Hospice Provider Specific Policy Manual

Revision Date	Sections Revised	Description
3/01/2015	All	Manual was revised in accordance with the State Plan Amendment to include updated reimbursement methodologies and Section 2302 of the Affordable Care Act. DSP language has been removed, provider can bill for DSP until 12/31/2015

Hospice Provider Specific Policy Manual

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Hospice Provider Specific Policy Manual

This manual reflects the policies as they relate to Medicaid clients who are paid Fee for Service (FFS).

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. Please contact the appropriate MCO.

Clients under 21 years of age who elect to receive Medicaid hospice care may also receive concurrent Medicaid State Plan treatment for the terminal illness and other related conditions.

1.0 Overview of 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 Delaware Medical Assistance Program (DMAP) provider agreement.

In order to be eligible to elect hospice care under DMAP, 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.

1.1 Duration of Hospice Coverage – Election periods

1.1.1 An individual may elect to receive hospice care during one or more of the following election periods:

- An initial 90 day period
- A subsequent 90 day period
- Unlimited number of subsequent 60 day periods

1.1.2 If the individual becomes DMAP eligible within a previously elected Medicare benefit period, the DMAP benefit period will be adjusted to align with Medicare's benefit period(s).

1.1.3 A per diem amount will be paid to the hospice organization for days on which routine home care or continuous home care is provided to the client.

1.1.4 The Medicare reimbursement cap will not be applied to DMAP hospice providers.

1.1.5 If an individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected and revoked simultaneously under both programs in order to assure that DMAP is the secondary payer.

1.2 Physician Certification of Terminal Illness

1.2.1 Coordination of physician certification for terminal illness for Medicare dual eligible.

1.2.1.1 DMAP will accept the Medicare Physician Certification of terminal illness to fulfill the Medicaid requirement.

1.2.2 Timing of the certification:

- The hospice must obtain written certification of terminal illness for each of the periods listed, even if a single election continues in effect for an unlimited number of periods
- The hospice must obtain the written certification before it submits a claim for payment. 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.
- Certifications may be completed no more than 15 calendar days prior to the effective date of election. Recertifications may be completed no more than 15 calendar days prior to the start of the subsequent benefit period.

1.2.3 Content of the Certification

1.2.3.1 Certification will be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness. The certification must conform to the following requirements:

1.2.3.2 The certification must specify that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.

1.2.3.3 Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification. Initially, the clinical information may be provided verbally, and must be documented in the medical record and included as part of the hospice's eligibility assessment.

1.2.3.4 The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms.

- If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician's signature.
- If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.
- The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his/her examination of the patient.
- The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients.

1.2.3.5 All certifications and recertification’s must be signed and dated by the physician(s), and must include the benefit period number and dates to which the certification or recertification applies.

1.2.4 Sources of Certification

- For the initial 90-day period, the hospice must obtain written certification statements (and oral certification statements if required) from: 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. An 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 subsequent periods, the only requirement is certification by the medical director of the hospice or the physician member of the hospice interdisciplinary group.

1.2.5 Maintenance of certification records. Hospice staff must:

- Make an appropriate entry in the patient's medical record as soon as they receive an oral certification; and
- File written certifications in the medical record.

2.0 Hospice Responsibility

2.0.1 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 has been followed.

2.0.2 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.

2.0.3 The hospice organization has the ethical and programmatic responsibility to direct clients to the most appropriate, medically necessary, and cost-efficient care possible.

2.1 Hospice Requirements for Coverage

2.1.1 To be covered, a certification that the individual is terminally ill must be completed. Hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. A plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care.

2.1.2 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) in collaboration to finalize the patient’s needs before writing the initial plan of care.

2.1.3 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.

2.2 Covered Services

2.2.1 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 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 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 Social Security 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.

2.2.2 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 during periods of peak patient loads and to obtain physician specialty services.

2.3 Special Coverage Requirements

2.3.1 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.

2.3.2 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.

2.3.3 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.

3.0 Billing and Reimbursement

3.1 Codes

3.1.1 The 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 Section 9.0 titled Hospice Revenue Codes.

3.2 Reimbursement

3.2.1 CMS computes a set of prospective DMAP hospice rates based on the methodology used in setting Medicare hospice rates, which are adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. DMAP hospice payment rates are also adjusted for regional differences in wages, using indices published in the Federal Register. In no case may hospice payment amounts be established in amounts lower than the DMAP hospice amounts computed by CMS.

3.3 Levels of Care

3.3.1 Reimbursement for Hospice care will be made at one of four predetermined rates. For each day that an individual is under the care of a hospice, DMAP will pay the hospice an amount applicable to the type and intensity of the services furnished to the individual for that day. For continuous home care, the amount of payment is determined based on the number of hours of continuous care

furnished to the beneficiary on that day. There are four levels of care into which each day of care is classified; a description of each level of care follows:

A. Routine Home Care - The hospice is paid the routine home care rate for each day the patient is under the care of the hospice when no other level of care applies. This rate is paid without regard to the volume or intensity of services provided on any given day.

B. Continuous Home Care –The hospice is paid the continuous home care rate when continuous home care is provided. 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. The hospice will be paid 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 - The hospice will be paid the inpatient respite care rate for each day the beneficiary is in an approved inpatient facility and is receiving respite care. Respite care is paid 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 - DMAP will pay at the general inpatient rate when general inpatient care is provided except as described in section 3.4 of this manual. General Inpatient Care means short-term, general inpatient care provided either through an appropriately certified hospital or hospice inpatient facility to provide pain control and symptom management that cannot be accomplished in another setting.

3.4 Date of Discharge

3.4.1 For the day of discharge from an inpatient unit, the hospice is paid 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.

3.5 Limitations on Payments for Inpatient Care

3.5.1 Federal Medicaid requirements mandate that payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to DMAP patients. Beginning November 1 of each year and ending October 31, during the 12-month period 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 DMAP 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. The limitation is calculated as follows:

A. The maximum allowable number of inpatient days is calculated by multiplying the total number of days of DMAP hospice care by 0.2.

B. If the total number of days of inpatient care furnished to DMAP hospice patients is less than or equal to the maximum, no adjustment is necessary.

C. 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 in 3 with interim payments made to the hospice for inpatient care during the "cap period."

   5. Any excess reimbursement is refunded by the hospice.

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 with the appropriate revenue 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.

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.

5.1.2 General inpatient care services are limited according to section 3.4 of this manual relating to the 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.

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.

- Payment for Room and Board in a Nursing Facility (NF) or Intermediate Care Facility / Individuals with Intellectual Disability (ICF/IID) - For Medicaid beneficiaries who elect to receive hospice care while residing in a nursing facility or ICF/IID facility, in addition to the payment for routine care or continuous care referenced above, the hospice provider will also be reimbursed a per diem amount to cover room and board services provided by the nursing facility or ICF/IID facility. This reimbursement rate is equal to 95 percent of the base rate that would have been paid to the facility under DMAP policy.

- 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.

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/Central Intake 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 1-866-940-8963.

6.2 Patient Pay

6.2.1 Medicaid's fiscal agent, DXC Technology, 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 A new patient pay notice will be generated whenever the patient pay amount changes.

6.2.3 Collection of the patient pay amount from the applicant or his representative is the responsibility of the Nursing Facility (NF).

6.2.4 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 D for a detailed listing of services included in the per diem.

6.2.5 It is the responsibility of the hospice organization to deduct the patient pay amount collected by the NF from the hospice bill.

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 per calendar year 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.

6.5 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.

7.0 Hospice Notification Requirements

7.1 Requirements

7.1.1 The hospice is required to notify the DMAP immediately when a patient elects hospice care, when a patient expires, or when a patient revokes hospice services, by contacting the Medicaid Services Specialist. DMAP can be notified 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 (contact the Medicaid Services Specialist for the fax number).
- Secure e-mail (contact the Medicaid Services Specialist for secure e-mail enrollment instructions).

7.2 Notification

7.2.1 Notification to DMAP must be followed by written confirmation using Medicaid Form 1- Patient’s Hospice Activity Dates located in Section 10.0, Appendix A, before submitting claims for payment.

7.2.2 Medicaid Form 1 must be submitted with the following documentation:

- Physician Certification of Terminal Illness (details located in section 1.2 titled Physicians Certification of Terminal Illness).

- Election Statement (details located in subsection 8.1 titled Election Procedures)
- Physician's Care Plan which must also be sent to DMAP's fiscal agent/pharmacy team DXC. Contact information for DXC is located in the Index, Section 20.0, of the General Policy Manual.
- Drugs listed on the Physician's Care Plan that are related to the terminal illness should be identified by an asterisk (*).

7.3 Start Date of Service

7.3.1 The hospice begin date is determined by Medicaid as one of the following:

- The begin date on the patient's election statement.
- The date of the hospice election written notification (if section 7.1. is not adhered to).
- The start date of Medicaid eligibility.
- The following day after revocation of care from another DMAP Hospice provider.

7.4 Patient Expiration

7.4.1 When a FFS client expires, the hospice is required to submit a completed copy of Medicaid Form 2 - Patient's Expiration Date. See Section 11.0 Appendix B for a copy of this document.

7.5 Revocation

7.5.1 When a FFS patient's hospice participation is revoked, the hospice is required to submit a copy of Medicaid Form 3 - Patient's Revocation Date. See Section 12.0 Appendix C for a copy of this document.

7.6 Notification of Updates and Changes

7.6.1 The hospice is required to notify the DMAP in writing within five (5) working days when any of the following events occur for a FFS patient.

- 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.

- When the physician's Plan of Care is updated/changed. Hospice is required to provide the DMAP with the most recent copy of the physician's Plan of Care. The updated Physician's Plan of Care must also be sent via fax to DXC Technology (DXC) Pharmacy Team. Drugs listed on the Physician's Plan of Care that are related to the terminal illness should be identified by an asterisk (*).

- 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.

8.0 Hospice Election Requirements

8.1 Election Procedures

8.1.1 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.

8.1.2 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.

8.1.3 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. The hospice reimburses the facility for services described in Section 6.0.

8.1.4 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 the following,
    - The Medicaid services Relinquishment of Rights
    - The effective date of the election
- The signature of the individual or representative

8.2 Relinquishment of Rights

8.2.1 An individual must waive all rights to Medicaid payments for the following services for the duration of the election of hospice care.

- Hospice care provided by a hospice other than the hospice designated by the Individual (unless provided under arrangements made by the designated hospice); and

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

- 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.

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

8.3 Revocation and Change of Hospice

8.3.1 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 DMAP 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. 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 DMAP 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.

8.3.2 An individual may change the designation of the hospice provider from which he or she elects to receive care. To change hospice providers, submit a revocation form to the current provider with the date of revocation. Following the revocation date, the individual may elect hospice care from a different provider. The revocation date and the election date cannot overlap.

Revenue Codes for Hospice Billing

9.0 Hospice 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

Form 1 – Patient's Hospice Election Information

10.0 Appendix A – Patient's Hospice Activity Dates

To: Medicaid Services Specialist

From: _____ NPI: _____
(Provider name) (Provider Number)

Hospice Signature: _____ Date: _____
(Name of person filling out this form)

Patient's Name: _____ Terminal Dx: _____

Patient's Medicaid ID#: _____ Hospice Election 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**
- **Election Statement**
- **Physician's Plan of Care**

Send this form and required documentation by one of the following formats: 1) secure email*; 2) FAX*; or 3) USPS mail to **Division of Medicaid & Medical Assistance, Attention: Medicaid Services Specialist,** Robscott Building – 2A, 153 E. Chestnut Hill Road, Newark, DE, 19713**.**

* Contact the Medicaid Services Specialist for this information.

NOTES:
- **DMMA must be notified immediately of hospice election/change.**
- Electronic copy of this form is available upon request.
- Incomplete information will result in termination of hospice benefit.

	Form 2 – Patient's Expiration Date

11.0 Appendix B – Patient's Expiration Date

To: Medicaid Services Specialist

From: _____ NPI: _____
(Provider name) (Provider Number)

Hospice Signature: _____ Date: _____
(Name of person filling out this form)

Patient's Name: _____ Patient's Medicaid ID#: _____

Hospice Election Date: _____ Patient's Expiration Date: _____

Total Number of Billable Days: _____

Send this form and required documentation by one of the following formats: 1) secure email*; 2) FAX*; or 3) USPS mail to **Division of Medicaid & Medical Assistance, Attention: Medicaid Services Specialist,** Robscott Building – 2A, 153 E. Chestnut Hill Road, Newark, DE, 19713**.**

* Contact the Medicaid Services Specialist for this information.

NOTES:
- **DMMA must be notified immediately of hospice election/change.**
- Electronic copy available upon request.

	**Form 3 – Patient's Revocation Date**

12.0 Appendix C – Patient's Revocation Date

To: Medicaid Services Specialist

From: _____ NPI: _____
(Provider name) (Provider Number)

Hospice Representative: _____ Date: _____
(Name of person filling out this form)

Patient's Name: _____ Patient's Medicaid ID#: _____

Hospice Election Date: _____ Patient's Revocation Date: _____

Total Number of Billable Days: _____

Send this form and required documentation by one of the following formats: 1) secure email*; 2) FAX*; or 3) USPS mail to **Division of Medicaid & Medical Assistance, Attention: Medicaid Services Specialist,** Robscott Building – 2A, 153 E. Chestnut Hill Road, Newark, DE, 19713**.**

* Contact the Medicaid Services Specialist for this information.

NOTES:
- **DMMA must be notified immediately of hospice election/change.**
- Electronic copy available upon request.

Nursing Home Responsibilities

13.0 Appendix D– Nursing Home Responsibilities

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

I. 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 lamb's wool
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.)

5. 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

II. Federal law prohibits nursing homes from charging Medicaid clients or their families for items and services covered by Medicaid.

III. 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.