HOSPICE MANUAL

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Introduction

Hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals, meets the Medicare conditions of participation for hospices, is licensed by the Department of Health and Senior Services (DHSS), Section for Health Standards and Licensure, and has a valid MO HealthNet provider agreement. Reimbursement is limited to qualified MO HealthNet enrolled hospice providers rendering services to terminally ill patients who have elected hospice benefits.

House Bill 1139, passed by the 1988 Missouri General Assembly, authorized MO HealthNet coverage of hospice services when provided by a Medicare certified hospice.

The hospice benefit is designed to meet the needs of participants with life-limiting illnesses and to help their families cope with related problems and feelings. Hospice care is an approach to treatment that recognizes that the impending death of an individual warrants a change in focus from curative care to palliative care.

Hospice utilizes an interdisciplinary team to provide comprehensive services that are primarily directed toward keeping the patient at home with minimal disruption in normal activities and keeping the patient and family as physically and emotionally comfortable as possible. A hospice team is specially trained to provide pain relief, symptom management, and supportive services to terminally ill persons and to their families.

Section 1: Reimbursement Methodology

1.1 The Basis for Establishing a Rate of Payment

The MO HealthNet Division (MHD) is charged with establishing and administering the rate of payment for those medical services covered by the Missouri Title XIX Program. The Division establishes a rate of payment that meets the following goals:

- Ensures access to quality medical care for all participants by encouraging a sufficient number of providers
- Allows for no adverse impact on private-pay patients
- Assures a reasonable rate to protect the interests of the taxpayers and
- Provides incentives that encourage efficiency on the part of medical providers

Funds used to reimburse providers for services rendered to eligible participants are received in part from federal funds and supplemented by state funds to cover the costs. The amount of funding by the federal government is based on a percentage of the allowable expenditures. The percentage varies from program to program and in some cases different percentages for some services within the same program may apply. Funding from the federal government may be as little as 60% or as much as 90%; depending on the service and/or program. The balance of the allowable, (10-40%) is paid from state General Revenue appropriated funds.

Total expenditures for MO HealthNet must be within the appropriation limits established by the General Assembly. If the expenditures do not stay within the appropriation limits set by the General

Assembly and funds are insufficient to pay the full amount, then the payment for services may be reduced pro rata in proportion to the deficiency.

1.2 Hospice Services

Reimbursement for hospice services is made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by MHD to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charge (should be the provider's usual and customary charge to the general public for the service), or the maximum allowable per unit of service.

1.3 Determining a Fee

Under a fee system each procedure, service, medical supply, and equipment covered under a specific program has a maximum allowable fee established.

In determining what this fee should be, MHD uses the following guidelines:

- Recommendations from the State Medical Consultant and/or the provider subcommittee of the Medical Advisory Committee
- Medicare's allowable reasonable and customary charge payment or cost-related payment, if applicable
- Charge information obtained from providers in different areas of the state. Charges refer to the usual and customary fees for various services that are charged to the general public. Implicit in the use of charges as the basis for fees is the objective that charges for services be related to the cost of providing the services

MHD then determines a maximum allowable fee for the service based upon the recommendations, charge information reviewed and current appropriated funds.

Online Fee Schedule

MO HealthNet fee schedules are available online. The **online fee schedule** identifies covered and non-covered procedure codes, restrictions, allowed units and the MO HealthNet allowable fee per unit.

The **online fee schedule** is updated monthly and is intended as a reference not a guarantee for payment.

The online fee schedule allows for the downloading of individual files or the search for a specific fee schedule. Some procedure codes may be billed by multiple provider types. Categories within the Fee Schedule are set up by the service rendered and are not necessarily provider specific.

Refer to Section 2 for program specific benefits and limitations.

Section 2: Benefits and Limitations

2.1 Provider Participation Requirements

To participate in the MO HealthNet Hospice Program, the hospice agency must have Medicare and DHSS Hospice Certification.

In addition to the general requirements (Refer to Section 2 of the General Sections Manual) of provider participation, the following must be submitted to the MO HealthNet Division (MHD):

- A copy of the Medicare Hospice Certification which includes the Medicare number
- A copy of the Missouri DHSS Hospice Certification/License.
  A completed Hospice-nursing facility (NF) or intermediate care home contracts **(H-NFC)** form. This is a comprehensive list of nursing facilities with whom the hospice has a contract/agreement. The **Hospice-nursing facility contract update** is required for the automated claims processing of nursing home room and board claims. The contracts must be part of the hospice's permanent file and must be produced upon request. It must include the hospice name, hospice MO HealthNet provider identifier, the nursing home name, the nursing home MO HealthNet provider identifier, and the contract begin date. Do not complete the "End Date" column with dates in the future. The end date column is used only to notify MHD of an actual contract cancellation. The hospice must notify MHD when a new contract/agreement is signed or if a contract is canceled. This notification must also be submitted on a Hospice-NF or intermediate care home contracts form. The information from the H-NFC form is entered on the MHD hospice provider file and is accessed for claims processing. Hospice claims for nursing home room and board charges deny if this form is not submitted and updated when necessary.

2.2 Eligibility

The participant must be eligible for MO HealthNet coverage for each date of service in order for reimbursement to be made to a provider. The participant must also be certified as being terminally ill and must have elected to receive hospice services.

Managed Health Care Program

MO HealthNet

One method through which MO HealthNet provides services is a MO HealthNet Managed Health Care Delivery System. A basic package of services is offered to the participant by the health plan; however, some services are not included and are covered by MO HealthNet on a fee-for-service basis.

Hospice services are included as a plan benefit in Missouri's MO HealthNet managed care program.

The Managed Care plan is responsible for paying for hospice services if the patient goes on hospice prior to admitting to a nursing facility (NF) or intermediate care home and is enrolled in the Managed Care plan.

Fee-For-Service MO HealthNet is responsible for hospice services when a participant is enrolled in Managed Care and is in a NF or intermediate care home or admitted to a NF or intermediate care home prior to going on hospice. The participant will be disenrolled from the Managed Care plan after a level of care is determined or after 60 calendar days; whichever comes first.

Pending Eligibility

It is the hospice provider's responsibility to verify patients' MO HealthNet coverage. Eligibility dates can be verified by using the Interactive Voice Response (IVR) system at (573) 751-2896, through the website at eMOMED or by contacting the local Family Support Division's (FSD) Office.

When the hospice patient's MO HealthNet eligibility is pending or is suspect (the participant does not have an ID card or a new approval letter), it is suggested that the hospice provider periodically check to verify approval of eligibility prior to submission of election documentation.

Do not submit election documentation to MHD for a patient who has not been approved for MO HealthNet. The patient, patient's family or authorized representative may apply for MO HealthNet benefits at a local FSD office.

2.3 MO HealthNet Spenddown

Refer to Section 1 of the General Sections Manual.

2.4 Patient Liability/Surplus

It is a federal requirement that the MO HealthNet payment to a nursing facility (NF) or intermediate care home be reduced by a participant's income less certain deductions; (personal expenses, medical insurance, etc.). This income is called patient liability or patient surplus and is computed by a Family Support Division's (FSD) county office worker. The patient's liability/surplus amount must be applied to the hospice room and board payment when a participant who has been certified as needing NF or intermediate care home level of care elects hospice while the participant is a resident of a MO HealthNet certified NF intermediate care home or when a participant who has elected the hospice benefit enters a MO HealthNet certified NF or intermediate care home. (Refer to section 2 for definition of MO HealthNet certified NF or intermediate care home.)

Patient surplus is not applied the first month a participant, enrolled in hospice, is admitted to a MO HealthNet certified NF or intermediate home care if admission is any date after the first day of the month. If admission is the first day of the month, then the patient surplus is applied for that month. Surplus is applied to all subsequent months even if the participant is not in the facility on the first day of the month if nursing home room and board is billed for any portion of that month. This policy also applies in situations where a participant changes NFs or intermediate home care during a subsequent month.

The participant or the participant's representative is responsible for paying the surplus amount to the hospice so it can be applied toward the participant's room and board charge. The hospice may enter into a contractual agreement with the NF or intermediate home care whereby the facility collects the surplus from the participant or the participant's representative.

The applicable patient surplus amount is deducted from the MO HealthNet allowable room and board reimbursement for each month the participant continues to reside in the nursing home.

Monthly Billing for Nursing Home Room and Board

It is the MO HealthNet Division (MHD) policy that a hospice submits one bill per month for any participant in a nursing home for whom a surplus or liability amount applies. When the hospice patient has a surplus or liability amount, the surplus is subtracted from the allowed amount of the nursing home room and board claim. MHD does not complete the adjustment forms if surplus is incorrectly applied when multiple claims were submitted for a single month. It is the responsibility of the hospice provider to submit adjustments for multiple room and board claims billed and paid incorrectly.

When billing for more than one (1) month of hospice NF or intermediate care home, the provider must submit a separate claim form for each month of service.

MO HealthNet does not reimburse nursing facilities for the date of discharge; therefore, the hospice provider must not bill room and board charges to MO HealthNet for the date of discharge from the facility. This includes date of discharge home, transfer to hospital or other facility, and date of death. The hospice provider's charges for its routine care or continuous care services to the participant are payable for the date of discharge from the facility or from hospice care.

2.5 Identification of Hospice Participants

Most services related to the terminal illness must be billed by and are reimbursed to the hospice provider elected by the participant; therefore, it is important that all providers be able to readily identify participants who have elected hospice services.

When providers verify participant eligibility, the hospice participant is identified by a lock-in and hospice provider’s name. Eligibility may be verified by calling the Interactive Voice Response (IVR) system at (573) 751-2896, which allows the provider to inquire on participant eligibility, check amount information and claim information without having to talk to a specialist. Providers can obtain the same information through the website at **eMOMED**. Refer to Sections 1 and 3 of the General Sections Manual for more information.

Non-hospice providers are encouraged to contact the hospice indicated on the IVR or through the website at **eMOMED** prior to provision of service or when they have questions about whom to bill for a specific service.

2.6 Participant Eligibility for Hospice

To be eligible to elect hospice care under MO HealthNet, individuals must be certified by a physician as being terminally ill. Individuals are considered terminally ill if they have a medical prognosis that their life expectancy is six (6) months or less. Hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. Individuals must elect hospice care and agree to seek only palliative care for the duration of the hospice enrollment. Care may be provided in the home, a nursing facility, intermediate care home, or in a hospital. Participants must be made aware that by the election of hospice services, they waive MO HealthNet coverage of active treatment of the terminal condition.

Concurrent Care for Children

MO HealthNet hospice services for children (ages 0-20) may be concurrent with the care related to curative treatment of the condition for which a diagnosis of a terminal illness has been made. The hospice provider continues to be responsible for all services related to the palliation and support services for the terminally ill.

Claims for curative treatment services for children enrolled in hospice should be submitted for reimbursement by the provider of the service in the same manner as claims for individuals not enrolled in hospice. Claims for curative services will be reviewed on an individual basis.

2.7 Enrollment Process

There are five (5) basic components involved in the MO HealthNet participant's enrollment in hospice: Physician Certification of Terminal Illness, election procedures, Hospice Election Statement, assignment of an attending physician, and development of the plan of care. There are specific time frames attributed to the enrollment process.

Physician Certification of Terminal Illness

The hospice must obtain physician certification that an individual is terminally ill. The Physician Certification of Terminal Illness includes the statement that the individual's medical prognosis is a life expectancy of six (6) months or less and must contain the physician's signature(s) and be dated by the physician(s).

Certifications must be submitted timely for each hospice benefit period through the end of the election. The hospice must submit certification and/or recertification for specific benefit periods before billing for that time frame. If the certification date(s) for the specific benefit period is not keyed into the system, the hospice claims deny.

Anytime a patient leaves hospice**,** whether it is a revocation, discharge, or decertification, and then reelects hospice, it is considered a new election. For new elections, the hospice must provide an initial Certification of Terminal Illness with signatures of both the attending physician and hospice medical director. Claims deny for lack of two (2) signatures on the Physician Certification of Terminal Illness for the first period of an election.

Election Procedures

An individual who elects to receive hospice care, must file a Hospice 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 conservatorship (guardian) or the power of attorney for the patient, State law determines the extent to which the individual may act on the patient's behalf.

A Hospice Election Statement must be completed for each MO HealthNet hospice participant and for each participant eligible for both Medicare and MO HealthNet. Failure to complete all fields results in denial of hospice claims. An individual receiving hospice services as a private pay client who becomes eligible for MO HealthNet must sign a Hospice Election Statement, which must be submitted to MO HealthNet as an attachment to the election statement under which hospice care was initiated. The participant's hospice election date for which services may be reimbursed by MO HealthNet is no earlier than the first date of MO HealthNet eligibility.

Election Periods

An election to receive hospice care continues 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, does not revoke the election, or is not decertified by a hospice physician or the individual's attending physician.

The date the election is made is the date the participant or representative signs the Hospice Election Statement. An individual may designate an effective date for the election by the date of signature or by designating any subsequent date. An individual may not designate an effective date for the election that is earlier than the date of the signature.

An individual who is eligible for both Medicare and MO HealthNet must elect and revoke the hospice benefit simultaneously under both programs. The Medicare hospice benefit covers all hospice services other than nursing home room and board.

MO HealthNet follows Medicare election periods of 90-90-60 days, followed by an unlimited number of 60 day periods while the individual remains in hospice care. However, anytime a patient leaves hospice, whether it is a revocation, discharge, or decertification, and then reelects hospice, it is considered a new election, beginning with an initial certification period of 90 days that requires the certifications signed by both the attending physician and the hospice medical director or physician member of the hospice's interdisciplinary group.

Medicare/ MO HealthNet	90	90	60	60	60	60	…	60

Nursing Facility or intermediate care home Residence

For purposes of the MO HealthNet hospice benefit, a MO HealthNet certified nursing facility (NF) or intermediate care home can be considered the residence of a participant. A participant residing either at home or in a NF or intermediate care home may elect the hospice benefit. When the hospice provides care to an individual residing in a NF or intermediate care home, MO HealthNet can make

reimbursement to the hospice, in addition to routine (or continuous) home care days, for the room and board provided by the NF or intermediate care home. For MO HealthNet to reimburse the room and board, the hospice and the NF or intermediate home care must have a written agreement or contract, the hospice must notify MHD of the contract utilizing a Hospice-NF or intermediate care home **contracts form**, and the hospice must reimburse the nursing home for room and board services. (Refer to Section 2.)

Waiver of Rights to Services

An individual must waive all rights to MO HealthNet services related to the treatment of the terminal condition and any related conditions for which hospice care was elected, or for services that are equivalent to hospice care, except for services:

- Provided by the designated hospice
- Provided by another hospice under arrangements made by the designated hospice and
- 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

The participant's signature on the Hospice Election Statement is the individual's waiver of rights to any other related services. Services not related to terminal conditions are exempt from this waiver of rights.

MO HealthNet participants who elect hospice do not waive their right to other home and community-based services under the state MO HealthNet plan or a waiver, so long as the services are not duplicative of the services available under the Hospice Program.

Dually Eligible Hospice Patients (Medicare/MO HealthNet)

Any time a hospice patient is eligible for both Medicare and MO HealthNet at the time of election, the hospice election for both programs must be made simultaneously. Do not wait until the patient enters a nursing home to elect MO HealthNet hospice. Making the hospice election for both Medicare and MO HealthNet concurrently enables MO HealthNet to avoid duplication of payments for services covered under the Medicare Hospice benefit.

If the patient's MO HealthNet eligibility begins or the hospice becomes aware of the MO HealthNet eligibility after Medicare Hospice benefits have been elected, complete the informational portion of a MO HealthNet **Hospice Election Statement** and attach a copy of the Medicare election form indicating the original election date. The signature(s) and dates on the Medicare election may be used as verification of the participant's election date and consent to use hospice benefits when attached to the MO HealthNet Hospice Election Statement. The hospice must submit these forms to MHD as soon as possible.

ICD Diagnosis Codes

At least one valid ICD diagnosis code must be entered in fields #14 and #15 of the Hospice Election Statement. Only enter terminal ICD diagnosis code(s) on the election statement. Enter only one (1)

ICD diagnosis code unless the patient has more than one (1) terminal diagnosis. If the patient has multiple terminal diagnoses, the hospice is responsible for all care including prescriptions related to all diagnoses, not just the primary diagnosis. If the ICD diagnosis code is missing from the election form, all hospice claims will deny*.* If the terminal diagnosis changes or a new terminal diagnosis is assigned, MHD must be notified with a letter specifically stating that fact and identifying the additional ICD diagnosis code and its effective date.

Assignment of the Attending Physician

The attending physician is a physician who is a doctor of medicine or osteopathy and is identified by the individual, at the time the individual elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

The attending physician is the participant's physician of choice who participates in the establishment of the plan of care and works with the hospice team in caring for the patient. The physician continues to give the medical orders and may have privileges in hospice inpatient care. A hospice physician is available as a consultant on matters of specialized pain and symptom control and to provide physician care when the patient and/or the attending physician prefers. The MO HealthNet hospice election does not affect either the personal or financial relationship between a patient and the attending physician.

The attending physician's MO HealthNet provider identifier must be included on the Hospice Election Statement. If this number is not provided, MO HealthNet does not reimburse the attending physician for services/treatment related to the terminal illness.

If a hospice patient changes attending physicians, the hospice must notify the MHD Hospice Unit. The notification must include the patient's name and MO HealthNet Designated Client Number (DCN), a statement that the patient has chosen a new attending physician, the attending physician's name, and MO HealthNet provider identifier, and the effective date of change.

Development of the Plan of Care

After an individual has been certified as terminally ill and has elected hospice services, a plan of care must be established before services can be rendered. Information regarding the patient's condition and treatment should be as specific as possible. All services rendered to the participant 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 (1) other group member (nurse, physician, medical social worker, or counselor) before writing the initial plan of care. At least one (1) of the persons involved in developing the initial plan must be a nurse or physician and the physician must sign the plan of care. 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 (2) 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 (2) calendar days following the day of assessment. Signatures of all parties are required within 10 days of establishment of the plan of care. The initial

plan of care, as well as significant updates to the plan of care must be maintained in the hospice provider's file.

Pharmacy Reimbursement

The hospice provider is responsible for all medications needed for the palliation and management of the terminal illness and related conditions as required by federal regulation (42 CFR 418.96). The plan of care must indicate all medication the patient uses and whether the medication is related to the terminal illness. MO HealthNet reimburses MO HealthNet pharmacy providers for pharmacy claims which are not related to the hospice patient's terminal diagnosis. It is the responsibility of the hospice to provide documentation that verifies that specific medication is not related to the terminal diagnosis. The hospice should provide a letter or statement to the pharmacy that includes the following information:

- Patient name
- Patient MO HealthNet ID Number (DCN)
- Service dates
- Drug name(s)
- Statement that the named drug(s) are not the responsibility of the hospice

Medication List

A medication list must be compiled per individual patient and kept in the individual patient's file. It must include the patient's name, MO HealthNet ID number (DCN), the hospice provider's name, hospice MO HealthNet provider identifier, and an explanation or interpretation of the coding used on the medication list to identify whether the medication is needed for the palliation and management of the terminal illness or a related condition. MO HealthNet may provide reimbursement to the pharmacy when the medication is not related to the terminal illness or related conditions. The medication list must be updated each time there is a change in the patient's pharmaceuticals.

Claims for medications that are not related to the terminal illness or related conditions are submitted by the Pharmacy through the Pharmacy Point of Sale system. A listing of therapeutic drug classes assumed to be related to the terminal illness has been developed and can be viewed at the following link **therapeutic drug classes.** Claims for medications in the listed therapeutic drug classes are not reimbursed by MO HealthNet without prior authorization. MO HealthNet prior authorizes drugs on the listed therapeutic drug classes only when it is determined the drugs are unrelated to the terminal diagnosis or a related condition.

Prior Authorization

It is the hospice's responsibility to obtain prior authorization (PA) for drugs on the listing of therapeutic drug classes when the drug is not related to the terminal illness or related conditions. PA requests are processed by calling the Pharmacy and Medical Pre-Certification Help Desk at (800) 392-8030 or by faxing a **Hospice Drug PA** form to (573) 526-4650. This form is available on the MHD website at **Wipro forms**.

It is the hospice's responsibility to reimburse the pharmacy for drugs MO HealthNet has deemed related to the participant's terminal condition(s).

Time Frames for Submission of Forms

Effective management of the Hospice Program requires the timely submission of forms by the hospice provider. It is the hospice provider's responsibility to timely submit all documentation including the **Hospice Election Statement**, and **Physician Certification of Terminal Illness** forms, substantiating required signatures and dates to the MHDs' Program Operation's Hospice Unit. The Medicaid Management Information System (MMIS) claims processing system verifies receipt of the required documentation and the accuracy of signatures and dates. Payment of hospice claims is dependent upon receipt of correctly completed documentation. If accurate documentation is not submitted to MHD timely, hospice claims will deny. Late submissions can cause denial of services to participants, denial of payments to providers, and incorrect payments. Each piece of documentation must contain the participant's MO HealthNet Designated Client Number (DCN) for identification purposes.

The list below is to serve as a guide to aid the provider and MHD in effective management. The information listed below must be received by MHD within the number of days shown. (The days shown in the "DUE" column are counted from the date the form is executed.) Failure to submit required documentation within these guidelines may result in denial of hospice claims or recoupment of MO HealthNet payments.

Form	Signature Requirements	Due
• Hospice- nursing facility or intermediate care home **Contracts**	None	Due 15 days prior to billing for nursing facility or intermediate care home Room & Board
New Enrollment		
• **Hospice Election Statement**	Yes-See Section 3 of the Hospice manual for further information.	Due within five (5) days of execution
• **Physician Certification of Terminal Illness**	Yes-See Section 3 of the Hospice manual for further information.	Due within ten (10) days of Hospice Election
Updates to Enrollment Status		
• **Physician Certification of Terminal Illness** (recertification)	Yes-See Section 3 of the Hospice manual for further information.	Due within five (5) days of recertification due date

Disenrollmet: Notification of Termination of Hospice Benefits		
• **Revocation of MO HealthNet Hospice Benefit**	Yes-See Section 3 of the Hospice manual for further information	Due within five (5) days of the Revocation
• **Change of Designated Hospice Provider** (New hospice must submit all election documentation)	Yes-See Section 3 of the Hospice manual for further information	Due within five (5) days of the Change in Designated Hospice Provider
• **Decertification of Terminal Illness** by Physician	Yes-See Section 3 of the Hospice manual for further information	Due within five (5) days of the Decertification
• **Discharge Due to Patient Relocation**	Yes-See Section 3 of the Hospice manual for further information	Due within five (5) days of the Relocation
• **Notification of Death of Patient**	Yes-See Section 3 of the Hospice manual for further information	Due within five (5) days of the Death of Patient

Method of Submission of Documentation

The Hospice Election Statement, Physician Certification of Terminal Illness, and Notification of Termination of Hospice Benefit may be faxed to MHD at (573) 526-2041. Do not routinely follow the faxed election statement, physician certification, or notification of termination with a copy in the mail. If the faxed copies are not legible, MHD will request a mailed copy.

All other documentation may be mailed to:

MO HealthNet Division
Clinical Services Hospice Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

Prompt submission of forms ensures continuity of care for the hospice participant and reimbursement for the provider.

Returned Documentation

If MHD returns an election statement to the hospice provider for some reason, such as missing documentation or signatures, the hospice provider must return the Hospice Election Statement to MHD with the requested documentation in order for the election to be recorded on the patient's file.

2.8 Revocation of Hospice Services

An individual or representative may revoke the election of hospice care at any time by filing a **Notification of Termination of Hospice Benefits** form with the hospice that includes a signed statement that the individual revokes the election for MO HealthNet coverage of hospice care for the remainder of that election period. Refer to Section 3 for further information. The effective date of the revocation is the date of the signature unless a subsequent date is designated. An individual or representative may not designate an effective date earlier than the date that the revocation is signed. The individual forfeits hospice coverage for any remaining days in that election period.

A revocation of hospice services is always the participant's choice. A hospice may not revoke an election because the participant is admitted to a hospital or chooses other curative care. Medicare and MO HealthNet do not recognize "revocation by action." It is the responsibility of the hospice to determine that the patient and patient's family fully understand that by electing hospice, the patient waives the right to treatment of the terminal illness except that treatment provided or arranged by the hospice or provided by the attending physician. The patient must understand that they can be financially liable for curative treatment not arranged by the hospice or provided by the attending physician. If the patient chooses to disregard this and is admitted to the hospital, the hospice cannot automatically remove the participant from hospice care.

Upon revoking the election of MO HealthNet coverage of hospice care for a particular election period, an individual resumes MO HealthNet coverage of the benefits waived when hospice care was elected. Individuals may at any time elect to receive hospice coverage for any other hospice election periods for which they are eligible.

The hospice must advise MO HealthNet Division (MHD) as soon as possible and no later than five (5) days from the date of revocation of hospice services. A copy of the **Notification of Termination of Hospice Benefits** form must be sent to MHD.

2.9 Change of the Designated Hospice

Individuals may change, once in each election period, the designation of the particular hospice from which they elect to receive hospice care. A change of the designated hospice is not considered a revocation of the election. Refer to Section 3 for further information. To change the designation of hospice programs, individuals should file, with the hospice from which they received care a completed **Notification of Termination of Hospice Benefits** form that includes the following information:

- The name of the hospice from which the individual has received care
- The name of the hospice from which the individual plans to receive care and
- The date the change is to be effective

The hospice from which the individual is transferring must advise MO HealthNet (MHD) as soon as possible and no later than five (5) days, following the effective date, by submitting a copy of a Notification of Termination of Hospice Benefits form.

The newly designated hospice must verify that a Notification of Termination of Hospice Benefits form indicating a **Change of Designated Hospice** was completed by the original hospice by viewing the patient's copy of the form. If the form was not completed, the new hospice must complete the form and submit a copy to the original hospice and to MHD within five (5) days.

In addition, the hospice to which the participant is changing should send a completed **Hospice Election Statement** as well as other documentation necessary for an initial election (Refer to Section 2.)

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.

The hospice care benefit consists of two 90 day election periods followed by unlimited 60 day periods, which run consecutively as long as the participant remains in the care of a hospice and the participant does not revoke the election.

2.10 Termination of MO HealthNet Hospice Benefits

The hospice agency is required to notify MO HealthNet Division (MHD) if a participant's hospice benefit is terminated. The hospice can take action to terminate the hospice benefit in only three (3) situations:

- The participant is not recertified as being terminally ill,
- The participant moves from the hospice service area, or
- The death of the participant while on hospice services.

Decertification of Terminal Illness by Physician

The hospice agency is required to notify MHD if the physician determines the patient does not have a terminal medical prognosis of six (6) months or less and no longer meets the criteria for hospice care. This information is to be submitted on a **Notification of Termination of Hospice Benefits** form and must be received by MHD within five (5) days.

Discharge Due to Patient Relocation

The hospice agency is required to notify MHD if the hospice patient moves from the hospice service area. This information is to be submitted on a Notification of Termination of Hospice Benefits form and must be received by MHD within five (5) days.

Notification of Death

The hospice agency is required to notify MHD of the death of a participant no later than five (5) days following the death. This notification is to be submitted on a Notification of Termination of Hospice Benefits form.

2.11 Covered Services-General

The MO HealthNet hospice benefit includes the following covered services provided according to a written plan of care. The first four (4) services (*) are "core" services, and must routinely be provided

directly by hospice employees or volunteers. The remaining are provided (either directly or under arrangement) by the designated hospice.

All services must be performed by appropriately qualified personnel and must be specified in the plan of care.

- 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 doctor of medicine or osteopathy to meet the general medical needs of the individual to the extent that these needs are not met by the attending physician.
- Counseling services, including dietary counseling, provided to both the patient and the family members or other persons caring for the individual at home. Counseling services must be available and may be provided both for the purpose of training the individual's family or other caregiver and for the purpose of helping the individual and the caregivers to adjust to the individual's approaching death.
    - Dietary counseling, when required, must be provided by a qualified individual
    - Spiritual counseling, including notice to the patient as to the availability of clergy
    - Counseling provided by members of the interdisciplinary group as well as by other qualified professionals as determined by the hospice
- Bereavement services under the supervision of a qualified professional. There must be an organized program for the provision of these services. The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to one (1) year following the death of the patient.)
- All drugs (prescription and over the counter) and biologicals used primarily for pain or symptom control of the terminal illness
- Short term inpatient care required for procedures necessary for pain control or acute or chronic symptom management provided in a participating hospice inpatient unit, or a participating hospital, or nursing facility or intermediate care home that additionally meets the special hospice standards regarding staffing and patient areas.
- Short-term inpatient respite care furnished as a means of providing respite for the individual's family or other persons caring for the individual at home
    - The participating hospice inpatient unit, or a participating hospital or nursing facility or intermediate care home must meet the special hospice standards regarding staffing and patient areas
- Medical appliances and supplies. 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 the patient is under hospice care. Medical supplies include those that are part of the written plan of care.

- Room and board in a MO HealthNet-certified nursing facility (NF) or intermediate care home
- Home health aide services furnished by certified 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 treatment plan.
- Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills. When provided, the services must be offered in a manner consistent with accepted standards of practice.

Core Services

Nursing care, physicians' services, medical social services, and counseling are core hospice services and must be routinely provided directly by hospice employees. Volunteers are considered hospice employees. A hospice must ensure that substantially all the core services are routinely provided directly by hospice employees. A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the hospice must maintain professional, financial, and administrative responsibility for the services and must ensure that the qualifications of staff and services provided meet all requirements.

2.12 MO HealthNet Hospice Noncovered Services

- Any service provided by inappropriately qualified personnel
- Any service or treatment not listed in the plan of care
- Any service or treatment that is not directly related to pain control or palliation of the participant's terminal illness
- Nurse aide services not under the supervision of a Registered Nurse (RN). To assure appropriate delivery and quality of care, the supervision of hospice aides by a registered nurse is required per CFR 418.76(h)
- Inpatient services beyond the boundaries of the inpatient cap and
- Respite care over five (5) days per calendar month

2.13 MO HealthNet Covered Services not Related to Terminal Illness

All medically necessary MO HealthNet covered services (prescribed drugs, inpatient and outpatient hospital services, physician, optical, dental services, personal care, homemaker/chore, etc.) not related to the terminal illness continue to be available through the regular MO HealthNet Program, subject to the benefits and limitations of each specific program.

2.14 Levels of Care

Hospice services are divided into four (4) basic levels of care. Physicians' services and a room and board allowance are reimbursed when applicable. Reimbursement rates for the four (4) basic levels of care are consistent with the rates established by the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS). Refer to Section 1 for reimbursement information.

Routine Home Care (Revenue Code 0651)

The hospice is paid the routine home care rate for each day the patient is at home, under the care of the hospice, and not receiving continuous home care, with a higher rate for the first 60 days of hospice care and a lower rate starting on day 61. These 60 days are counted across any hospice benefit periods that are not separated by a 60 day break. The higher hospice rate would restart only if the patient had a greater than 60 day break in all hospice services. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

CyberAccess includes a feature to allow users to view the participants' hospice enrollment history to be able to properly count the hospice. To become a CyberAccess user, contact the Conduent help desk at 888-581-9797 or send an E-mail to CyberAccessHelpdesk@conduent.com.

Routine home care includes routine nursing service, social work, counseling services, durable medical equipment, supplies, drugs, home health aide/homemakers, physical therapy, occupational therapy and speech, and language pathology therapy relating to the terminal illness.

Continuous Home Care (Revenue Code 0652)

The hospice is paid the continuous home care rate when continuous home care is needed in periods of acute medical crisis. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate is reimbursed to the hospice up to 24 hours a day.

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. A minimum of eight (8) hours of care must be provided during a 24 hour day, which 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 provided in the evening of that day.

- Nursing care for continuous home care must be provided by either a registered nurse (RN) or a licensed practical nurse (LPN). Homemaker and aide services may also supplement the nursing care; however, a nurse must provide care for more than half of the period of 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, it is covered as routine home care.

Inpatient Respite Care (Revenue Code 0655)

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 (5) consecutive days per calendar month. Respite care may be provided in a MO HealthNet certified nursing facility (NF) or intermediate care home or an acute care hospital.

The hospice is paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient, NF, or intermediate care home and is receiving respite care.

- Payment for respite care may be made for a maximum of five (5) days at a time including the date of admission but not counting the date of discharge. Payment for the sixth (6th) and any subsequent days is made at the routine home care rate.
- Respite care may not be provided when the hospice patient is a nursing home resident

General Inpatient Care (Revenue Code 0656)

General inpatient care is covered for periods of acute medical crisis for palliative care.

- Payment at the hospice inpatient care rate is made when general inpatient care is provided.
- None of the other fixed payment rates (routine home care, continuous home care, or inpatient respite) are reimbursed for a day on which the patient receives hospice inpatient care except for the date of discharge
- For the day of discharge from an inpatient unit, the appropriate home care rate is paid 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
- Payments to a hospice for inpatient care are limited according to the number of days of inpatient care furnished to MO HealthNet patients. (Refer to Section 2)

Nursing Home Room and Board (Revenue Code 0658)

MO HealthNet eligible individuals who reside in MO HealthNet certified NFs (vendor beds) or intermediate care home and who meet the hospice eligibility criteria may elect MO HealthNet hospice care services. Nursing home room and board payments cannot be made for a participant residing in an area that has not been certified. It is the provider's responsibility to ensure that a participant for whom MO HealthNet payment is made is placed in a Title XIX certified bed. Any payments made for a participant who was not in a Title XIX certified bed will be recouped. In addition to the routine home care or continuous home care per diem rates, an amount may be paid to the hospice to cover the NF or intermediate home care room and board costs. The hospice reimburses the NF or intermediate home care Room and board includes the performance of personal care services that a caregiver would provide if the individual were at home. These services include assistance in the activities of daily living: washing and grooming, toileting, dressing, meal service, socializing

(companionship, hobbies, etc.), administration of medication, maintaining the cleanliness of the resident's bed and room, and supervising and assisting in the use of durable medical equipment and prescribed therapies (such as range of motion exercises, speech, and language exercises).

There must be a written agreement between the hospice and the NF or intermediate home care under which the hospice takes full responsibility for the professional management of the individual's hospice care and the NF or intermediate home care agrees to provide room and board to the individual. The hospice and the NF or intermediate home care must retain a copy of the agreement and a Hospice- NF or intermediate care home **Contracts form** advising of this agreement must be on file at the following address prior to submitting claims for NF or intermediate home care room and board services:

Missouri Medicaid Audit and Compliance
Provider Enrollment Unit
P.O. Box 6500
Jefferson City, Missouri 65102-6500

Licensed/Certified Facilities

To participate in the MO HealthNet Vendor Nursing Care Program (Title XIX), a facility must be licensed as a skilled nursing or intermediate care home and must also be certified as meeting federal requirements as a provider of NF services or intermediate care services for the mentally retarded (ICF/MR). Provider participation in the Vendor Nursing Care Program is voluntary.

When a participant, who has elected hospice services, enters a NF or intermediate care home, the participant must reside in a "vendor" (MO HealthNet-certified) bed for the Family Support Division (FSD) to do a division of assets and/or to calculate surplus.

The following outline represents the procedure for each MO HealthNet participant or applicant who enters a MO HealthNet-certified facility.

- Any MO HealthNet participant (or applicant) who enters a MO HealthNet-certified facility (in a vendor bed) has the **Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability or Related Condition** and the **Level II Nursing Facility Level of Care Assessment** completed by NF or intermediate care home personnel
- NF or intermediate care home personnel (or the MO HealthNet participant) are responsible for notifying the FSD County Office that the individual has entered a vendor bed
- FSD performs necessary "division of assets" for MO HealthNet applicants and calculates surplus for all individuals in MO HealthNet vendor beds (MO HealthNet-certified facility)
- FSD sends an FA-465 to the NF or intermediate care home for each MO HealthNet participant in a vendor bed. The FA-465 notifies the NF or intermediate care home of the surplus amount, the effective date of vendor status, and is the nursing homes authorization to bill MO HealthNet. The hospice should request

and maintain, from the nursing home, a copy of the FA-465 and any subsequent FA-465s

- The contract/agreement established between the hospice and nursing home should identify whether the hospice or the nursing home is responsible for collecting surplus
- The hospice is reimbursed for nursing home room and board for each MO HealthNet hospice patient residing in a MO HealthNet-certified nursing facility (NF) or intermediate care home (vendor bed). Surplus is deducted from the hospice room and board payment (0658). The hospice reimburses the NF or intermediate care home

Distinct Part

A nursing home may choose not to have all of its licensed areas certified for participation in the MO HealthNet Program or there may be some licensed areas that do not meet MO HealthNet certification requirements. Federal regulations allow a facility to establish a "distinct part" provided the distinct part meets requirements for certification. The distinct part must be an identifiable unit such as an entire ward, floor, or wing. When a facility designates a distinct part, **Form DA-113**, Bed Classification Listing by Category, must be completed showing which rooms are in the distinct part. A copy of this form is sent to the MO HealthNet Divisions' (MHD) Reimbursement Unit.

Revenue Code 0658

Hospice billing instructions require that hospice providers include the nursing home MO HealthNet provider identifier in Field #56 of the UB-04 when billing for nursing home room and board (0658.) (Refer to Section 4.)

The nursing home MO HealthNet provider identifier shown in Field #56 must agree with a corresponding nursing home provider identifier included in the Hospice-nursing facility or intermediate care home contracts form. The information in the hospice provider file must show a valid contract with the nursing home shown in Field #56 in effect for the dates of service billed.

It is the hospice's responsibility to determine that a hospice patient residing in a nursing home is in a MO HealthNet certified vendor bed prior to submitting claims for Nursing Home Room and Board charges. If MO HealthNet's file does not indicate the participant/patient is in a certified Medicaid vendor bed, the claim denies. Certification in the correct nursing home is dependent upon the proper forms being completed by the nursing home and submitted to the Division of Senior and Disability Services. The hospice should request, for each hospice nursing home patient, a copy of the FA-465 and any subsequent FA-465s from the patient, the patient's family or the nursing home. This form is the hospice's assurance that the certification has been completed. It also identifies the patient's surplus amount that is applied to the reimbursement amount for the nursing home room and board claim.

Service Intensity Add-On (Revenue Codes 0551 and 0561)

The Service Intensity Add-On (SIA) payment is made for a visit by a social worker or a registered nurse (RN) when provided during routine home care in the last seven (7) days of a patient's life. The SIA payment is in addition to the routine home care rate. The SIA payment rate is limited to four (4) hours combined for both RNs and social workers on each date of service. The SIA payment is only for those social worker and RN services provided during an in-person visit and does not apply to phone visits. Hospice providers must differentiate between nursing services provided by a RN and nursing services provided by a licensed practical nurse (LPN) because an LPN is not eligible for the SIA payment.

There are two (2) procedure codes for providers to distinguish between RN services, G0299 (direct skilled nursing services of a registered nurse, RN, in the home health or hospice setting) and LPN services, G0300 (direct skilled nursing of a LPN, in the home health or hospice setting). The procedure code for social work services is G0155 (medical social service visit). Revenue code 551 (skilled nursing) must be used with procedure code G0299 and revenue 561 (medical social service visit) must be used with procedure code G0155, or claims will deny. SIA services must be billed for each date of service. A date span cannot be used.

2.15 Physician Services

The basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the participant'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, inpatient respite care, and general inpatient care.

MO HealthNet reimburses the hospice for other physicians' services, such as direct patient care services, furnished to individual participants 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. (Reference the Physician manual for information on the physician's program services.)

The hospice is reimbursed in accordance with the usual MO HealthNet reimbursement policy for physicians' services. The appropriate procedure code must be entered on the **UB-04 claim form**. This reimbursement is in addition to the daily hospice rates. To simplify the billing procedures, the hospice provider may want to request that the physician complete and send to the hospice a **CMS-1500 claim form** completed in accordance with MO HealthNet claim filing requirements. The hospice can then use these procedure codes and include the physician billing information on the **UB-04 claim form**. Do not attach the CMS-1500 claim to the UB-04.

Physician services provided by the individual's attending physician, who is not an employee of or receiving compensation from the hospice, for services provided for the hospice are reimbursed directly to the physician at the lesser of the billed amount or the MO HealthNet maximum allowable amount, subject to the benefits and limitations of the Physicians Program. These services must be billed directly to the fiscal agent by the attending physician on the CMS-1500 claim form using the appropriate physician or clinic provider identifier. To be reimbursed, the physician must be a MO HealthNet participating provider on the date of service.

The only services to be billed by the attending physician are the physician's personal professional services. Other services such as lab or x-rays cannot be billed by the attending physician or any other provider.

2.16 Limitation on Payments for Inpatient Care

Payments to a hospice for inpatient care are limited according to the number of days of inpatient care furnished to MO HealthNet 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 MO HealthNet participants during that same period. This limitation is applied once each year, at the end of the hospice's "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 payment is recalculated at a home care rate are not counted as inpatient days. The limitation is calculated as follows:

- The maximum allowable number of inpatient days is calculated by multiplying the total number of days of MO HealthNet hospice care by 0.2
- If the total number of days of inpatient care furnished to MO HealthNet 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 one (1) and two (2) above
    4. Comparing the amount in three (3) above with interim payments made to the hospice for inpatient care during the "cap period"

Any excess reimbursement is recouped from the hospice.

2.17 Hospice and Other Community-Based Services

MO HealthNet participants who elect the hospice benefit do not automatically forfeit their right to receive medical services such as Home and Community-based Waiver services; however, the Division of Senior and Disability Services case manager or the Division of Community and Public Health, AIDS Waiver contract service coordinator must develop a care plan in collaboration with the hospice

provider to ensure services are not duplicative. Upon request, the hospice must provide a copy of the existing plan of care and the newly developed plan of care to the Division of Senior and Disability Services case manager or Division of Community and Public Health contract service coordinator.

Personal Care Services Under the MO HealthNet State Plan

MO HealthNet covers personal care services to persons at home or residing in a Residential Care Facility (RCF) or Assisted Living Facility (ALF), licensed by the Department of Health and Senior Services (DHSS), Division of Senior and Disability Services. Personal care services consist of assistance with any activity of daily living such as meal preparation and assistance with eating, personal hygiene, toileting, hair, teeth and nail care, and assistance with ambulation and transfers. Household chores such as laundry incidental to the care of the patient and housecleaning in the area occupied by the patient are also covered under personal care. Personal care includes an advanced level of care for persons with altered body functions such as persons with ostomies, catheters, persons with paraplegia or quadriplegia. The personal care services also include a visit by a nurse, up to weekly in frequency, for set up of self-administered medications, nail care for persons with medically contraindicating conditions, skin monitoring, and increased supervision for the advanced personal care participants.

Participants are considered eligible for personal care if they have needs that otherwise require nursing home care. Eligibility for services is determined by the Division of Senior and Disability Services, or in the case of persons with AIDS or HIV, by DHSS, Division of Community and Public Health. Personal care for children under 21 years of age is prior authorized by the Bureau of Special Health Care Needs.

Personal care under the State Plan for persons 21 years of age and over is subject to a fiscal cap, predetermined annually based on average MO HealthNet nursing home costs. When the dollar cap is translated into a limit on services, the limit is approximately 80 to 120 hours of service per month. This is only an approximate, as the actual number of hours in each case depends upon the individual's need for basic or advanced personal care, and the frequency of nurse visits, if needed.

Home and Community Based Waiver for Persons with AIDS/HIV

MO HealthNet participants with diagnoses of AIDS or HIV-related illnesses may be eligible for waiver services if they have needs that otherwise require nursing home care. A functional assessment is completed by contract service coordinators from the Division of Community and Public Health to determine eligibility for both State Plan personal care and waiver services. The following are the services available under the AIDS Waiver:

- Private Duty Nursing: Individual and continuous care greater than three (3) hours in a 24 hour period (in contrast to intermittent or part-time care) provided by licensed nurses within the scope of the state's Nurse Practice Act
- Waiver Personal Care: This service is in addition to the personal care available under the State Plan. The waiver personal care service provides assistance with activities of daily living, however, it may continue beyond the limits of hours under the State Plan. Under the waiver, the aide may accompany the participant

on visits to obtain medical care, whereas the aide under personal care cannot. Housekeeping chores necessary to maintain a safe and sanitary environment may not comprise more than 1/3 of the time spent in the home.

- Waiver Attendant Care: Waiver attendant care service is hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. Waiver attendant care includes skilled or nursing care. Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity.
- Supplies: Limited to diapers, underpads, and gloves

Home and Community Based Waiver for the Aged and Disabled

The MO HealthNet Home and Community-based Waiver for the Aged and Disabled is a program available to MO HealthNet-eligible persons 63 years of age or older who otherwise require care in a nursing facility (NF) or intermediate care home. Eligibility for aged and disabled waiver services is determined by case managers from the Division of Senior and Disability Services. The aged and disabled waiver also has a special MO HealthNet eligibility provision that allows an individual to have a higher monthly income without spending down, and allows couples to divide assets. The spouse who does not require care may keep more assets than MO HealthNet participants who do not qualify under this special provision.

Services under the Home and Community-based Waiver for the Aged and Disabled are as follows:

Homemaker/Chore services: General household activities such as meal preparation and cleanup, sweeping or vacuuming and mopping floors, cleaning kitchen appliances and bathroom fixtures, tidying and dusting the home, laundry, and washing windows. The service covers heavier chores such as washing walls and woodwork, airing mattresses and bedding, cleaning closets, basements, and attics, shampoo rugs, and spray for insects within the home with over the counter supplies, and provide rodent control within the home. The participant is eligible for these services to the extent that they are necessary to maintain a safe and hazard-free home environment, there is no family support or other resource to provide the service, and the participant has to enter a nursing home if these services are not available. While there is some overlap in personal care and homemaker/chore, a key difference is that homemaker/chore provides no "hands on" care of the patient, and the coverage of household tasks and chores is much broader.

- Respite Care: This service provides relief to a caregiver for periods of time from a few hours to several days. Services may be provided in the individual's home or in MO HealthNet-certified nursing homes. Respite care includes assistance with personal care needs, as well as limited homemaking services (i.e., meal preparation and cleanup as part of the respite care.)
- Home Delivered Meals: Home delivered meals is a service to provide an individual with one (1) or two (2) meals per day. Each meal contains at least 1/3 of the recommended daily nutritional requirements.

Authorization of Home and Community-Based Services for Persons who Elect Hospice

The following guideline is used by DHSS service coordinators and Division of Senior and Disability Services case managers when assessing initial or continued eligibility for waiver or personal care services for persons who have elected hospice.

Private Duty Nursing

The hospice benefit does not include private duty nursing as defined by the AIDS waiver, but does include nursing as defined in the list of covered hospice services in Section 2 Hospice nursing care also includes a provision for continuous home care to be provided only during a period of crisis.

Under the hospice benefit, a minimum of eight (8) hours of nursing care per a 24 hour period beginning at midnight must be provided during a crisis period. A crisis is described as a period in which a patient requires continuous care, which is primarily nursing care, to achieve palliation or management of acute medical symptoms.

If private duty nursing is to be authorized under the AIDS Waiver, the service coordinator must plan the frequency and duration of the private duty visits with the hospice provider, to be sure the private duty service augments any service for which the hospice provider is responsible either during a period of crisis or to maintain the patient on a routine basis.

Private duty nursing as defined by the AIDS waiver does not include crisis intervention, whereas hospice nursing care as continuous home care is for crisis intervention.

Supplies

The hospice reimbursement is structured to include any palliative care or service that is directly related to the terminal illness. Diapers, underpads, and gloves fit this definition and are the financial responsibility of the hospice. Supplies under the AIDS waiver should never be authorized under the waiver for a participant who has elected hospice.

State Plan Personal Care, Waiver Personal Care and Waiver Attendant Care

The hospice benefit includes home health aide and homemaker services. Home health aide and homemaker services are intended to meet personal care needs that are the result of the terminal illness. The hospice benefit, however, is not intended to provide a full-time caregiver. It is appropriate for a person who has elected hospice to also receive personal care and waiver attendant care.

The AIDS waiver service coordinator or case manager needs to develop a personal care or waiver attendant care plan in collaboration with the hospice provider, who maintains primary responsibility for the patient, to ensure services are arranged appropriately in the best interest of the participant and to augment services which are the responsibility of the hospice.

Homemaker/Chore

While the homemaker/chore service is similar to the homemaker service the hospice must provide to maintain a safe and sanitary environment in areas of the home used by the patient, the homemaker/chore service may go beyond the scope of the hospice in providing other housekeeping and maintenance services, both indoors and outdoors. For example, the Homemaker/Chore Program may include washing windows, vacuuming, dusting, cleaning kitchen appliances, bathroom fixtures, and ironing and mending of clothes.

The Division of Senior and Disability Services Case manager must develop a homemaker/chore care plan in collaboration with the hospice provider, who maintains primary responsibility of the patient, to ensure services are arranged appropriately in the best interest of the participant and augment services that are the responsibility of the hospice.

Respite

The hospice may provide short-term inpatient respite care. Aged and disabled waiver respite services are provided in the home or in a nursing facility (NF) or intermediate care home. The waiver respite service cannot be authorized during times when inpatient respite care under the hospice benefit is used. Respite care is appropriate for the hospice participant who has a caregiver (other than the hospice provider) who needs to be away from the home for periods of time (two (2) to 12 hour periods, for up to several days at a time). The Division of Senior and Disability Services case manager authorizes respite, when necessary, to augment hospice services.

Other Instructions

The hospice service may be provided in the home, a nursing facility (NF) or intermediate care home, or in a hospital according to hospice regulations. State Plan personal care services or waiver services cannot be delivered and are not reimbursed while the participant is in a hospital or nursing home. The only exception to this is institutional respite care, which is authorized by the Division of Senior and Disability Services and may only be provided by a MO HealthNet-enrolled institutional respite provider, who must also be a licensed certified NF or intermediate care home.

The MO HealthNet Division (MHD) conducts post-payment reviews of hospice services billed on the same dates as other home and community-based services. The hospice provider maintains responsibility for nursing, home health aide, and homemaker services. The AIDS Waiver, Aged and Disabled Waiver, and Personal Care Programs may provide authorized services that are beyond the responsibility of the hospice so long as those services do not duplicate those which are the responsibility of the hospice. A hospice may not refuse to provide services on the basis that these services are available under other provisions of the plan or waiver, or because the hospice has inadequate staff to meet the needs of a particular patient.

2.18 Emergency Services

An emergency medical condition for a MO HealthNet participant means a medical or a behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

1. Placing the physical or behavioral health of the individual (or, with respect to a pregnant woman, the health of the woman, or her unborn child) in serious jeopardy or
2. Serious impairment of bodily functions or
3. Serious dysfunction of any bodily organ or part or
4. Serious harm to self or others due to an alcohol or drug abuse emergency; or
5. Injury to self or bodily harm to others or
6. With respect to a pregnant woman having contractions: (a) that there is inadequate time to affect a safe transfer to another hospital before delivery or; (b) that transfer may pose a threat to the health or safety of the woman or the unborn child

Post stabilization care services mean covered services, related to an emergency medical condition, that are provided after a participant is stabilized in order to maintain the stabilized condition or to improve or resolve the participant's condition.

2.19 Out-of-State, Nonemergency Services

All nonemergency, MO HealthNet covered services that are to be performed or furnished out-of-state for eligible MO HealthNet participants, and for which MO HealthNet is to be billed, must be prior authorized before the services are provided. Services that are not covered by the MO HealthNet are not approved.

Out-of-state is defined as not within the physical boundaries of the State of Missouri nor within the boundaries of any state that physically borders on the Missouri boundaries. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are considered as being on the same MO HealthNet participation basis as providers of services located within the State of Missouri.

A **Prior Authorization (PA) Request form** is not required for out-of-state nonemergency services. To obtain PA for out-of-state, nonemergency services, a written request must be submitted by a physician to:

MO HealthNet Division
Participant Services Unit
P.O. Box 6500
Jefferson City, MO 65102

The request may be faxed to (573) 526-2471.

The written request must include:

1. A brief past medical history
2. Services attempted in Missouri
3. Where the services are being requested and who will provide them
4. Why services can't be done in Missouri

NOTE: The out-of-state medical provider must agree to complete an enrollment application and accept MO HealthNet reimbursement. PA for out-of-state services expires 180 days from the date the specific service was approved by the state.

Exceptions to Out-of-State Prior Authorization Requests

The following are exempt from the out-of-state PA requirement:

1. All Medicare/MO HealthNet crossover claims
2. All Foster Care children living outside the State of Missouri. However, nonemergency services that routinely require PA continue to require PA by out-of-state providers even though the service was provided to a Foster Care child.
3. Emergency ambulance services
4. Independent laboratory services

Section 3: Special Documentation Requirements

3.1 List of Hospice Forms

Standardized Forms

Hospice Election Statement

Hospice nursing facility (NF) or intermediate care home Contracts

Certificate of Medical Necessity

Physician Certification of Terminal Illness

Notification of Termination of Hospice Benefits

Nonstandardized Forms

Hospice Initial Plan of Care

Hospice Plan of Care Supplement

Medication List

Forms Submission

The Hospice Election Statement, Physician Certification of Terminal Illness, and Notification of Termination of Hospice Benefit may be faxed to MO HealthNet Division (MHD) at (573) 526-2041. Do not routinely follow the faxed election statement, physician certification, or notification of termination with a copy in the mail. If the faxed copies are not legible, MHD will request a mailed copy.

MO HealthNet Division
Clinical Services Hospice Unit
P.O. Box 6500
Jefferson City, Missouri 65102-6500

The Hospice-NF or intermediate care home contracts form is submitted to the Missouri Medicaid Audit and Compliance (MMAC) Provider Enrollment Unit at the address listed above. Copies of the actual contracts/agreements listed on this form are not submitted to MHD.

Plans of care, both initial and supplemental are not submitted to MHD.

The hospice must retain all election documentation and furnish it to MHD or its representative upon request.

3.2 Forms Instructions

Hospice Election Statement

This form is required to enroll a MO HealthNet participant in a hospice. Providers are required to use the MO HealthNet Division (MHD) standardized **Hospice Election Statement**.

Hospice Election Statement Instructions

Field Number & Name	Instructions for Completion
1. Patient Name	Enter last name, first name, and middle initial as shown on the ID card.
2. Date of Birth	Enter date of participant's birth in MMDDYY format.
3. MO HealthNet Designated Client Number (DCN)	Enter the eight (8) digit MO HealthNet ID number exactly as it appears on the participant's ID card or letter.
4. Name of Hospice	Enter hospice name as found on the hospice provider label.
5a. Hospice Provider Identifier	Enter hospice National Provider Identifier (NPI) as found on the hospice provider label.
5b. Hospice Provider Taxonomy Code	Enter Hospice Taxonomy Code for identifier reported in 5a.
6. Hospice Telephone Number	Enter telephone number of hospice.
7. Attending Physician Name	Enter name of attending physician.
8. Employed by Hospice	Circle "yes" if the attending physician is employed by the hospice and "no" if the attending physician is not employed by the hospice.
9. A.P. Provider Identifier	Enter the ten (10) digit MO HealthNet National Provider Identifier (NPI) of the attending

Field Number & Name	Instructions for Completion
	physician. (If attending physician is not a MO HealthNet provider enter letters "NA".)
10. Telephone Number	Enter telephone number of the attending physician.
11. Nursing Home Name/Provider Taxonomy Code	Enter nursing home name as it appears in the hospice's nursing facility or intermediate care home agreements and on the Hospice- nursing facility or intermediate care home contracts form.
12. MO HealthNet Provider Identifier (Nursing Home)	Enter the ten (10) digit MO HealthNet NPI of the nursing facility or intermediate care home as indicated on the Hospice-nursing facility or intermediate care home contracts form
13. Telephone Number	Enter the telephone number of the nursing facility or intermediate care home.
14. Primary Diagnosis	Enter the participant's primary terminal diagnosis code as found in the International Classification of Diseases (ICD) diagnosis listing.
15. Secondary Diagnosis	Enter the secondary terminal diagnosis code as found in the ICD diagnosis listing.

There is a space at the bottom of the form for two (2) signatures. The signature of the patient should be obtained whenever possible. If the patient is not available or is unable to sign his or her name the patient representative is required to sign. A witness signature is required when the patient representative signs.

Hospice-Nursing Facility or Intermediate Home Care Contracts

This Hospice Nursing Facility (NF) or intermediate care home contracts form is utilized by the hospice to notify MHD of each NF or intermediate care home with whom the hospice has a contract/agreement to provide hospice care to the NF or intermediate care home resident(s). A comprehensive list of contracted nursing facilities must be submitted as a requirement of provider participation (See Section 2.). Also, the hospice must submit this form as notification to MHD when a new contract/agreement is signed or when a contract is canceled.

This form must be completed by the hospice and submitted to MHD before nursing home room and board (0658) payments can be made to the hospice. Failure to submit this form results in denial of all hospice claims for nursing home room and board charges. Allow 15 days for new information to be entered into the claims processing system before billing.

Information required on the form:

1. Hospice name
2. Hospice MO HealthNet provider identifier

3. NF or intermediate care home MO HealthNet provider identifier
4. NF or intermediate care home name
5. Contract begin date MMDDYY
6. Contract end date MMDDYY (when applicable)

The hospice and the NF or intermediate care home must retain a copy of the agreement and a Hospice-NF or intermediate care home Contracts form advising of this agreement must be on file at the following address prior to submitting claims for NF or intermediate care home room and board services:

Missouri Medicaid Audit and Compliance Unit
Provider Enrollment Unit
P.O. Box 6500
Jefferson City, Missouri 65102-6500

Certificate of Medical Necessity

A completed Certificate of Medical Necessity form is required to request coverage for the following physician services:

- Additional medically necessary office visits
- Concurrent care provided by second physician for the same diagnosis

The form must be attached to the claim form on which the service is billed. For more information on the **Certificate of Medical Necessity form**, including a sample form, reference Section 7 of the General Sections Manual.

Physician Certification of Terminal Illness

The Physician Certification of Terminal Illness is required (Section 2) and is part of the election process.

MHD provides a standardized form that meets Medicare Certification requirements. This form must be used for the initial certification of terminal illness and the recertification for all subsequent benefit periods. Space for certifications for eight (8) benefit periods is provided on this form. Should the patient enter the ninth (9th) benefit period, use another copy of the form with the number of the benefit period manually entered in the field describing the benefit period.

According to the Department of Health and Senior Services (DHSS), Section for Health Standards and Licensure, the hospice may not date the signature(s) of the attending physician or the hospice medical director. The dates must be entered on the form by the respective physicians. Failure to comply with this rule may result in denial or recoupment of hospice payments.

If requirements are not met regarding obtaining verbal orders and/or signatures in the first benefit period and the two (2) day time limit for obtaining the physician signature in subsequent benefit periods, payment is not made for any days prior to the latest date(s) of signature on the certification or recertification.

The Physician Certification of Terminal Illness example references the field explanations by numbers in parentheses for the purpose of illustration. These numbers do not appear on the actual form.

Information required on the form:

- Patient's name (last name, first name, and middle initial)
- Patient's MO HealthNet number Designated Client Number (DCN)
- Hospice name
- MO HealthNet hospice National Provider Identifier (NPI)
- Provider Taxonomy Code
- Patient Social Security Number (SSI)
- Patient Health Insurance Claim Number (HIC) Number
- Hospice Medicare NPI

For initial certification period:

- From and through dates of benefit period
- Patient's name
- Attending physician and date of the verbal order
- Hospice medical director and date of the verbal order
- Signature of the attending physician
- Date of signature MMDDYY. (must be entered by the attending physician)
- Signature of hospice medical director and
- Date of signature MMDDYY (must be entered by the hospice medical director)

For second and subsequent benefit periods:

- From and through dates of benefit period
- Signature of physician recertifying terminal illness and
- Date of signature MMDDYY (must be entered by the recertifying physician)

Copies and Distribution of Physician Certification of Terminal Illness

- A copy of the Physician Certification of Terminal Illness must be received by MHD within ten (10) days of the participant's election of hospice benefits
- Certification dates must be keyed into the claims processing system before hospice claims pay for a specific benefit period. Allow ten days after mailing the **Physician Certification of Terminal Illness form** to MHD for the information to be keyed. Do not submit claims before ten days have elapsed.
- The hospice is required to retain one (1) copy for its records

Hospice Initial Plan of Care

All services provided by the hospice must be consistent with the hospice initial plan of care. The Hospice Initial Plan of Care provides a written plan stating the services, medical, and pharmaceutical care that the hospice makes a commitment to provide to the patient. The Hospice Initial Plan of Care must contain the signatures of the members of the basic interdisciplinary group who are involved in the establishment of the Hospice Initial Plan of Care. MHD does not provide a standardized form, however, any form used must meet Medicare certification requirements.

Information required on the form:

1. Patient's name

2. Patient's MO HealthNet number
3. Name of the hospice
4. MO HealthNet hospice NPI
5. Start of care date and
6. All necessary information regarding the participant's condition and required treatments

Hospice medication lists should specify plainly which medications are the responsibility of the hospice and which are not. (Reference Section 3.)

Copies and Distribution of Initial Plan of Care

- The Hospice Initial Plan of Care is not submitted to MHD. It must be retained by the hospice.
- Additional copies should be kept on file and distributed as the hospice finds necessary

Hospice Plan of Care Supplement

The Hospice Plan of Care Supplement is used to update or amend the Hospice Initial Plan of Care. This form is in effect at the time of and following the physician's signature. MHD does not provide a standardized form; however, any form used must meet Medicare Certification requirements.
Information required on the form:

1. Patient's name
2. Patient's MO HealthNet DCN
3. Name of the hospice
4. MO HealthNet hospice NPI and
5. All necessary information regarding the participant's condition and required treatments. Hospice medication lists should specify plainly which medications are the responsibility of the hospice and which are not. Reference Section 3.

Copies and Distribution of Plan of Care Supplement

The Hospice Plan of Care Supplement is not submitted to MHD. It must be retained by the hospice and furnished to MHD or its representative upon request.

Notification of Termination of Hospice Benefits

MHD provides a standardized form, Notification of Termination of Hospice Benefits that must be used to notify MHD when a patient's hospice benefit is terminated. This form is used if the patient chooses to revoke hospice benefits, changes designated hospices, is decertified due to a change in the terminal prognosis, moves from the hospice service area, or dies while on hospice service. This form must be received within five (5) days of the change or termination of benefits.

Each type of termination has different requirements for dates and signatures. Requirements for each type are listed on the reverse side of the Notification of Termination of Hospice Benefits form.

Revocation of MO HealthNet Hospice Benefit

The hospice must notify MHD when participants choose to revoke their hospice benefit. MHD provides a standardized form, Notification of Termination of Hospice Benefits that must be used by the hospice provider when participants choose to revoke their MO HealthNet hospice benefit. The date of signature is the effective date of revocation unless a subsequent date is designated.

Information required on the form:

1. Patient's name
2. Patient's MO HealthNet DCN
3. Name of the hospice
4. MO HealthNet hospice NPI
5. Provider Taxonomy Code
6. Medicare ID Number
7. Medicare Provider Identifier
8. Date the revocation is effective
9. Signature of the patient or the patient's representative
10. Date the signature is obtained
11. Signature of the witness (when applicable) and
12. Date of signature of the witness (when applicable)

The hospice provider is reimbursed for the date of revocation. The MO HealthNet participant resumes MO HealthNet coverage for services related to the terminal illness the day following the day of revocation.

Change of Designated Hospice

The hospice must notify MHD when hospice patients change their enrollment from one hospice to another. MHD provides a standardized form, Notification of Termination of Hospice Benefits that must be used when there is a change of designated hospice. The newly designated hospice must verify that a Notification of Termination of Hospice Benefits form, indicating a change of designated hospice, was completed by the original hospice by viewing the patient's copy of the form. If the form was not completed, the new hospice must complete the form and submit a copy to the original hospice and to MHD.

Information required on the form:

1. Patient's name
2. Patient's MO HealthNet DCN
3. Name of the hospice completing form
4. MO HealthNet hospice NPI
5. Provider Taxonomy
6. Medicare ID Number
7. Medicare Provider Identifier
8. Name of hospice with whom the patient is discontinuing care
9. Date service is to be discontinued
10. Name of the newly designated hospice
11. Date hospice care is elected with the new hospice

12. Signature of the patient, patient representative or hospice representative; and
13. Date of signature

The hospice to which the patient is changing must submit a new completed Hospice Election Statement and include the start date for the new hospice. The hospice must also submit other documentation necessary for an initial election (see Section 2.)

Decertification of Terminal Illness

Written notification is required when a hospice patient is no longer certified as terminally ill. MHD provides a standardized form, Notification of Termination of Hospice Benefits that must be used when the patient cannot be recertified as terminally ill. The date designated is the effective date of the termination of hospice benefits.

Information required on the form:

1. Patient's name
2. Patient's MO HealthNet DCN
3. Name of the hospice
4. MO HealthNet hospice NPI
5. Provider Taxonomy
6. Medicare ID Number
7. Medicare Provider Identifier
8. Date the termination is effective
9. Signature of the Medical Director or attending physician who is providing the new prognosis decertifying the patient and
10. Date of signature
11. Signature of the physician or hospice representative who has informed the patient that MO HealthNet benefits are waived under the Hospice program have been restored
12. Date of signature

Discharge Due to Patient Relocation

Written notification is required when a hospice patient moves out of the hospice service area. MHD provides a standardized form, Notification of Termination of Hospice Benefits that must be used when the patient relocates from the hospice service area. The date designated on the form is the effective date of the termination of hospice benefits.

Information required on the form:

1. Patient's name
2. Patient's MO HealthNet DCN
3. Name of the hospice
4. MO HealthNet hospice NPI
5. Provider Taxonomy
6. Medicare ID Number
7. Medicare Provider Identifier

8. Effective date of the move
9. Signature of the hospice representative and
10. Date of signature

Notification of Death of Patient

The hospice is required to notify MHD within five (5) days following a MO HealthNet patient's death. The standardized form Notification of Termination of Hospice Benefits is used for this purpose. Although the hospice may continue spiritual counseling and bereavement services for the family subsequent to the patient's death, MO HealthNet hospice benefits are terminated effective on the date of death.

Information required on this form:

1. Patient's name
2. Patient's MO HealthNet DCN
3. Name of Hospice
4. MO HealthNet hospice NPI
5. Provider Taxonomy
6. Medicare ID Number
7. Medicare Provider Identifier
8. Date of the patient's death
9. Signature of the hospice representative and
10. Date the form is completed

Copies and Distribution of Notification of Termination of Hospice Benefits Form

The Notification of Termination of Hospice Benefits must be received by MHDs Clinical Service's Hospice Unit within five (5) days of the change.

Medication Lists

A medication list must be compiled per individual patient, be kept in each individual's record and include an explanation or interpretation of the coding used on the medication list to identify if the medication is needed for the palliation and management of the terminal illness or a related condition. MO HealthNet may provide reimbursement to the pharmacy when the medication is not related to the terminal illness or related conditions.

Information required on the form:

1. Patient's name
2. Patient's MO HealthNet DCN
3. Name of the hospice
4. MO HealthNet hospice NPI
5. List of patient's medication and
6. Code indicating responsible party

The medication list must be updated each time there is a change in the patient's pharmaceuticals.

3.3 Computer-Generated Letters

The Hospice Enrollment/Update system produces the following computer-generated letters:

- Hospice Enrollment Computer-Generated Letter
- Hospice Disenrollment Computer-Generated Letter
- Change of Hospice Computer-Generated Letter

The letters are generated when a participant enrolls in the MO HealthNet Hospice Program, changes the designated hospice within the MO HealthNet Hospice Program, or revokes the election of hospice. The original letter is sent to the participant or guardian, and a copy is sent to the hospice provider. Receipt of these letters assures the hospice that requested action is finalized.

It is vital that hospice patients and their family or representative understand the restrictions on the patient's access to care. Review of these letters with the hospice client affords the opportunity for the hospice to reiterate these restrictions.

Section 4: Billing Instructions

4.1 Electronic Data Interchange

Providers exchanging electronic transactions with MHD should access the **ASC X12 Implementation Guides**, adopted under the Health Insurance Portability and Accountability Act (HIPAA). For Missouri specific information, including connection methods, the biller's responsibilities, forms to be completed prior to submitting electronic information, as well as supplemental information, reference the **X12 Version v5010** and **NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guides**.

4.2 Electronic Claim Submission

Providers may submit claims via the internet. The website address is **eMOMED**. Providers are required to complete the online Application for MO HealthNet Internet Access Account. Please reference **DSS** for further information. Providers are unable to access **eMOMED** without proper authorization. An authorization is required for each individual user.

The following claim types can be used in internet applications: Medical (NSF), Inpatient and Outpatient (UB-04), Dental (2019 American Dental Association), Nursing Home and Pharmacy. For convenience, some of the input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

4.3 Provider Relations Communication

It is the responsibility of the Provider Relations Communication Unit to assist providers in filing claims. For questions, providers may call (573) 751-2896. Section 3 of the General Sections Manual has a detailed explanation of this unit. If assistance is needed regarding establishing required electronic claim formats for claims submissions, accessibility to electronic claim submission via

eMOMED, network communications, or ongoing operations, the provider should contact the Infocrossing Healthcare Services Help Desk at (573) 635-3559.

4.4 Resubmission of Claims

Any line item on a claim that resulted in a zero payment can be resubmitted if it denied due to a correctable error. The error that caused the claim to deny must be corrected before resubmitting the claim. The provider may resubmit electronically or on a **UB-04 claim form**. If a line item on a claim paid but the payment was incorrect, do not resubmit that line item. For instance, if the provider billed 21 units of service but should have billed 31 and there is nothing else wrong with the claim, it will pay. That claim cannot be resubmitted. It will deny as a duplicate. In order to correct that payment, the provider must submit an Individual Adjustment Request. Section 6 of the General Sections Manual explains the adjustment request process.

4.5 Diagnosis Code

The diagnosis code is a required field and the accuracy of the code that describes the participant's condition is important.

The diagnosis code must be entered on the claim form and Hospice Election Statement exactly as it appears in the current International Classification of Diseases (ICD) reference book. Diagnosis codes are not included in this section. The current ICD reference book should be used as a guide in the selection of the appropriate diagnosis code.

4.6 UB-04 Claim Filing Instructions

The **UB-04 claim form** is always used to bill MO HealthNet for hospice services unless a provider bills those services electronically. Instructions on how to complete the UB-04 claim form are on the following pages.

The **UB-04 claim form** should be typed or legibly printed. It may be duplicated if the copy is legible. MO HealthNet claims should be mailed to:

Wipro Infocrossing
P.O. Box 5200
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the General Sections Manual.

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two (2) asterisks (**) beside the field number indicate a field is required in specific situations.

Field Number & Name	Instructions for Completion
*1. Provider Name, Address, Telephone Number	Enter the provider name and address exactly as it appears on the provider label. For convenience, affix the provider label issued by the fiscal agent. This preprinted label contains all required information. When affixing the label, do not cover other fields. Claim forms may be ordered from the fiscal agent with this required information preprinted on the form.
2. Unlabeled Field	Leave blank.
3a. Patient Control Number	For the provider's own information, a maximum of 20 alpha/numeric characters may be entered here.
3b. Med Rec #	Leave blank.
*4. Type of Bill	Valid three digit codes for hospice claims are: 811—Freestanding 821—Provider affiliated
5. Federal Tax Number	Enter the provider's federal tax number or leave blank.
*6. Statement Covers Period (from and through dates)	Indicate the beginning and ending dates on this claim. Enter in MMDDYY or MMDDYYYY numeric format. Only one calendar month of services may be shown on a claim. If all services billed are on a single day, enter that date as both "from" and "through."
7. Unlabeled Field	Leave blank.
8a. Patient's Name - ID	Enter the patient's 8-digit MO HealthNet Designated Client Number (DCN) or MO HealthNet Managed Care identification number. (Optional) NOTE: The MO HealthNet DCN or Managed Care identification number is required in Field #60.
*8b. Patient Name	Enter the patient's name in the following format: last name, first name, and middle initial.
9. Patient Address	Enter the patient's full mailing address, including street number and name, post office box number or RFD, city, state and zip code.
10. Patient Birth Date	Enter the patient's date of birth in MMDDYY format.
11. Patient Sex	Enter the patient's sex, "M" (male) or "F" (female).
12. Admission Date	Leave blank.

Field Number & Name	Instructions for Completion
13. Admission Hour	Leave blank.
14. Admission Type	Leave blank.
15. Source of Admission (SRC)	Leave blank.
16. Discharge Hour	Leave blank.
*17. Patient Status	Enter "50" hospice home or "51" hospice medical facility, which includes nursing facilities.
18-24. Condition Codes	"A1" is the only valid value.
25-28. Condition Codes	Leave blank.
29. Accident State	Leave blank.
30. Unlabeled field	Leave blank.
**31-34. Occurrence Code and Date	If one (1) or more of the following occurrence codes apply, enter the appropriate code(s) on the claim: 01—Auto Accident 02—No Fault 03—Accident/Tort Liability 04—Accident/Employment Related 05—Other Accident 06—Crime Victim
35-36. Occurrence Span Codes and Dates	Leave blank.
37. Unlabeled field	Leave blank.
38. Responsible Party Name and Address	Leave blank.
39-41. Value Codes and Amounts	Leave blank.
*42. Revenue Code	Enter one of the following Revenue Codes: 0551 - Skilled Nursing Visit 0561 - Medical Social Services Visit 0651 - Hospice/Routine Home Care 0652 - Hospice/Continuous Home Care 0655 - Hospice/Inpatient Respite Care 0656 - Hospice/General Inpatient Care 0658 - Hospice/Room & Board- nursing facility or intermediate care home
43. Revenue Description	Leave blank.

Field Number & Name	Instructions for Completion
*44. Healthcare Common Procedure Coding System/Rates/Health Insurance Premium Payments System code	Only enter the procedure code if billing for physician services. Modifier 1 - Enter the applicable modifier, if any, corresponding to the service rendered.
*45. Service Date	Enter the date of service on each line billed in MMDDYY format. When billing a revenue code for multiple days of service on a single line, enter the first day being billed. NOTE: that each date on which continuous home care (revenue code 0652) is provided must be billed on a separate line. Charges for continuous home care for multiple days cannot be combined on one line.
*46. Service Units	Enter the number of units for each revenue code billed. The last date of service is automatically calculated. NOTE: 0652 is billed by hourly units. Each line must include charges for only one day.
*47. Total Charges	Enter the total charge for each line. After all charges are listed, skip a line and enter the total of all charges for this claim to correspond to revenue code 0001.
48. Non-covered Charges	Leave blank.
49. Unlabeled Field	Leave blank.
*50. Payer Name	The primary payer is always listed first. If the patient has insurance, the insurance plan is the primary payer and “MO HealthNet” is listed last.
51. Health Plan ID	Leave blank.
52. Release of Information Certification Indicator	Leave blank.
53. Assignment of Benefits Certification of Indicator	Leave blank.
**54. Prior Payments	Indicate the amount the hospice has received toward payment of this bill from a health insurance company.

Field Number & Name	Instructions for Completion
	Payments must correspond with the payer information entered in Field #50.
55. Estimated Amount Due	Leave blank.
56. National Provider Identifier (NPI)	Enter the provider's 10-digit NPI number
*57. Other Provider ID	Enter the provider's nine (9)-digit MO HealthNet legacy provider number.
**58. Insured's Name	Complete if the insured's name is different from the patient's name.
59. Patient's Relationship to Insured	Leave blank.
*60. Insured's Unique ID	Enter the patient's eight (8)-digit MO HealthNet or MO HealthNet Managed Care identification number. If insurance was indicated in Field #50, enter the insurance number to correspond to the order shown in Field #50.
**61. Insurance Group Name	If insurance is shown in Field #50, state the name of the group or plan through which the insurance is provided to the insured.
**62. Insurance Group Number	If insurance is shown in Field #50, state the number assigned by the insurance company to identify the group under which the individual is covered.
63. Treatment Authorization Codes	Leave blank.
**64. Document Control Number	If the current claim exceeds the timely filing limit of one (1) year from the "through" date, but was originally submitted timely and denied, the provider may enter the 13-digit Internal Control Number (ICN) from the remittance advice that documents that the claim was previously filed and denied within the one (1) year limit.
65. Employer Name	If the patient is employed, the employer's name may be entered here.
66. Diagnosis & Procedure Code Qualifier	Leave blank.

Field Number & Name	Instructions for Completion
*67. Principal Diagnosis Code	Enter the complete International Classification of Diseases (ICD) diagnosis code for the condition for which the services were provided. Remember to code to the highest level of specificity shown in the current version of the ICD diagnosis code book.
**67. A-D Other Diagnosis Codes	Enter any additional diagnosis codes that have an effect on the treatment received.
67. E-Q Other Diagnosis Codes	Leave blank.
68. Unlabeled Field	Leave blank.
69. Admitting Diagnosis	Leave blank.
70. Patient's Reason for Visit	Leave blank.
71. Prospective Payment system (PPS) Code	Leave blank.
72. External Cause of Injury Code (E Code)	Leave blank.
73. Unlabeled Field	Leave blank.
**74. Principal Procedure Code and Date	If billing for physician services and a surgical procedure was performed, enter the Current Procedural Terminology (CPT) code. The date on which the procedure was performed must be stated.
**74. A-E Other Procedure Codes and Dates	If billing for physician services and more than one (1) surgical procedure was performed, state the additional procedure codes and dates performed.
75. Unlabeled field	Leave blank.
*76. Attending Provider Name and Identifiers	Physician's National Provider Identifier (NPI) is optional Enter the attending physician's name, last name first. Use the appropriate qualifier when entering the Missouri (or state) license number, MO HealthNet legacy provider number or UPIN number. The appropriate qualifier is: 0B-State License Number 1G-Provider UPIN Number G2-MO HealthNet Legacy Provider Number

Field Number & Name	Instructions for Completion
77. Operating Provider Name and Identifiers	Physician's NPI is optional. Enter the operating physician's name, last name first. Use the appropriate qualifier when entering the Missouri (or state) license number, MO HealthNet legacy provider number or UPIN number. The appropriate qualifier is: 0B-State License Number 1G-Provider UPIN Number G2-MO HealthNet Legacy Provider Number
**78-79. Other Provider Name and Identifiers	Physician's NPI is optional. Enter the physician's name, last name first. Use the appropriate qualifier when entering the Missouri (or state) license number, MO HealthNet legacy provider number or UPIN number. If billing for revenue code 0658, enter the legacy provider number for the nursing home in which the hospice patient resides. The nursing home room and board claim denies ifs this field is not completed. The appropriate qualifier is: 0B-State License Number 1G-Provider UPIN Number G2-MO HealthNet Legacy Provider Number
80. Remarks	Use this field to draw attention to attachments such as operative notes, Third Party Liability (TPL) denial, Medicare Part B only, etc.
81CC. Code-Code Field	Enter the taxonomy qualifier and corresponding 10-digit Provider Taxonomy code for the NPI number reported in Field # 56. The appropriate qualifier is: B3—Healthcare Provider Taxonomy code.

* These fields are mandatory on all Inpatient **UB-04 claim forms**.

** These fields are mandatory only in specific situations, as described.

(1) NOTE: This field is for private insurance information only. If no private insurance is involved leave blank. If Medicare, MO HealthNet, employer's name or other information appears in this

field, the claim will deny. See Section 5 of the General Sections Manual for further Third Party Liability (TPL) information.

4.7 Insurance Coverage Codes

Type of insurance coverage codes identified on the Interactive Voice Response (IVR) system, or eligibility files accessed via the internet are listed in Section 5 of the General Sections Manual, Third Party Liability (TPL).

While providers are verifying the patient's eligibility, they can obtain the TPL information contained on the MO HealthNet Division's (MHD) participant file. Eligibility may be verified by calling the IVR system at (573) 751-2896, which allows the provider to inquire on third party resources. The provider may also use the website at **eMOMED** to verify eligibility and inquire on third party resources. Reference Sections 1 and 3 of the General Sections Manual for more information.

Participants must always be asked if they have third party insurance regardless of the TPL information given by the IVR or internet. It is the provider's responsibility to obtain from the patient the name and address of the insurance company, the policy number, and the type of coverage. Reference Section 5 of the General Sections Manual, TPL.

Section 5: Procedure Codes

Procedure codes used by MO HealthNet are identified as Health Care Procedure Coding System (HCPCS) codes. The HCPCS is divided into three (3) subsystems, referred to as Level I, Level II and Level III. Level I is comprised of Current Procedural Terminology (CPT) codes that are used to identify medical services and procedures furnished by physicians and other health care professionals. Level II is comprised of the HCPCS National Level II codes that are used primarily to identify products, supplies and services not included in the CPT codes.

The CPT and HCPCS books may be purchased at any medical bookstore.

5.1 Current Procedural Terminology Codes

A copy of the Physician's Current Procedural Terminology (CPT) may be purchased by writing to the following address:

American Medical Association
AMA Plaza
330 North Wabash Ave., Suite 39300
Chicago IL, 60611-5885
Telephone Number: (312) 464-4782
Fax Orders: (312) 464-5600
AMA Store

5.2 Hospice Revenue Codes

Revenue Codes	Description	Medicaid Maximum Allowable Amount
0551	Skilled Nursing Visit	Medicare Rate
0561	Medical Social Service Visit	Medicare Rate
0651	Routine Home Care	Medicare Rate
0652	Continuous Home Care	Medicare Rate
0655	Inpatient Respite Care	Medicare Rate
0656	General Inpatient Care	Medicare Rate
0658	Nursing Home Room and Board	95% of the Medicaid Nursing Home Rate

Payment for hospice services is made to a designated hospice provider based on the hospice rates published annually by the Centers for Medicare & Medicaid Services (CMS). These hospice rates are effective from October 1 of each year through September 30 of the following year. The MO HealthNet Division publishes a provider information bulletin annually with the hospice rates in effect for the current year.