A COPY TRANSMITTED TO DOM'S FISCAL AGENT WITHIN 48 HOURS OF THE DISENROLLMENT, OR THE HOSPICE WILL BE RESPONSIBLE FOR ANY OR ALL CHARGES INCURRED BY THE BENEFICIARY.

The beneficiary forfeits coverage for any remaining days in that election period. 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 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/Legal 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 09/01/07
Section: Hospice	Section: 14.07	
Subject: Dually Eligible Beneficiaries <u>Dual Eligibles</u>	Pages: 1	Cross Reference: Third Party Recovery 6

Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source, and to file and collect all third party coverage prior to billing Medicaid. This includes beneficiaries who are Medicare/Medicaid (dual) eligible. Refer to Third Party Recovery, Section 6, in this manual.

Medicare is the primary coverage for ~~dually dual~~ eligible individuals beneficiaries; 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 dual~~ eligible individuals beneficiaries. Conversely, the hospice benefit and each period therein, must be elected and revoked simultaneously under both programs.

~~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 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 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.~~

Language deleted because enrollment and disenrollment are already covered in 14.06.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 10/01/00 09/01/07
Section: Hospice	Section: 14.08	
Subject: Covered Services	Pages: 42 Cross Reference:	

Appropriately qualified personnel, to include licensure, when required by state law, must perform all services. The following are covered hospice services:

DOM covers the following hospice services:

- Nursing care provided by or under the supervision of a registered nurse
- Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician
- Physician services performed by a physician as defined in 42 CFR 410.20. ~~for~~ (Exception: the services of the hospice medical director or the physician member of the interdisciplinary group, must be performed by a doctor of medicine or osteopathy)
- Counseling services provided to the terminally ill individual beneficiary and the family members or other persons caring for the individual beneficiary at home

~~Counseling, including dietary counseling, may be provided for the training of an individual's to train the beneficiary's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him or her beneficiary and those providing care to adjust to the individual's beneficiary's approaching death.~~

- Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital or nursing facility that ~~additionally~~ meets the special hospice standards regarding staffing and patient areas

Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be ~~required for~~ furnished if procedures necessary for pain control or acute or chronic symptom management that cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's beneficiary's family or other persons caring for the individual beneficiary at home.

- Medical appliances and supplies, drugs, and biologicals

~~Only drugs medical appliances and supplies, drugs, and biologicals~~ that are used primarily for the relief of pain and symptom control related to the individual's beneficiary's terminal illness are covered. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the beneficiary's terminal illness. Equipment is provided by the hospice for use in the beneficiary's home. ~~while he/she is under hospice care.~~ Medical supplies include those that are part of the written plan of care.

- Home health aide services furnished by qualified aides and homemaker services

Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the beneficiary, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the beneficiary. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care,

maintenance of a safe and healthy environment and services to enable the individual beneficiary to carry out the plan of care.

- Physical therapy, occupational therapy, and speech-language pathology services may be provided for purposes of symptom control or to enable the individual beneficiary to maintain activities of daily living and basic functional skills.

Core hospice services include nursing care, physician services, medical social services, and counseling. All core services must routinely be provided by hospice employees with the exception of physician services, which may be contracted as outlined in section 4445 of the Balanced Budget Act of 1997. Supplemental services may be contracted for during periods of peak beneficiary loads and to obtain physician specialty services. All personnel must meet applicable state and federal licensing/certification requirements.

When a beneficiary qualifies for state plan services and chooses to be certified for hospice end of life services, the services available under the hospice benefit may not be duplicated by another Medicaid program.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 10/01/00 09/01/07
Section: Hospice	Section: 14.09	Pages: 1
Subject: Special Coverage Requirements	Cross Reference:	

Continuous Home Care

Continuous home care is to may be provided **only** during a period of crisis. A period of crisis is defined as a period in which a beneficiary requires continuous care, ~~which is~~ primarily nursing care, to achieve palliation or management of acute medical symptoms.

~~The hospice must provide Nursing care must be provided by a registered nurse for a minimum of eight (8) hours of care by a Registered Nurse (RN) during a 24-hour day that begins and ends at midnight. This care need not be continuous (ex: e.g., four (4) hours could be provided in the morning and another four (4) hours provided in the evening of that day). However, a combined total of eight (8) hours of nursing care is required. Services provided by a Nurse Practitioner (NP) that, in the absence of a NP, would be performed by an RN will be paid at the same continuous home care rate. LPN (Licensed Practical Nurse), homemaker, or aide services must be provided continuously for that day to supplement the nursing care. may be provided to supplement the nursing care.~~

Continuous home care is covered when it is provided to maintain ~~an individual~~ the beneficiary at home during a medical crisis. If less skilled care (less than eight (8) hours of R.N. care) is needed on a continuous basis to enable the ~~person~~ beneficiary to remain at home, ~~this care it~~ is covered as routine home care.

Continuous home care may not be provided when the hospice beneficiary is a nursing home resident or an inpatient of a free-standing hospice.

Respite Care

Respite care is short-term inpatient care provided to the ~~individual~~ beneficiary only when necessary to relieve the family members or other persons caring for the ~~individual~~ beneficiary at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five (5) consecutive days at a time.

Respite care may not be provided when the hospice beneficiary is a nursing home resident, is an inpatient of a free-standing hospice, or the services are a duplication of any other like services being delivered to the beneficiary .

Bereavement Counseling

Bereavement counseling consists of counseling services provided to the ~~individual's~~ beneficiary's family after the ~~individual's~~ beneficiary's death. Bereavement counseling is a required hospice service, but it is not reimbursable reimbursed separately.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 12/01/05 09/01/07
Section: Hospice	Section: 14.10	
Subject: Hospice Reimbursement	Pages: 4	
	Cross Reference: Nursing Facility 36.0	

With the exception of payment of for attending physician services, Medicaid payment reimbursement for hospice care is made at one of four (4) predetermined rates for each day in which an individual that the beneficiary 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 beneficiary.

Levels of Care

There are The four (4) levels of care into which each day of care is classified are as follows:

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,~~ For information on beneficiaries residing in a nursing facility (Revenue Code 659) refer to: "Reimbursement for Beneficiaries in a Nursing Facility Residents" in this section of the manual.

For each ~~Each~~ day that an individual the beneficiary is under the care of a hospice, Medicaid will pay reimburse the hospice an amount applicable to the type and intensity of the services furnished to the individual beneficiary for that day. For continuous home care, a registered nurse must have provided a minimum of eight (8) 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 reimburse the hospice the routine home care rate for each day the beneficiary is under the care of the hospice. ~~This~~ The rate is paid will be reimbursed 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 reimburse the hospice at the ~~continuous home care~~ an hourly rate when for continuous home care is provided which includes at least a minimum of 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~~ Every hour or part of an hour of continuous care furnished, the hourly rate is paid for will be reimbursed at the hourly rate up to

twenty-four (24) hours per day. ~~This~~ **The rate is not payable for when the hospice beneficiary is a resident of a free-standing hospice or nursing facility or an inpatient of a free-standing hospice.**

- **Inpatient Respite Care**

Medicaid will ~~pay~~ reimburse the hospice at the an inpatient respite care rate for each day in which the beneficiary stays in an approved inpatient respite 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~~ be reimbursed at the routine home care rate. **This rate is not payable for when the hospice beneficiary is a resident of a free-standing hospice or nursing facility or an inpatient of a free-standing hospice.**

- **General Inpatient Care**

~~The hospice reimburses the facility that provides the inpatient care to their patients.~~ Medicaid will ~~pay~~ reimburse 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.~~

Respite and general inpatient days are payable to the hospice. The hospice is responsible for reimbursing the facility that provides the inpatient care.

Date of Discharge

Medicaid will not reimburse for the date of discharge or the date of death.

Limitation on Payments Reimbursement for Inpatient Care

Payments Reimbursement 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~~ **The** limitation is applied once each year at the end of the hospice "cap period" (11/1-10/31) (November 1st-October 31st). ~~This~~ **The** 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 Reimbursement for Physician Services under Hospice

The basic ~~payment~~ reimbursement 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~~ example, 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~~ serve on a volunteer or contracted basis, the only services that may be billed by the attending physician are the physician's personal professional services.

Reimbursement for Beneficiaries in a 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. For DOM purposes, beneficiaries residing in a nursing facility may elect to receive hospice benefits and the nursing facility may be considered the beneficiary's place of residence. In addition to the hospice reimbursement for services, the hospice may also request receive reimbursement for room and board. of the beneficiary residing in a nursing facility. DOM reimburses room Room and board will be reimbursed to the hospice at 95% of the nursing home's established Medicaid per diem. The hospice reimburses the facility must reimburse the nursing 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 appropriate UB claim form or appropriate ESC format. This revenue Revenue code 659 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 beneficiary's hospice care and the facility agrees to provide room and board to the individual beneficiary. ~~In this context, the The term "room and board" includes performance of personal care services, including assistance in the activities of daily living, in and socializing activities, administration of medication, maintaining the cleanliness of a resident's the beneficiary's room, and supervision supervising and assisting the beneficiary in the use of durable medical equipment and prescribed~~

therapies (including palliative therapy). **These services are considered part of the per diem rate and will not be reimbursed separately.**

The nursing facility where the beneficiary resides is responsible for completing a ~~DOM-317~~ DOM-317 form when the beneficiary is admitted, transferred, discharged or expires in the facility. The ~~DOM-317~~ DOM-317 form documents the most recent date of Medicaid eligibility and the amount of Medicaid income (beneficiary liability) due from the beneficiary each month. Medicaid income is the amount of money the resident beneficiary in the nursing facility must pay toward the cost of his/her care. The nursing facility must provide the hospice provider with a verbal/written monthly account of the beneficiary Medicaid income.

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~~ ensuring that the beneficiary's Medicaid income is collected for the hospice dates of service provided ~~to the beneficiary~~ while the beneficiary is residing in the nursing facility. If the beneficiary is Medicaid only, DOM will reimburse for revenue codes 651 and 659. If the beneficiary is a dual eligible, DOM will reimburse for revenue code 659.

DOM does not reimburse the hospice provider for nursing facility bed-hold days. Refer to Nursing Facility, Section 36 in this manual.

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

Division of Medicaid	New:	Date:
State of Mississippi	Revised: X	Date: 10/01/00
Provider Policy Manual	Current:	09/01/07
Section: Hospice	Section: 14.11	
	Pages: 1	
Subject: Hospice Payment Groups by Counties County	Cross Reference:	

The Mississippi 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 payment group for each county is listed below.

Group 1

Adams	Franklin	Leake	Pike	Walthall
Alcorn	George	Lee	Pontotoc	Warren
Amite	Greene	Leflore	Prentiss	Washington
Attala	Grenada	Lincoln	Quitman	Wayne
Benton	Holmes	Lowndes	Scott	Webster
Bolivar	Humphreys	Marion	Sharkey	Wilkinson
Calhoun	Issaquena	Marshall	Simpson	Winston
Carroll	Itawamba	Monroe	Smith	Yalobusha
Chickasaw	Jasper	Montgomery	Stone	Yazoo
Choctaw	Jefferson	Neshoba	Sunflower	
Claiborne	Jefferson Davis	Newton	Tallahatchie	
Clarke	Jones	Noxubee	Tate	
Clay	Kemper	Oktibbeha	Tippah	
Coahoma	Lafayette	Panola	Tishomingo	
Copiah	Lauderdale	Pearl River	Tunica	
Covington	Lawrence	Perry	Union	

Group 2

Hancock
Harrison
Jackson
Stone

Group 3

Copiah
Hinds
Madison
Rankin
Simpson

Group 4

Forrest
Lamar
Perry

Group 5

None

Group 6

Desoto
Marshall
Tate
Tunica

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 06/01/05 09/01/07
Section: Hospice	Section: 14.12	
Subject: Documentation Requirements	Pages: 1	
	Cross Reference: General Policy 7.0	

All professional and institutional providers participating in the Medicaid program are required to maintain records that disclose the services rendered and billed under the program and, upon request, to make such records available to representatives of DOM to substantiate any or all claims. These records should be retained a minimum of five (5) years in order to comply with all state and federal regulations and laws.

In order for DOM to fulfill its obligations to verify services to Medicaid beneficiaries and paid for by Medicaid, the hospice must maintain auditable records that will substantiate the claim submitted to Medicaid.

At a minimum, the hospice medical records must contain the following on each beneficiary:

- Physician's certification of terminal illness for each enrollment period
- A diagnosis consistent with a terminal stage of six (6) months or less
- The original copy of each period of enrollment signed by the beneficiary or beneficiary/legal representative
- The original copy of the election statement signed by the beneficiary or beneficiary/legal representative and the hospice provider
- The original copy of the disenrollment form signed by the beneficiary or beneficiary/legal representative and the hospice provider
- A plan of care that supports each hospice service rendered
- Treatment rendered
- Documentation to show relationship of the treatment plan and medications to the terminal illness
- Provider's signature or initials on all medical records

In addition to the general requirements noted above, providers should refer to documentation requirements found in General Policy, Section 7.03 in this manual.

~~Providers must maintain proper and complete documentation to verify the services provided. The provider has full responsibility for maintaining documentation to justify the services provided.~~

~~DOM, the fiscal agent, Medicaid fraud control unit, state auditor, Department of Health and Human Services, office of the Inspector General, and any of their designated representatives, have the authority to request any beneficiary records at any time to conduct a random sampling review and/or document any services billed by the hospice provider.~~

~~If a hospice's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the agency will be asked to refund to the Mississippi Medicaid Program any money received for such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.~~

~~A hospice provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the hospice provider as a provider of Medicaid services.~~

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 10/01/00 09/01/07
Section: Hospice Subject: Transportation	Section: 14.13 Pages: 1 Cross Reference: <u>Non-Emergency Transportation (NET) 12</u>	

If a beneficiary elects the hospice benefit and requires transportation, the following guidelines apply:

Covered Transportation

- If transportation for medical services relating to the terminal illness is required, the hospice provider will arrange for and be responsible for payment for such transportation.
- If the hospice benefit is elected during a period of hospitalization, the effective enrollment date into the hospice will be the hospital discharge date. Therefore, transportation from the hospital to the beneficiary's residence or to a free-standing hospice facility is the responsibility of the hospice provider.

Non-Covered Transportation

- If a the hospice beneficiary calls 911 for ambulance/medical assistance, the hospice benefit period is considered revoked and the hospice will not be responsible for any transportation services received by the beneficiary.
- If a the hospice beneficiary requests transportation for services that are not palliative in nature, the hospice provider will not be held responsible for payment of transport, however, the hospice provider should arrange non-emergency transportation through the Medicaid non-emergency transportation program.
- If the hospice beneficiary requires or seeks transportation for medical services unrelated to the terminal illness, the hospice provider is not responsible for payment of transport; however, the hospice provider should arrange non-emergency transportation through the Medicaid non-emergency transportation program.

Refer to Non-Emergency Transportation (NET), Section 12.0 in this manual for additional information.