



Hospice Provider Specific Policy

Revision Table

Revision Date	Sections Revised	Description
10/31/03	9.2	Correcting Revenue Center Codes from a 3-digit number to a 4-digit number.
12/10/03	6.3.1, 6.3.2, 6.3.3	Effective 12/10/03 "bed-hold" days are being reduced from 14 to 7 days per hospitalization in any 30-day period. This change is consistent with those made in the Long Term Care Provider Specific Policy Manual.
6/28/04	6.1.3	Corrected phone number for Kent & Sussex Counties Pre-Admission Screening Unit.
8/20/04	9.1 and 9.2	Providers do not use local codes to bill for Hospice services. Therefore, references to local codes are being removed.
10/06/05	Added new section 1.1.7	Clarification of policy regarding hospice and assisted living.
10/06/05	All sections referencing DSS	Changed to reflect the creation of the Division of Medicaid & Medical Assistance (DMMA).
08/15/08	Appendix C, D, and E. Sections 7.1.1, 7.1.1.1, 7.1.2, 7.1.3.2	Clarification of contact addresses and contact information under Hospice Notification.
09/18/08	Overview	Removed obsolete numbering.
10/08/08	9.2	Changed revenue code on Hospice service – Other
10/16/08	9.0	Clarified the 10/8/08 revision of section 9.0 revenue codes
4/8/09	10.0	Replaced current Patient's Hospice Activity Dates form with updated form.
4/8/09	7.1	Clarified Hospice Notification Requirements
4/8/09	5.0	Added new section titled General Inpatient Care
4/8/09	9.0	Added revenue code 0657
4/8/09	4.1	Clarified billing instructions for Physicians Services
4/30/09	1.1.4	Clarified the wording which addresses how providers are paid for servicing institutionalized individuals.
4/19/2010	1.1.7	Removed obsolete wording.
6/3/10	8.3	Update of hospice provider policy to meet Section 2302 of the Affordable Care Act.
3/27/12	Above the hospice overview	Updated policy to reflect that effective 04/01/2012 additional Medicaid populations will now be serviced through a Managed Care Organization (MCO).

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Hospice Provider Specific Policy Manual

This manual reflects the policies as they relate to Medicaid clients who are either exempt from managed care coverage, or enrolled with Diamond State Partners. However, to ensure correct coverage of pharmacy benefits, the hospice organization must comply with the Hospice Notification Requirements noted in Section 7.1.1.1 b for all clients.

Hospice services are included in the MCO benefits package. All Medicaid clients who are enrolled with an MCO must receive hospice services through the MCO.

1.0 Overview

1.1 Hospice Services

- 1.1.1 Hospice services will be provided in accordance with Sections 4305 through 4307 and 4308.2 of the State Medicaid Manual. These parts of the State Medicaid Manual are reproduced in their entirety in Appendix A and Appendix G of this manual.
- 1.1.2 An individual may elect to receive hospice care during one or more of the following election periods:
 - 1.1.2.1 An initial 90 day period
 - 1.1.2.2 A subsequent 90 day period
 - 1.1.2.3 Unlimited number of subsequent 60 day periods
- 1.1.3 The periods of care are available in the order listed and may be elected separately at different times.
- 1.1.4 A per diem amount will be paid to the hospice organization for days on which routine home care or continuous home care are provided to the client. For days on which hospice care is furnished to an individual residing in a Nursing Facility (NF), an Intermediate Care Facility for the Mentally Retarded (ICF/MR), or an Intermediate Care Facility/Institute for Mental Disease (ICF/IMD), the hospice provider will be paid 95% of the appropriate Medicaid reimbursement level for the nursing facility in which the hospice patient is residing, in addition to the per diem amount paid for routine home care and continuous home care.
- 1.1.5 The Medicare reimbursement cap will not be applied to Medicaid hospice providers.
- 1.1.6 Dually eligible beneficiaries must elect the Medicare hospice benefit at the same time that the Medicaid hospice benefit is elected in order to assure that Medicaid is the secondary payer.

2.0 Hospice Responsibility

2.1 Requirements

- 2.1.1 It is the responsibility of the hospice organization to maintain a detailed record that clearly documents that they have followed the policy cited in this manual. Claims for payment may be denied or dollars recovered if the record is insufficient to document that the policy is followed.
- 2.1.2 The hospice organization must clearly and accurately represent the clinical assessment of the patient's condition and the functional status when recommending and providing the necessary services.
- 2.1.3 The hospice organization has the ethical and programmatic responsibility to direct clients to the most appropriate, medically necessary, and cost-efficient care possible.

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3.0 Billing

3.1 Codes

- 3.1.1 The Delaware Medical Assistance Program (DMAP) uses CPT/HCPCS procedure codes as its listing of descriptive terms and identifying codes for reporting medical services and procedures performed by practitioners. The purpose of the terminology is to provide a uniform language that will accurately designate medical, surgical, and diagnostic services.
- 3.1.2 The DMAP uses revenue codes as its listing for reporting services and procedures performed by hospice organizations.
- 3.1.3 Valid hospice codes are found in Appendix B.

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4.0 Hospice Billing for Physician Services

4.1 General Instructions

- 4.1.1 The hospice must bill for physician services rendered to a hospice patient for a diagnosis related to the terminal illness in two circumstances:
- 4.1.1.1 Circumstance 1: When a physician employee of the hospice is performing services as an attending physician.
- 4.1.1.2 Circumstance 2: When the attending physician requests medically necessary services be provided by another doctor.
- 4.1.2 When billing the DMAP for these physician services, the hospice must use the procedure code that reflects what the physician would have billed the DMAP had (s)he been able to bill directly. For each claim line enter the procedure code and corresponding date of service. In addition, the following documentation must be attached to the UB-04 or if billing on the 837 Institutional claims attachments will be submitted as approved by the HIPAA claims attachment requirements.
- 4.1.2.1 Notes written by the physician at the time that the service was rendered that clearly documents the service given.
- 4.1.2.2 For Circumstance 1, a statement by hospice personnel that clearly establishes that the hospice physician employee is performing services as attending physician rather than acting in an administrative capacity for hospice.
- 4.1.3 When a physician is acting in an administrative capacity for hospice, the DMAP cannot be billed by anyone for these physician services.

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5.0 General Inpatient Care

5.1 General Instructions

- 5.1.1 Send an updated plan of care indicating Inpatient level of care to DMAP as required in section 7.1.3.2.
- 5.1.2 General inpatient care services are limited according to section 8.10 of this manual relating to date of discharge.
- 5.1.3 To determine the correct reimbursement, general inpatient care (revenue code 0656) must be submitted on a separate claim form.
- 5.1.4 The Patient Status field of the UB-04 must reflect the status of the general inpatient care services, not the status of the hospice benefit. If the client is no longer receiving general inpatient care services on the "to date of service", the claim must accurately reflect a discharge/expired status.

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6.0 Nursing Home Room/Board with Routine or Continuous Home Care

6.1 General Instructions

- 6.1.1 When hospice care is furnished to an individual residing in a nursing facility an additional reimbursement is made to the hospice on routine home care and continuous home care days to take into account the room and board furnished by the facility. The DMAP will reimburse the hospice the rate negotiated with the nursing facility by hospice or the DMAP capped rate, whichever is less. The hospice reimburses the nursing facility for these services
- 6.1.2 It is the responsibility of the hospice organization to ensure that the hospice patient is placed in an appropriately certified nursing facility bed. If Medicaid is reimbursing hospice for nursing home room and board, the hospice patient must be placed in a Medicaid certified bed.
- 6.1.3 All Medicaid clients/applicants entering a Nursing Facility (NF) must be processed through the Medicaid Pre Admission Screening Unit. It is the responsibility of the hospice organization to contact this unit prior to placement of a patient in a nursing home. This unit can be reached by dialing (302) 368-6610 in New Castle County and (302) 422-1416 in Kent and Sussex Counties.

6.2 Patient Pay

- 6.2.1 Medicaid's fiscal agent, HP Enterprise Services, LLC, will send a patient pay notice to the hospice organization for any hospice nursing home patient. The notice will indicate the patient pay amount, the effective date and the Medicaid number to be used for billing.
- 6.2.2 Please note the following:
- 6.2.2.1 If the resident has no income except a Supplemental Security Income (SSI) check, there will be no patient pay amount.
- 6.2.2.2 Non SSI clients retain a specified amount for personal needs.
- 6.2.2.3 Additional amounts of income may be protected from the client's income to cover medically necessary services not normally covered by the DMAP. These amounts may vary from month to month. A new patient pay notice will be generated whenever the patient pay amount changes.
- 6.2.2.4 The DMAP counts income the month it is received. A Social Security check received in January will be budgeted for January's patient pay amount. Similarly, lump sums will be budgeted in the month received even if it is for a prior period.

- 6.2.2.5 Collection of the patient pay amount from the applicant or his representative is the responsibility of the NF. It is the responsibility of the hospice organization to deduct the patient pay amount collected by the NF from the hospice bill.
- 6.2.2.6 It is the responsibility of the hospice to understand what is included in the DMAP NF per diem rate, to clearly communicate this to the NF, and to assure that the NF is not billing the patient/family for covered services. See Appendix F for a detailed listing of services included in the per diem.
- 6.2.2.7 If the hospice nursing home client is an SSI client, the local Social Security Office must be notified that the individual is institutionalized. Any SSI checks should not be cashed until authorized by the Social Security Office.
- 6.2.2.8 Whenever the hospice organization is billing for Nursing Home Room/Board With Routine or Continuous Home Care the following items must be clearly indicated on the UB92 or in the comment field of the electronic 837 Institutional transaction: the daily negotiated rate and the name and address of the facility.
- 6.2.2.9 Reserved

6.3 Temporary Absence for Hospitalization

- 6.3.1 If a client is hospitalized for a short period of time and is expected to return to the facility, payment may continue for a period of not more than 7 days provided that the nursing home agrees to hold the bed for the resident.
- 6.3.2 DMAP reimbursement is available for only 7 days within any 30-day period. The 30-day count begins with the first day of hospitalization or a day of hospitalization that immediately follows a previous 30-day period.
- 6.3.3 Patient pay amount may change because of temporary absence from the facility. The facility may ask the family to pay privately to hold a bed for a patient who is hospitalized longer than 7 days.

6.4 Temporary Absence for Personal Reasons

- 6.4.1 A patient may be absent from the nursing home for reasons other than hospitalization for a period of 18 days during the hospice election without interruption of payment to the hospice for room and board, as long as such absences are provided for in the patient's plan of care.
- 6.4.2 If a patient's physical condition is being negatively impacted by his emotional need to be in a family setting, prior approval maybe obtained for a waiver of the 18 day leave of absence limitation (for other than acute care hospitalization) from the Medical Review Team in order to allow the patient more time to visit with his family.

- 6.4.2.1 To obtain prior approval, a written request must be submitted by the hospice to the Medical Review Team. The mailing address for the DMAP state office is in the Index at the back of the General Policy.
- 6.4.3 The request must include the following information:
 - 6.4.3.1 Name of patient
 - 6.4.3.2 Patient's Delaware Medical Assistance ID number
 - 6.4.3.3 Reason for the request
 - 6.4.3.4 Medical summary
 - 6.4.3.5 Statement from the hospice medical director regarding the medical necessity of the patient being absent from the nursing home in excess of 18 days per year
 - 6.4.3.6 Anticipated frequency of absence
 - 6.4.3.7 The number of days the patient was absent from the facility previously
- 6.4.4 If prior approval is granted, the hospice will receive written notification.

6.5 Discharge/Death

- 6.5.1 If a patient dies or is discharged from a nursing home, the DMAP will not pay room and board for the day of discharge or death.

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7.0 Hospice Notification

7.1 Requirements

- 7.1.1 The hospice is required to notify the DMAP immediately by contacting the Medicaid Services Specialist, by telephone (the telephone number for the DMMA Robscott state office is located in the Index, section 20.0, of the General Policy Manual), fax (the fax number for the DMMA Robscott state office is located in the Index, section 20.0, of the General Policy Manual), or by secure e-mail (contact the Medicaid Services Specialist for enrollment instructions).
- 7.1.1.1 a) When a Medicaid client becomes a hospice patient, hospice is required to submit a completed copy of Medicaid Form 1 - Patient's Hospice Activity Date with the required documentation: Physician Certification of Terminal Illness, Election Statement, and the Physician's Plan of Care. See Appendix C for a copy of this document.
- b) The Physician's Plan of Care must also be sent via fax to HP Enterprise Services, LLC (HP) Pharmacy Team. Drugs listed on the Physician's Care Plan that are related to the terminal illness should be identified by an asterisk (*).
- 7.1.1.2 When a patient expires. Hospice is required to submit a completed copy of Medicaid Form 2 - Patient's Expiration Date. See Appendix D for a copy of this document.
- 7.1.1.3 When a patient's hospice participation is revoked. Hospice is required to submit a copy of Medicaid Form 3 - Patient's Revocation Date. See Appendix E for a copy of this document.
- 7.1.2 Notification (7.1.1) must be followed by written confirmation (Medicaid Form 1 – Patient Hospice Election Information, 10.0 Appendix C, with attachments) before submitting claims for payment.
- 7.1.3 The hospice is required to notify the DMAP in writing within five (5) working days when any of the following events occur:
- 7.1.3.1 When a physician employee (volunteers are considered employees in this context) of the hospice changes. Hospice must describe the change and the effective date of this change.
- 7.1.3.2 When the physician's plan of treatment is updated/changed. Hospice is required to provide the DMAP with the most recent copy of the physician's plan of treatment. The updated Physician's Plan of Care must also be sent via fax to HP Enterprise Services, LLC (HP) Pharmacy Team. Drugs listed on the Physician's Care Plan that are related to the terminal illness should be identified by an asterisk (*).

- 7.1.3.3 When the Physician Certification is renewed. Hospice is required to provide the DMAP with a copy of the physician certification for each subsequent benefit period.
- 7.1.4 It is essential for the DMAP to have written verification of each of these items in order to expedite proper claim processing and to ensure appropriate opening/closing of each case.

8.0 Appendix A - Requirements and Limits Applicable to Specific Services – 10-90/4305.2

8.1 4305. Hospice Services

Hospice care is an optional benefit under the Medicaid program. A hospice is 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 meets the Medicare conditions of participation for hospices and has a valid provider agreement. Hospice coverage must be available for at least 210 days and may be subdivided into two or more periods at State option. (The Medicare benefit is divided into two 90-day periods and one 30-day period.)

In order to be eligible to elect hospice care under Medicaid, an individual must be certified as being terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less.

8.2 4305.1 Physician Certification

The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures:

- For the first period of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician (if the individual has an attending physician).

If the hospice does not obtain a written certification within two days after the initiation of hospice care, a verbal certification may be obtained within these 2 days, and a written certification obtained no later than 8 days after care is initiated. If these requirements are not met, no payment can be made for days prior to the certification. The attending physician is a physician who 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.

- For any subsequent period, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must

include the statement that the individual's medical prognosis is that his or her life expectancy is six months or less if the terminal illness runs its normal course and the signature(s) of the physician(s). The hospice must retain the certification statements.

8.3 Election Procedures

8.3.1 If an individual elects to receive hospice care, he or she must file an election statement with a particular hospice. An election may also be filed by a representative acting pursuant to State law. With respect to an individual granted the power of attorney for the patient, State law determines the extent to which the individual may act on the patient's behalf.

An election to receive hospice care is considered to continue through the initial election period and through any subsequent election periods without a break in care as long as the individual remains in the care of the hospice and does not revoke the election. An individual may designate an effective date for the election period that begins with the first day of hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

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. An addition to hospice reimbursement is made in this situation to take the room and board provided by the facility into account. (See §4308.2). The hospice reimburses the facility for these services.

An individual 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 (unless provided under arrangements made by the designated hospice); and

An individual, age 21 or older, must also waive all rights to Medicaid payments for the duration of the election of hospice care for the following services:

- Any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services
 - Provided (either directly or under arrangement) by the designated hospice;
 - Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services; or

- Provided as room and board by a nursing facility if the individual is a resident.

After the hospice benefit expires, the patient's waiver of these other Medicaid benefits expires and coverage of certain services provided through the hospice may be possible. For example, if the hospice must provide acute inpatient care in a hospital with which it has an agreement, the hospital could bill Medicaid for covered hospital services.

8.4 4305.3 Election, Revocation and Change of Hospice

The election statement must include the following items of information:

- Identification of the particular hospice that will provide care to the individual;
- The individual's or representative's acknowledgement that he or she has been given a full understanding of hospice care;
- The individual's or representative's acknowledgement that he or she understands that
- The Medicaid services listed in §4305.2 are waived by the election;
- The effective date of the election; and
- The signature of the individual or representative.

An individual or representative may revoke the election of hospice care at any time. To revoke the election of hospice care, the individual must file a document with the hospice that includes a signed statement that the individual revokes the election for Medicaid coverage of hospice care and the date that the revocation is to be effective. The individual forfeits coverage for any remaining days in that election period if the benefit is broken into periods. If it is not or no periods are left, the revocation is permanent. An individual may not designate an effective date earlier than the date that the revocation is made.

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

An individual may change, once in each election period, the designation of the particular hospice from which he or she elects to receive hospice care. The change of the designated hospice is not considered a revocation of the election. To change the designation of hospice programs, the individual must file, with the hospice from which he or she has received care and with the newly designated hospice, a signed statement that includes the following information: the name of the hospice from which the individual has received care, the name of the hospice from which he or she plans to receive care and the date the change is effective. A change of ownership of a hospice is not considered a change in the patient's designation of a hospice, and requires no action on the patient's part.

If an individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected and revoked simultaneously under both programs if the State offers the benefit.

8.5 4305.4 Requirements for Coverage

To be covered, a certification that the individual is terminally ill must have been completed as set forth in §4305.1, and hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care in accordance with §4305.2, and a plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care.

In establishing the initial plan of care, the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member (nurse, physician, medical social worker or counselor) before writing the initial plan of care.

At least one of the persons involved in developing the initial plan must be a nurse or physician. This plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care. The other two members of the basic interdisciplinary group must review the initial plan of care and provide their input to the process of establishing the plan of care within two calendar days following the day of assessments.

8.6 4305.5 Covered Services

All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered 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's services performed by a physician (as defined in 42 CFR 410.20) except that 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 and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual'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 staff and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for 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 family or other person caring for the individual at home.

- Medical appliances and supplies, including drugs and biologicals. Only drugs as defined in §1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual'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 patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or 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 patient such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. 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 to carry out the plan of care.
- Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Nursing care, physicians' services, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees. Supplemental services may be contracted for during periods of peak patient loads and to obtain physician specialty services.

8.7 4305.6 Special Coverage Requirements

Continuous home care is to be provided only during a period of crisis. A period of crisis is a period in which a patient requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of 8 hours of care must be provided during a 24-hour day that begins and ends at midnight. This care need not be continuous, i.e., 4 hours could be provided in the morning and another 4 hours provided in the evening of that day. Homemaker and aide services may also be provided to supplement the nursing care. Continuous home care is covered when it is provided to maintain an individual at home during a medical crisis. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

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

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

8.8 4306 Hospice Reimbursement

With the exception of payment for physician services (see §4307) Medicaid payment for hospice care is made at one of four predetermined rates for each day in which an individual is under the care of the hospice. Establish rates no lower than the rates used under Part A of Title XVIII (Medicare), adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, using the same methodology used under Part A. The four rates are prospective rates. There are no retroactive adjustments other than the optional application of the "cap" on overall payments and the limitation on payments for inpatient care, if applicable. The rate paid for any particular day varies depending on the level of care furnished to the individual. The "cap" and the limitations on payment for inpatient care are described in sections that follow.

8.9 4306.1 Levels of Care

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

- Routine Home Care
- Continuous Home Care
- Inpatient Respite Care, or
- General Inpatient Care

For each day that an individual is under the care of a hospice, pay the hospice an amount applicable to the type and intensity of the services furnished to the individual for that day. For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the beneficiary on that day. A description of each level of care follows:

- A. Routine Home Care - Pay the hospice the routine home care rate for each day

the patient is under the care of the hospice and you do not pay at another rate. This rate is paid without regard to the volume or intensity of services provided on any given day.

B. Continuous Home Care - Pay the hospice at the continuous home care rate when continuous home care is provided. (See §4305.6.) The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of 8 hours per day must be provided. Pay the hospice for every hour or part of an hour of continuous care furnished up to a maximum of 24 hours a day.

C. Inpatient Respite Care - Pay the hospice at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. (See §4305.6.) Pay for respite care for a maximum of 5 days at a time including the date of admission but not counting the date of discharge. Pay for the sixth and any subsequent days at the routine home care rate.

D. General Inpatient Care - Pay at the general inpatient rate when general inpatient care is provided except as described in §4306.2.

8.10 4306.2 Date of Discharge

For the day of discharge from an inpatient unit, pay the appropriate home care rate unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient rate (general or respite) is paid for the discharge date.

8.11 4306.3 Hospice Payment Rates

The minimum national Medicaid hospice rates, before area wage adjustments for each of the categories of care described in §4306.1 are:

Routine Home Care Rate	\$ 79.85	
Continuous Home Care Rates	\$ 465.57	Full Rate-24 hours of care
	\$ 19.40	Hourly Rate
Inpatient Respite Care Rate	\$ 86.82	
General Inpatient Care Rate	\$ 354.73	

These rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. Under the Medicaid hospice benefit, no cost sharing may be imposed with respect to hospice services rendered to Medicaid clients. These rates are in effect for services provided on or after January 1, 1990.

Effective on or after April 1, 1990, the State may choose to establish hospice payment rates at higher amounts than those listed above. In no case may hospice payment amounts be established in amounts lower than the amounts listed above.

8.12 4306.4 Local Adjustment of Payment Rates

The payment rates in §4306.3 are adjusted for regional differences in wages, using indices published in Addenda A and B. To select the proper index for an area, first determine if the hospice is located in one of the Urban Areas listed in Addendum A. If so, use the index for that area. If the hospice is not listed as one of the Urban Areas in Addendum A, use the index number of the rural area for the State listed in Addendum B. If the index number for the applicable area is less than 0.8, use 0.8 as the index. Once the appropriate index figure is determined, the computation of the rates for a hospice can be made using the methodology contained in the following tables in this section. Table I indicates the portion of each of the

Continuous Home Care	----	----	----	----	----	----
Inpatient Respite	----	----	----	----	----	----
General Inpatient Care	----	----	----	----	----	----

Continuous Home Care Rate, adjusted for wages = $\$ \div 24 \text{ hours} = \$ \underline{\hspace{2cm}}$ Hourly Rate

* If index for an area is less than 0.8, use 0.8.

8.13 4306.5 Limitation on Payments for Inpatient Care

Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. 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 of the aggregate total number of days of hospice care provided to all Medicaid clients during that same period. The State may exclude Medicaid clients afflicted with Acquired Immunodeficiency Syndrome (AIDS) in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (11/1 – 10/31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate are not counted as inpatient days. Calculate the limitation as follows:

- The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicaid hospice care by 0.2.
- If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment is necessary.
- If the total number of days of inpatient care exceeded the maximum allowable number, the limitation is determined by:
 - 1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made,
 - 2. Multiplying excess inpatient care days by the routine home care rate,
 - 3. Adding together the amounts calculated in 1 and 2, and
 - 4. Comparing the amount I 3 with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement is refunded by the hospice.

8.14 4307. Payment For Physician Services Under Hospice

The basic payment rates for hospice care which are listed in Table I 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. These activities are generally performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. 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.

Pay the hospice for other physicians' services, such as direct patient care services, furnished to individual patients by hospice employees and for physician services furnished under arrangements made by the hospice unless the patient care services were furnished on a volunteer basis. At your option, the hospice may be reimbursed in accordance with the usual Medicaid reimbursement policy for physicians services contained in 42 CFR 447ff or in accordance with the Medicare methodology for payment of hospice physician services. This reimbursement is in addition to the daily rates. Total payments made to the hospice for these services are counted, along with total payments made at the various hospice daily rates, in determining whether the optional hospice cap amount has been exceeded.



Revenue Codes for Hospice Billing

9.0 Appendix B – Revenue Codes

Revenue Code	Description
0651	Hospice service - Routine Home Care
0652	Hospice service -Continuous Home Care
0655	Hospice service -Inpatient Respite Care
0656	Hospice service -General Inpatient Care
0657	Hospice service – Physician services
0658	Hospice service – Hospice Room and Board – Nursing Facility (effective 11/01/08 for all dates of service)
0659	Hospice service – Other (Discontinued 11/01/08)

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Form 1 – Patient’s Hospice Activity Date

10.0 Appendix C – Patient’s Hospice Activity Dates

TO: Medicaid Services Specialist

From: _____ NPI No. _____
 (Hospice Name) (Provider Number)

RE: Form 1 - Patient's Hospice Activity Date

Patient's Name: _____ Terminal Dx: _____

Patient's Medicaid ID#: _____ Hospice Election Date: _____

Hospice Signature: _____ Date: _____

Attending Physician: _____ Hospice Employee/Volunteer? YES NO
PRINT PHYSICIAN NAME

The form must be submitted with the following documentation:

Physician Certification of Terminal Illness –

For the first period of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician (if the individual has an attending physician). If the hospice cannot obtain the written certification within 2 calendar days, after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment. Incomplete forms will not be accepted.

Election Statement –

The election statement must include the following items of information: identification of the particular hospice that will provide care to the individuals; the individual's or representative's acknowledgment that he or she has been given a full understanding of hospice care; the individual's or representative's acknowledgment that he or she understands that the Medicaid services listed in S4305.2 are waived by the election; the effective date of the election; and, the signature of the individual or representative.

Physician's Care Plan -

Drugs listed on the Physician's Care Plan that are related to the terminal illness should be identified by an (*).

Mail or Fax (302-368-6593) this form and the required information to: Division
 of Medicaid & Medical Assistance, Robscott Building, 153 E. Chestnut Hill
 Road, Newark, DE, 19713, Attention: Medicaid Services Specialist.

NOTES: Electronic copy available upon request.

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Form 2 – Patient’s Expiration Date

11.0 Appendix D – Form 2 – Patient’s Expiration Date

TO: Medicaid Services Specialist

FROM:

RE: Form 2 - Patient's Expiration Date

Patient's Name: _____

Patient's Medicaid ID#: _____ Hospice election date: _____

Patient's expiration date: _____ Total # of billable days: _____

Hospice signature _____ Date: _____

Return this form and the required information to: Division of Medicaid and Medical Assistance, Robscott Building, 153 E. Chestnut Hill Road, Newark, DE, 19713, Attention: Medicaid Services Specialist.

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Form 3 – Patient’s Revocation Date

12.0 Appendix E – Patient’s Revocation Date

TO: Medicaid Services Specialist

FROM:

RE: Form 3 - Patient's Revocation Date

Patient's Name: _____

Patient's Medicaid ID#: _____ Hospice Election Date: _____

Date of Revocation: _____ Total # of Billable Days: _____

Hospice Signature: _____ Date: _____

Return this form and the required information to: Division of Medicaid and Medical Assistance, Robscott Building, 153 E. Chestnut Hill Road, Newark, DE, 19713, Attention: Medicaid Services Specialist.

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Nursing Home Responsibilities

13.0 Appendix F – Nursing Home Responsibilities

The following is a list of what Medicaid pays for and what the nursing home is required to supply.

1. The Facility Will Provide:
 - a. Medical Supplies
 1. Adhesive tape and Band-Aids
 2. Cellucotton, cotton, and cotton balls
 3. Disposable diapers and/or incontinent pads
 4. Gauzes and lambswool
 5. Paper handkerchiefs
 6. Thermometers
 7. Water proof sheets
 - b. Medical Equipment
 1. Bed pans, urinals, and commodes
 2. Catheters
 3. Crutches
 4. Emesis basins and enema bags
 5. Hot water bottles and ice bags
 6. Invalid rings
 7. Nasal atomizers
 8. Rectal tubes
 9. Rubber gloves and finger cots
 10. Syringes and needles
 11. Wheelchair and walkers
 - c. Non-Medical Supplies
 1. O.T. Supplies
 2. R.T. Supplies
 - d. Non-Legend Drugs and Medications
 1. Analgesic (aspirin, aspirin compounds, Tylenol, etc.)
 2. Antiseptics (mercurochrome, merthiolate, zephiran, betadine, etc.)
 3. Dental and oral (dentifrice's, denture adherents, mouthwash, etc.)

4. Dermatologics (phisohex, rubbing alcohol, soap, talcum powder, hydrogen peroxide, petrolatum, lotions, creams, ointments, etc.)
Diagnostics (acetest tablets, clinitest tablets, taptest, etc.)
 6. Laxatives, enemas, lubricants, (cascara, milk of magnesia, mineral oil, prepared enemas, etc.)
 7. Dietary supplements (sustagen, meritene, vitamins, etc.)
- e. Services
1. Shave
 2. Shampoo given by facility employees
 3. Laundering of linens
 4. Hand feeding
 5. Incontinence care and training
 6. Cost of billing procedures
 7. Personal laundry

The Patient and/or Family May be Billed for:

- a. Personal Items
 1. Cosmetics
 2. Cologne, perfume, aftershave, etc.
 3. Letter paper, stamps, and greeting cards
 4. Newspapers and magazine subscriptions
 5. Clothing
 6. Cigarettes
 - b. Services
 1. Shampoo given by beautician
 2. Hair cut or set
 3. Permanent
 4. Personal dry cleaning
2. Federal law prohibits nursing homes from charging Medicaid clients or their families for items and services covered by Medicaid.
 3. Nursing homes that accept Medicaid cannot ask Medicaid clients or their families for contributions as a condition of admission or charge fees to supplement the Medicaid rate.
 - a. Federal regulations prohibit the displacement of a resident once admitted to a nursing home participating in the Medicaid program on the basis of a change in source of payment for the resident. One example of a prohibited action would occur when a Medicaid participating nursing home refuses to continue to care for a resident because the individual's source of payment has changed from private funds to Medicaid. A

second example would be when a nursing home terminated one or more services to a resident who goes on Medicaid. It is important to note there should be evidence that the nursing home's termination of service was based on a medical rather than a financial reason.

- b. Federal laws prohibit a nursing home from requiring a Medicaid eligible client or the legal custodian or guardian of a resident to supplement Medicaid coverage for basic care and services. This includes requiring continuation of a "private pay contract" once the resident becomes eligible for Medicaid; and/or asking for contributions, donations, or gifts as a condition of admission or continued stay.

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Additional Information for Nursing Home Facility Residents

14.0 Appendix G - 4308.2 Additional Amount for Nursing Facility Residents, State Medicaid Manual, Part 4 (CMS-Pub.45-4)

When hospice care is furnished to an individual residing in a nursing facility, pay the hospice an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility. This amount is determined in accordance with the rates established under §1902(a)(13) of the Act. The additional amount paid to the hospice on behalf of an individual residing in a nursing facility must equal at least 95 percent of the per diem rate that you would have paid to the nursing facility for that individual in that facility under your State plan. In this context, the term 'room and board' includes performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies. These additional payment amounts are not subject to the optional cap on overall reimbursement specified in §4308.

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