

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.02</b>	
<b>Subject: Program Overview</b>	<b>Pages: 3</b>	
	<b>Cross Reference: Physician Certification/Re-Certification and Plan of Care 14.03</b>	
	<b>Revocation and Change of Hospice 14.06</b>	
	<b>Documentation Requirements 14.12</b>	

Admission to hospice and subsequent re-enrollment periods must be certified through the Division of Medicaid's Utilization Management and Quality Improvement Organization. Procedures and criteria set forth by the UM/QIO are applicable and are approved by the Division of Medicaid (DOM).

### **Hospice Services**

Hospice provides **palliative** treatment 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, 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.

---

---

## **Exceptions for Children Under the Age of 21**

According to the Patient Protection and Affordable Care Act of 2009 for Hospice, children under the age of 21 may receive hospice benefits including curative treatment upon the election of the hospice benefit without foregoing any other service to which the child is entitled under Medicaid.

## **Enrollment and 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 dis-enrolls, 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:

- 1<sup>st</sup> – 90 days
- 2<sup>nd</sup> – 90 days
- 3<sup>rd</sup> – 60 days - unlimited increments

To be eligible to elect hospice care under Medicaid, 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 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. Refer to section 14.03 Physician Certification/Plan of Care for documentation requirements. The Election Package at a minimum must be completed in order for the beneficiary to be enrolled in the Medicaid Hospice program.

The Election Package includes:

- 1) The Election Statement (DOM-1165-A) signed by the beneficiary,

The original document of each enrollment period signed by the beneficiary/legal representative; and the original election statement signed by the beneficiary/legal representative and the hospice provider;

- 2) The Enrollment Form (DOM 1165-B) completed by the hospice provider;
- 3) Physician's Certification/Re-certification (DOM 1165-C), with appropriate signatures for each enrollment period;  
A physician's certification and diagnosis consistent with a terminal stage of six (6) months or less must be documented;
- 4) All additional documentation as required in Provider Policy Manual section 14.12 Documentation Requirements.

## **Plan of Care**

Services must be provided under a written plan of care (POC). The POC must be established by the hospice's interdisciplinary team before hospice care is provided and it must be reviewed/revised as specified in Provider Policy Manual Section 14.03 Physician Certification/Re-Certification and Plan of Care.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.03</b> <b>Pages: 2</b>	<b>Cross Reference: Documentation Requirements 14.12</b>
<b>Subject: Physician Certification/Re-Certification and Plan of Care</b>		

All certification/recertification requirements under CFR 42, Part 418 must be met except as otherwise noted below and within the Hospice Provider Policy Manual sections.

### **Initial Certification to Hospice**

- The written initial certification statement must be signed by the medical director of the hospice OR the physician member of the hospice interdisciplinary group, AND the beneficiary's attending physician. The written certification must include a statement that the beneficiary's medical prognosis is six (6) months or less, and that hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions
- The attending physician is a doctor of medicine or osteopathy and is identified by the individual at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.
- The medical director of the hospice or physician member of the hospice interdisciplinary group and the beneficiary's attending/certifying physician MUST be different physicians. Medical certification is required by the individual's attending physician; however, if the beneficiary's primary attending physician and the hospice interdisciplinary physician or the hospice medical director is the same person, the documentation must be provided to show that this person has been treating the beneficiary for the end of life illness prior to admission.

### **Re-certification Requirements**

- The written re-certification statement must be signed by the medical director of the hospice OR the physician member of the hospice interdisciplinary group. The written certification must include a statement that the beneficiary's medical prognosis is six (6) months or less and that hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.

### **Other Certification Requirements**

- The physician signing the written certification/re-certification statement can be held liable for causing false claims to be submitted.
- If the written certification is not obtained prior to initiation of hospice care, a verbal certification must have been made. If the written order has not been received within 30 days of the verbal order, no prior authorization will be issued and the case is closed. A written certification must be obtained before billing for hospice services.
- According to the Patient Protection and Affordable Care Act of 2009 for Hospice, DOM will require a hospice physician to determine, in a face-to-face encounter, a patient's hospice eligibility prior to the 180<sup>th</sup> day recertification, and each subsequent recertification, and attest that such visit took place.
- Additional documentation is required at each certification period. Refer to Provider Policy manual Section 14.12 for documentation requirements policy.

---

---

The hospice must retain the certification/re-certification statement in the beneficiary's medical record. This must be maintained at the hospice site issued the provider license and DOM provider number.

### **Plan of Care**

Services must be provided under a written plan of care (POC). The POC must be implemented by a registered nurse and established by the hospice's interdisciplinary team/group (IDT or IDG) before hospice care is provided. The plan must include a comprehensive assessment of the beneficiary's needs and identification of the care/services including the management of discomfort and symptom relief. The POC must state in detail the scope and frequency of services needed to meet the beneficiary's and family's needs. 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. The POC must be signed by all members of the IDT or IDG and be regularly reviewed and updated as stated below:

1. Within 48 hours of the admission, a written plan of care must be developed for each beneficiary/family by a minimum of two (2) IDT or IDG members and approved by the full IDT or IDG and the Medical Director at the next meeting. The care provided to a beneficiary must be in accordance with the POC.
2. The plan of care is reviewed and updated at intervals specified in the POC, when the beneficiary's condition changes and a minimum of every 14 days for home care and every 7 days for general inpatient care, collaboratively with the IDT or IDG.
3. The hospice must retain the POC in the beneficiary's medical record. This must be maintained at the hospice site issued the provider license and DOM provider number.

### **Interdisciplinary Team or Group Description and Involvement**

An interdisciplinary team (IDT) or group(s) (IDG) designated by the hospice is composed of representatives from all the core services. The IDT/IDG must include at least a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor. The IDT/IDG is responsible for participation in the establishment of the plan of care; provision or supervision of the hospice care and services; periodic review and updating of the plan of care for each beneficiary receiving hospice care, and establishment of policies governing the day-to-day provision of hospice care and services. The IDT/IDG is required to hold regularly scheduled meetings to review the most current beneficiary/family assessment, evaluate care needs, and update the plan of care.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.04</b>	
<b>Subject: Beneficiary Election Requirements</b>	<b>Pages: 1</b> <b>Cross Reference: Waiver of Medicaid Services 14.05</b>	

The beneficiary/legal representative must elect hospice care in order to receive it. To elect hospice, the beneficiary/legal representative must sign and file an Election Statement with the hospice. The signed Election Statement (DOM 1165-A) allows Medicaid to make payments for hospice care in lieu of payments made for treatment of the condition for which hospice care is sought. Exceptions may be found in Section 14.05 of this manual.

The election to receive hospice care is considered continuous for each election period 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.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date:</b> <b>01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.05</b>	
<b>Subject: Waiver of Medicaid Services</b>	<b>Pages: 1</b>	<b>Cross Reference:</b>

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 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:
  - Services provided (either directly or under arrangement) by the designated hospice.
  - Services provided by the beneficiary's attending physician, if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.
  - Services provided as room, board, and services by a nursing facility if the beneficiary is a resident at the time the hospice election is made and Medicaid was paying for that service.

When a hospice benefit period is completed 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.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date:</b> <b>01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.06</b>	
<b>Subject: Revocation and Change of Hospice</b>	<b>Pages: 2</b> <b>Cross Reference:</b> <b>Dual Eligibles 14.07</b>	

## Revocation

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

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

The Disenrollment Form (DOM-1166) must be completed, signed and dated, filed in the beneficiary's medical record, and a copy transmitted to DOM's designee within forty-eight (48) hours of the disenrollment. Failure to comply will result in the hospice 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. For re-enrollment of a beneficiary after dis-enrollment, the hospice must provide all certification documentation as required for the appropriate certification period.

When the election 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.

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 Provider Policy manual Section 14.07 for Dual Eligibles policy.

## Change in Hospice Designation

The beneficiary may change the designation of hospice care once per election period. A change in the designated hospice is not considered a revocation of the election.

To change the designation of the hospice provider the beneficiary must file a signed statement with the current hospice and with the newly designated hospice. Each hospice provider must provide the other with a copy of the signed statement and both must file both statements in the beneficiary's medical record. The signed 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
- The date the change is effective. – **Medicaid will not reimburse for the date of discharge or the date of death.**

---

---

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 Election Package (DOM 1165 A, B, and C) on the next date of service. All forms must be sent to DOM's designee.

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.

Refer to <http://www.medicaid.ms.gov/providerforms.aspx> to retrieve a copy of the Election Package and Disenrollment forms.



<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.08</b>	
<b>Subject: Covered Services</b>	<b>Pages: 2</b> <b>Cross Reference: Special Coverage Requirements 14.09</b>	

Core hospice services include physician services, nursing care, medical social services, and counseling services. 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.

- Physician services performed by a physician as defined in 42 CFR 410.20. (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).
- Nursing care provided by a registered nurse (RN). The RN shall identify the beneficiary/family's physical, psychosocial, and environmental needs and reassess as needed but no less than every 14 days at the beneficiary's residence. When aide services are being provided, the registered nurse will make supervisory visits to the beneficiary's residence at least every other week to provide direct supervision, assess relationships, and evaluate care plan goals. For the initial visit, the RN must accompany the nurse aide.
- Medical social services provided by a licensed 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.
- Counseling services provided to the terminally ill beneficiary and the family members or other persons caring for the beneficiary at home.

Counseling, including dietary counseling, may be provided to train the beneficiary's family or other caregiver, and for the purpose of helping the beneficiary and those providing care to adjust to the beneficiary's approaching death.

- Medical appliances and supplies, drugs, and biologicals.

Only Medical appliances and supplies, drugs, and biologicals that are used primarily for the relief of pain and symptom control related to the beneficiary's terminal illness are covered per the approved written plan of care. 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.

- Hospice aide services furnished by qualified aides and homemaker services.

Hospice 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. The RN must visit the beneficiary's residence at least every two (2) weeks when aide services are being provided, and the visit must include an assessment of the aide services.

Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the 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 beneficiary to maintain activities of daily living and basic functional skills.

**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.**

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.09</b>	
<b>Subject: Special Coverage Requirements</b>	<b>Pages: 1</b> <b>Cross Reference:</b>	

### **Continuous Home Care**

Continuous home care 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, primarily nursing care, to achieve palliation or management of acute medical symptoms. The medical record must include specific documentation for each day of the crisis period.

The hospice must provide 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 e.g., four (4) hours could be provided in the morning and another four (4) hours in the evening. 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 may be provided to supplement the nursing care.

Continuous home care is covered when it is provided to maintain 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 beneficiary to remain at home, 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 beneficiary only when necessary to relieve the family members or other persons caring for the 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 beneficiary's family after the beneficiary's death up to twelve (12) months. Bereavement counseling is a required hospice service, but it is not reimbursed separately.

### **General Inpatient Care**

Short-term inpatient care may be provided in a participating hospice inpatient unit, hospital, or a participating SNF or NF that additionally meets the special hospice standards regarding patient and staffing areas. General inpatient care may be required for procedures necessary for pain control or acute symptom management which cannot feasibly be provided in other settings. Services provided in an inpatient setting must conform to the written plan of care and the medical record must included specific documentation for each day of the crisis period.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.10</b>	
<b>Subject: Reimbursement</b>	<b>Pages: 3</b>	
	<b>Cross Reference: Nursing Facility 36.0</b>	

With the exception of payment for attending physician services, Medicaid reimbursement for hospice care is made at one of four (4) predetermined rates for each day 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 rates are prospective rates. The rate paid for any particular day varies depending on the level of care furnished to the beneficiary.

### Levels of Care

The four (4) levels of care are as follows:

<b>HOSPICE SERVICES</b>	<b>UB REVENUE CODE</b>
Routine Home Care	651
Continuous Home Care	652
Inpatient Respite Care	655
General Inpatient Care	656

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

Each day that the beneficiary is under the care of a hospice, Medicaid will reimburse the hospice an amount applicable to the type and intensity of the services furnished to the 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 reimburse the hospice the routine home care rate for each day the beneficiary is under the care of the hospice. The rate 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 reimburse the hospice an hourly rate for continuous home care which includes a minimum of eight (8) hours of care rendered by a registered nurse. Every hour or part of an hour of continuous care will be reimbursed at the hourly rate up to twenty-four (24) hours per day. **The rate is not payable when the hospice beneficiary is a resident of a nursing facility or an inpatient of a free-standing hospice.**

---

---

- **Inpatient Respite Care**

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

- **General Inpatient Care**

Medicaid will 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 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.

### **Reimbursement for Physician Services under Hospice**

The basic 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 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 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**

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 receive reimbursement for room and board. Room and board will be reimbursed to the hospice at 95% of the nursing home's established Medicaid per diem. The

---

---

hospice must reimburse the 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 beneficiary's hospice care and the facility agrees to provide room and board to the beneficiary. All services included in the nursing facility per diem rate will not be reimbursed separately to the hospice. Refer to Provider Policy manual Section 36.07 for Per Diem Cover Services policy.

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 (beneficiary liability) due from the beneficiary each month. Medicaid income is the amount of money the beneficiary in the nursing facility must pay toward the cost. 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 ensuring that the beneficiary's Medicaid income is collected for the hospice dates of service provided 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 Provider Policy Manual Section 36.0 for Nursing Facility policy.

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

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date: 01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.12</b>	
<b>Subject: Documentation Requirements</b>	<b>Pages: 2</b> <b>Cross Reference: Maintenance of Records 7.03</b>	

At a minimum, hospice medical records must be maintained at the hospice site issued the provider license and provider number by DOM. Each record must contain the following for each beneficiary:

A. The Election Package which includes:

- 1) The Election Statement (DOM-1165-A) signed by the beneficiary;

The original document of each enrollment period signed by the beneficiary/legal representative; and the original election statement signed by the beneficiary/legal representative and the hospice provider;

- 2) The Enrollment Form (DOM 1165-B) completed by the Hospice provider;

- 3) Physician's Certification/Re-certification (DOM 1165-C), with appropriate signatures for each enrollment period;

A physician's certification and diagnosis consistent with a terminal stage of six (6) months or less must be documented;

- 4) Additional Documentation Requirements:

a) Initial 90 day physician certification requires:

- History and Physical (not older than 30 days from start of care date).
- A clinical explanation of why the prognosis is less than 6 months.
- Lab results.
- Test results.
- List of current hospice medications ordered.
- Use of a scale such as: Karnofsky Performance Status Scale, Palliative Performance Scale, or the Functional Assessment Tool (FAST).

b) 2<sup>nd</sup> 90 day physician certification requires:

- Registered nurse assessment which should include:
  1. Description of hospice diagnosis; description of changes in diagnoses.
  2. Pain level and pain management.
  3. Decrease in level of consciousness.
  4. ADL dependency.
  5. Nutritional status.
  6. Vital sign ranges.
- History of Disease progression.
- Lab values obtained since the previous certification.
- List of current hospice medications ordered.
- An updated scale such as: Karnofsky Performance Status Scale, Palliative Performance Scale, or the Functional Assessment Tool (FAST).

- 
- 
- 
- c) According to the Patient Protection and Affordable Care Act of 2009 for Hospice, DOM will require a hospice physician to determine, in a face-to-face encounter, a patient's hospice eligibility prior to the 180<sup>th</sup> day re-certification, and each subsequent re-certification, and attest that such visit took place.
- d) 1<sup>st</sup> 60 day subsequent period:
- Documentation required for Initial (4(a) above) and the 2<sup>nd</sup> 90 day requirements (4(b) above).
  - \*History and Physical is required and MUST not be more than 30 days older from start of recertification date.
- 2<sup>nd</sup> 60 day subsequent period:
- Documentation required for 2<sup>nd</sup> 90 day physician certification (4(b) above).
- e) Any additional re-certification period will be determined on a case by case basis as to whether the individual continues to meet medical necessity for hospice benefits. Adequate justification must be provided by the physician for review and approval for continuation in the Hospice program.
- B. The original Disenrollment Form (Form 1166) signed by the beneficiary/legal representative and the hospice provider, as required;
- C. An interdisciplinary Plan of Care that supports each hospice service rendered including needs, care, services and goals;
- D. Treatment rendered including:
- 1) Each discipline's visit or contact of the treatment or intervention rendered at the frequency ordered on the plan of care.
  - 2) Documentation to show relationship of the treatment plan and medications to the terminal illness.
  - 3) Provider's signature or initials on all medical records.
- E. An auditable medication list that is updated monthly and clearly indicates the medications the hospice paid related to the terminal illness. This list shall contain the name and address of the pharmacy that was paid. The medical record must include a medication list for each month of certification that clearly indicates which medications are being paid by the hospice.
- F. A monthly updated list of medical appliances and supplies related to the terminal illness paid for by the hospice; and the names and address(s) of the providers paid.

Each claim submitted to DOM is subject to audit and review for the required documentation to support the dates of service for each from and through date.

Refer to Provider Policy Manual Section 7.03 for Maintenance of Records policy.



<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date:</b> <b>Date: <del>09/01/07</del></b> <b>01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.02</b>	
<b>Subject: Program Overview</b>	<b>Pages: 2-3</b>	
	<b>Cross Reference: <u>Physician Certification/Re-Certification and Plan of Care 14.03</u></b>	
	<b><u>Revocation and Change of Hospice 14.06</u></b>	
	<b><u>Documentation Requirements 14.12</u></b>	

Admission to hospice and subsequent re-enrollment periods must be certified through the Division of Medicaid's Utilization Management and Quality Improvement Organization. Procedures and criteria set forth by the UM/QIO are applicable and are approved by the Division of Medicaid (DOM).

### **Hospice Services**

Hospice provides **palliative** treatment 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, 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.

---

---

## **Exceptions for Children Under the Age of 21**

According to the Patient Protection and Affordable Care Act of 2009 for Hospice, children under the age of 21 may receive hospice benefits including curative treatment upon the election of the hospice benefit without foregoing any other service to which the child is entitled under Medicaid.

## **Enrollment and 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 dis-enrolls, 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:

- 1<sup>st</sup> – 90 days
- 2<sup>nd</sup> – 90 days
- 3<sup>rd</sup> – 60 days - unlimited increments

To be eligible to elect hospice care under Medicaid, 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 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. Refer to section 14.03 Physician Certification/Plan of Care for documentation requirements. The Election Package at a minimum must be completed in order for the beneficiary to be enrolled in the Medicaid Hospice program.

The Election Package includes:

- 5) The Election Statement (DOM-1165-A) signed by the beneficiary. The original document of each enrollment period signed by the beneficiary/legal representative; and the original election statement signed by the beneficiary/legal representative and the hospice provider;
- 6) The Enrollment Form (DOM 1165-B) completed by the hospice provider;
- 7) Physician's Certification/Re-certification (DOM 1165-C), with appropriate signatures for each enrollment period: A physician's certification and diagnosis consistent with a terminal stage of six (6) months or less must be documented;
- 8) All additional documentation as required in Provider Policy Manual section 14.12 Documentation Requirements.

## **Plan of Care**

Services must be provided under a written plan of care (POC). The POC must be established by the hospice's interdisciplinary team before hospice care is provided and it must be reviewed/revised as specified in Provider Policy Manual Section 14.03 Physician Certification/Re-Certification and Plan of Care. at each enrollment period. 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 and/or nursing notes), must be retained in the beneficiary's medical record. 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.

### **Revocation and Change of Hospice**

Refer to Provider Policy Manual Section 14.06 for revocation and change of hospice policy.

### **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:

- 1<sup>st</sup> — 90 days
- 2<sup>nd</sup> — 90 days
- 3<sup>rd</sup> — 60 days — unlimited increments

To be eligible to elect hospice care under Medicaid, 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 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.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date:</b> <b>Date: 09/01/07</b> <b>01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.03</b>	
<b>Subject: Physician Certification/Re-Certification and Plan of Care</b>	<b>Pages: 1-2</b>	<b>Cross Reference: <u>Documentation Requirements 14.12</u></b>

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 six (6) months or less, 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, (example: history and physical or copies of hospital admit or discharge summaries).~~
- ~~A Hospice Election Form that is signed and dated by the beneficiary/legal representative and by the hospice provider. The hospice must retain the form in the beneficiary's case record.~~

All certification/recertification requirements under CFR 42, Part 418 must be met except as otherwise noted below and within the Hospice Provider Policy Manual sections.

### **Initial Certification to Hospice**

- The written initial certification statement must be signed by the medical director of the hospice OR the physician member of the hospice interdisciplinary group, AND the beneficiary's attending physician. The written certification must include a statement that the beneficiary's medical prognosis is six (6) months or less, and that hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions
- The attending physician is a doctor of medicine or osteopathy and is identified by the individual at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.
- The medical director of the hospice or physician member of the hospice interdisciplinary group and the beneficiary's attending/certifying physician MUST be different physicians. Medical certification is required by the individual's attending physician; however, if the beneficiary's primary attending physician and the hospice interdisciplinary physician or the hospice medical

- 
- 
- 
- director is the same person, the documentation must be provided to show that this person has been treating the beneficiary for the end of life illness prior to admission.

### **Re-certification Requirements**

- The written re-certification statement must be signed by the medical director of the hospice OR the physician member of the hospice interdisciplinary group. The written certification must include a statement that the beneficiary's medical prognosis is six (6) months or less and that hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.

### **Other Certification Requirements**

- The physician signing the written certification/re-certification statement can be held liable for causing false claims to be submitted.
- If the written certification is not obtained prior to initiation of hospice care, a verbal certification must have been made. If the written order has not been received within 30 days of the verbal order, no prior authorization will be issued and the case is closed. A written certification must be obtained before billing for hospice services.
- According to the Patient Protection and Affordable Care Act of 2009 for Hospice, DOM will require a hospice physician to determine, in a face-to-face encounter, a patient's hospice eligibility prior to the 180<sup>th</sup> day recertification, and each subsequent recertification, and attest that such visit took place.
- Additional documentation is required at each certification period. Refer to Provider Policy manual Section 14.12 for documentation requirements policy.

The hospice must retain the certification/re-certification statement in the beneficiary's medical record. This must be maintained at the hospice site issued the provider license and DOM provider number.

### **Plan of Care**

Services must be provided under a written plan of care (POC). The POC must be implemented by a registered nurse and established by the hospice's interdisciplinary team/group (IDT or IDG) before hospice care is provided. The plan must include a comprehensive assessment of the beneficiary's needs and identification of the care/services including the management of discomfort and symptom relief. The POC must state in detail the scope and frequency of services needed to meet the beneficiary's and family's needs. 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. The POC must be signed by all members of the IDT or IDG and be regularly reviewed and updated as stated below:

1. Within 48 hours of the admission, a written plan of care must be developed for each beneficiary/family by a minimum of two (2) IDT or IDG members and approved by the full IDT or IDG and the Medical Director at the next meeting. The care provided to a beneficiary must be in accordance with the POC.
2. The plan of care is reviewed and updated at intervals specified in the POC, when the beneficiary's condition changes and a minimum of every 14 days for home care and every 7 days for general inpatient care, collaboratively with the IDT or IDG.

- 
- 
- 
3. The hospice must retain the POC in the beneficiary's medical record. This must be maintained at the hospice site issued the provider license and DOM provider number.

**Interdisciplinary Team or Group Description and Involvement:**

An interdisciplinary team (IDT) or group(s) (IDG) designated by the hospice is composed of representatives from all the core services. The IDT/IDG must include at least a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor. The IDT/IDG is responsible for participation in the establishment of the plan of care; provision or supervision of the hospice care and services; periodic review and updating of the plan of care for each beneficiary receiving hospice care, and establishment of policies governing the day-to-day provision of hospice care and services. The IDT/IDG is required to hold regularly scheduled meetings to review the most current beneficiary/family assessment, evaluate care needs, and update the plan of care.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date:</b> <b>Date: <del>09/01/07</del></b> <b>01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.04</b>	
<b>Subject: <u>Beneficiary Election Procedures Requirements</u></b>	<b>Pages: 1</b>	<b>Cross Reference: <u>Waiver of Medicaid Services 14.05</u></b>

The beneficiary/legal representative must elect hospice care in order to receive it. To elect hospice, the beneficiary/legal representative must sign and file an Election Statement with the hospice. The signed Election Statement (DOM 1165-A) allows Medicaid to make payments for hospice care in lieu of payments made for treatment of the condition for which hospice care is sought. Exceptions may be found in Section 14.05 of this manual. ~~The hospice must retain the original copy of the Election Statement and the DOM 1165 Enrollment 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.~~

The election to receive hospice care is considered continuous ~~from the initial~~ for each 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.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date: Date: <del>09/01/07</del> 01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.05</b>	
<b>Subject: Waiver of Medicaid Services</b>	<b>Pages: 1</b> <b>Cross Reference:</b>	

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 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:
  - Services provided (either directly or under arrangement) by the designated hospice.
  - Services provided by the beneficiary's attending physician, if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.
  - Services provided as room, board, and services by a nursing facility if the 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).~~

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.



<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date:</b> <b>Date: 07/01/09</b> <b>01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.06</b>	
<b>Subject: <del>Election</del>, Revocation and Change of Hospice</b>	<b>Pages: 2</b>	<b>Cross Reference: Dual Eligibles 14.07</b>

## Election and Enrollment

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

- ~~• The name of the hospice that will provide care to the beneficiary~~
- ~~• The beneficiary's/legal representative's written acknowledgment that he/she has been given a full understanding of hospice care~~
- ~~• The beneficiary's/legal representative's written acknowledgment that he/she understands the listed Medicaid services that are waived by the election~~
- ~~• The hospice benefit period in which the beneficiary is enrolling (periods must be used in order)~~
- ~~• The signature of the hospice 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 Provider Policy Manual Section 14.07 for Dual Eligibles policy.~~

## Revocation

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

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

The Disenrollment Form (DOM-1166) must be completed, signed and dated, filed in the beneficiary's medical record, and a copy transmitted to DOM's ~~fiscal agent~~ designee within forty-eight (48) hours of the disenrollment. Failure to comply will result in the hospice 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. For re-enrollment of a beneficiary after dis-enrollment, the hospice must provide all certification documentation as required for the appropriate certification period.

When the election 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.

---

---

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 Provider Policy manual Section 14.07 for Dual Eligibles policy.

### **Change in Hospice Designation**

The beneficiary may change the designation of hospice care once per election period. A change in the designated hospice is not considered a revocation of the election.

To change the designation of the hospice provider the beneficiary must file a signed statement with the current hospice and with the newly designated hospice. Each hospice provider must provide the other with a copy of the signed statement and both must file both statements in the beneficiary's medical record. The signed 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
- The date the change is effective. – **Medicaid will not reimburse for the date of discharge or the date of death.**

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)~~ Election Package (DOM 1165 A,B, and C) on the next date of service. ~~Both~~ All forms must be ~~mailed~~ sent to DOM's fiscal agent designee. ~~The Election Statement must accompany the DOM-1165.~~

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.

Refer to <http://www.medicaid.ms.gov/providerforms.aspx> to ~~view~~ retrieve a copy of the Election Statement Package and Disenrollment forms.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date:</b> <b>Date: 09/01/07</b> <b>01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.08</b>	
<b>Subject: Covered Services</b>	<b>Pages: 2</b>	<b>Cross Reference: <u>Special Coverage Requirements 14.09</u></b>

DOM covers the following hospice services:

Core hospice services include physician services, nursing care, medical social services, and counseling services. 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.

- Physician services performed by a physician as defined in 42 CFR 410.20. (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).
- Nursing care provided by ~~or under the supervision of~~ a registered nurse (RN). The RN shall identify the beneficiary/family's physical, psychosocial, and environmental needs and reassess as needed but no less than every 14 days at the beneficiary's residence. When aide services are being provided, the registered nurse will make supervisory visits to the beneficiary's residence at least every other week to provide direct supervision, assess relationships, and evaluate care plan goals. For the initial visit, the RN must accompany the nurse aide.
- Medical social services provided by a licensed 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. (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 beneficiary and the family members or other persons caring for the beneficiary at home.

Counseling, including dietary counseling, may be provided to train the beneficiary's family or other caregiver, and for the purpose of helping the beneficiary and those providing care to adjust to the beneficiary's approaching death.

- ~~Short term inpatient care provided in a participating hospice inpatient unit, or a participating hospital or nursing facility that 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 furnished if procedures necessary for pain control or acute or chronic symptom management cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the beneficiary's family or other persons caring for the beneficiary at home.~~

- Medical appliances and supplies, drugs, and biologicals.

~~Only Medical appliances and supplies, drugs, and biologicals that are used primarily for the relief of pain and symptom control related to the beneficiary's terminal illness are covered per the approved written plan of care. 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. ~~Medical supplies include those that are part of the written plan of care.~~

- ~~Home health~~ Hospice aide services furnished by qualified aides and homemaker services.

~~Home health~~ Hospice 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. The RN must visit the beneficiary's residence at least every two (2) weeks when aide services are being provided, and the visit must include an assessment of the aide services.

Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the 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 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.**

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date:</b> <b>Date: <del>09/01/07</del></b> <b>01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.09</b>	
<b>Subject: Special Coverage Requirements</b>	<b>Pages: 1</b>	<b>Cross Reference:</b>

### **Continuous Home Care**

Continuous home care 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, primarily nursing care, to achieve palliation or management of acute medical symptoms. The medical record must include specific documentation for each day of the crisis period.

The hospice must provide 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 e.g., four (4) hours could be provided in the morning and another four (4) hours in the evening. 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 may be provided to supplement the nursing care.

Continuous home care is covered when it is provided to maintain 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 beneficiary to remain at home, 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 beneficiary only when necessary to relieve the family members or other persons caring for the 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 beneficiary's family after the beneficiary's death up to twelve (12) months. Bereavement counseling is a required hospice service, but it is not reimbursed separately.

### **General Inpatient Care**

Short-term inpatient care may be provided in a participating hospice inpatient unit, hospital, or a participating SNF or NF that additionally meets the special hospice standards regarding patient and staffing areas. General inpatient care may be required for procedures necessary for pain control or acute symptom management which cannot feasibly be provided in other settings. Services provided in an inpatient setting must conform to the written plan of care and the medical record must included specific documentation for each day of the crisis period.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date:</b> <b>Date: <del>09/01/07</del></b> <b>01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.10</b>	
<b>Subject: Reimbursement</b>	<b>Pages: 3</b>	
	<b>Cross Reference: Nursing Facility 36.0</b>	

With the exception of payment for attending physician services, Medicaid reimbursement for hospice care is made at one of four (4) predetermined rates for each day 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 rates are prospective rates. The rate paid for any particular day varies depending on the level of care furnished to the beneficiary.

### Levels of Care

The four (4) levels of care are as follows:

<b>HOSPICE SERVICES</b>	<b>UB REVENUE CODE</b>
Routine Home Care	651
Continuous Home Care	652
Inpatient Respite Care	655
General Inpatient Care	656

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

Each day that the beneficiary is under the care of a hospice, Medicaid will reimburse the hospice an amount applicable to the type and intensity of the services furnished to the 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 reimburse the hospice the routine home care rate for each day the beneficiary is under the care of the hospice. The rate 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 reimburse the hospice an hourly rate for continuous home care which includes a minimum of eight (8) hours of care rendered by a registered nurse. Every hour or part of an hour of continuous care will be reimbursed at the hourly rate up to twenty-four (24) hours per day. **The rate is not payable when the hospice beneficiary is a resident of a nursing facility or an inpatient of a free-standing hospice.**

---

---

- **Inpatient Respite Care**

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

- **General Inpatient Care**

Medicaid will 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 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 Reimbursement for Inpatient Care**

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. The limitation is applied once each year at the end of the hospice "cap period" (November 1<sup>st</sup> - October 31<sup>st</sup>). 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.

**Reimbursement for Physician Services under Hospice**

The basic 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 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 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**

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 receive reimbursement for room and board. Room and board will be reimbursed to the hospice at 95% of the nursing home's established Medicaid per diem. The hospice must reimburse the 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 beneficiary's hospice care and the facility agrees to provide room and board to the beneficiary. ~~The term "room and board" includes personal care services, assistance in the activities of daily living and socializing activities, administration of medication, maintaining the cleanliness of the beneficiary's room, and 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.** All services included in the nursing facility per diem rate will not be reimbursed separately to the hospice. Refer to Provider Policy manual Section 36.07 for Per Diem Cover Services policy.~~

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 (beneficiary liability) due from the beneficiary each month. Medicaid income is the amount of money the beneficiary in the nursing facility must pay toward the cost. 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 ensuring that the beneficiary's Medicaid income is collected for the hospice dates of service provided 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.~~ Refer to Provider Policy Manual Section 36.0 for Nursing Facility policy.

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



<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date: Date: 09/01/07 01/01/11</b>
<b>Section: Hospice</b>	<b>Section: 14.12</b>	
<b>Subject: Documentation Requirements</b>	<b>Pages: 1-2</b>	<b>Cross Reference: General Policy 7 Maintenance of Records 7.03</b>

At a minimum, hospice medical records must be maintained at the hospice site issued the provider license and provider number by DOM. Each record must contain the following ~~on~~ for 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/legal representative~~
- ~~• The original copy of the election statement signed by the beneficiary/legal representative and the hospice provider~~
- ~~• The original copy of the disenrollment form signed by the 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.~~

A. The Election Package which includes:

- 1) The Election Statement (DOM-1165-A) signed by the beneficiary;  
The original document of each enrollment period signed by the beneficiary/legal representative; and the original election statement signed by the beneficiary/legal representative and the hospice provider;
- 2) The Enrollment Form (DOM 1165-B) completed by the Hospice provider;
- 3) Physician's Certification/Re-certification (DOM 1165-C), with appropriate signatures for each enrollment period;  
A physician's certification and diagnosis consistent with a terminal stage of six (6) months or less must be documented;
- 4) Additional Documentation Requirements:
  - a) Initial 90 day physician certification requires:
    - History and Physical (not older than 30 days from start of care date).
    - A clinical explanation of why the prognosis is less than 6 months.
    - Lab results.

- 
- 
- Test results.
  - List of current hospice medications ordered.
  - Use of a scale such as: Karnofsky Performance Status Scale, Palliative Performance Scale, or the Functional Assessment Tool (FAST).
- b) 2<sup>nd</sup> 90 day physician certification requires:
- Registered nurse assessment which should include:
    7. Description of hospice diagnosis; description of changes in diagnoses.
    8. Pain level and pain management.
    9. Decrease in level of consciousness.
    10. ADL dependency.
    11. Nutritional status.
    12. Vital sign ranges.
  - History of Disease progression.
  - Lab values obtained since the previous certification.
  - List of current hospice medications ordered.
  - An updated scale such as: Karnofsky Performance Status Scale, Palliative Performance Scale, or the Functional Assessment Tool (FAST).
- c) According to the Patient Protection and Affordable Care Act of 2009 for Hospice, DOM will require a hospice physician to determine, in a face-to-face encounter, a patient's hospice eligibility prior to the 180<sup>th</sup> day re-certification, and each subsequent re-certification, and attest that such visit took place.
- d) 1<sup>st</sup> 60 day subsequent period:
- Documentation required for Initial (4(a) above) and the 2<sup>nd</sup> 90 day requirements (4(b) above).
  - \*History and Physical is required and MUST not be more than 30 days older from start of recertification date.
- 2<sup>nd</sup> 60 day subsequent period:
- Documentation required for 2<sup>nd</sup> 90 day physician certification (4(b) above)
- e) Any additional re-certification period will be determined on a case by case basis as to whether the individual continues to meet medical necessity for hospice benefits. Adequate justification must be provided by the physician for review and approval for continuation in the Hospice program.
- B. The original Disenrollment Form (Form 1166) signed by the beneficiary/legal representative and the hospice provider, as required;
- C. An interdisciplinary Plan of Care that supports each hospice service rendered including needs, care, services and goals;
- D. Treatment rendered including:
- 1) Each discipline's visit or contact of the treatment or intervention rendered at the frequency ordered on the plan of care.
  - 2) Documentation to show relationship of the treatment plan and medications to the terminal illness.

---

---

3) Provider's signature or initials on all medical records.

- E. An auditable medication list that is updated monthly and clearly indicates the medications the hospice paid related to the terminal illness. This list shall contain the name and address of the pharmacy that was paid. The medical record must include a medication list for each month of certification that clearly indicates which medications are being paid by the hospice.
- F. A monthly updated list of medical appliances and supplies related to the terminal illness paid for by the hospice; and the names and address(s) of the providers paid.

Each claim submitted to DOM is subject to audit and review for the required documentation to support the dates of service for each from and through date.

Refer to Provider Policy Manual Section 7.03 for Maintenance of Records policy.