

Chapter 28

Hospice Services

The hospice benefit is a comprehensive package of services offering palliative care support to terminally ill members and their family. Hospice care is palliative, with a focus on holistic support and relieving pain and other symptoms of the terminal illness. Recipient electing the hospice benefit agree to receive only palliative care for their terminal illness or condition. When a member voluntarily elects the hospice benefit, they agree to forego curative care for their terminal diagnosis. In exchange, the member receives the hospice package of services.

The hospice benefit is available to members who have been certified by a physician as terminally ill. A recipient is considered to be terminally ill if he or she has a medical prognosis with life expectancy of six months or less when the disease runs its normal course. Hospice may be in effect greater than 6 months. Members who meet these requirements may elect the hospice benefit. Dually eligible members who elect the Medicare hospice benefit must also elect the MA hospice benefit. Recipients with a terminal illness must be informed of all MA services and support options including the hospice benefit. Hospice care is entirely optional and the recipient may revoke their election at any time.

The MA hospice benefit follows the same rules and regulations as the Medicare hospice benefit, which was designed to supplement the care provided by primary care givers such as family (as the member defines family), friends and neighbors. The hospice benefit is not intended to replace the supportive role of the recipient's informal support network of primary care givers. As such MA-covered services that replace the duties of primary care givers do not duplicate the hospice team's services. Examples of supportive functions that are provided by primary care givers include:

- Coordinating the recipient's care;
- Performing personal care;
- Assisting with activities of daily living, assisting with incidental activities of daily living;
- Providing nutrition; and
- Assisting with medications.

Examples of services that may resemble the supportive role provided by primary care givers include:

- Adult foster care services;
- Personal care assistant services;
- Home delivered meals;
- Lifeline; and
- CAC, CADI, TBI, EW, and MR/RC waiver services

Definitions

Cap Amount: The limit on overall hospice payment.

Crisis: A period during which the recipient requires continuous care for palliation or management of acute medical symptoms.

Continuous Home Care Day: A day in which the recipient receives nursing services including home health or homemaker services, on a continuous basis during a period of crisis, for at least eight hours and as many as 24 hours per day, as necessary to maintain the recipient at home. More than half the care during the crisis must be nursing care provided by a registered nurse or licensed practical nurse. The hospice uses the hourly rate for the actual hours of services provided, up to 24 hours.

Employee: An employee of the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization assigned to the hospice unit, including a volunteer under the supervision of the hospice.

General Inpatient Day: A day in which the recipient receives general inpatient care in a hospital, skilled nursing facility, or inpatient hospice unit for control of pain or management of acute or chronic symptoms that cannot be managed in the home.

Home: The recipient's place of residence.

Hospice Care: The services provided by a hospice to a terminally ill recipient.

Inpatient Care: The hospice services provided by an inpatient facility to a recipient who has been admitted to a hospital, long term care facility, or facility of a hospice that provides care 24 hours per day.

Inpatient Facility: A hospital, long term care facility, or facility of a hospice that provides care 24 hours per day.

Interdisciplinary Group: A group of qualified individuals with expertise in meeting the special needs of hospice recipients and their families, including, at a minimum, providers of core services. An interdisciplinary group must have at least one physician, one registered professional nurse, one social worker, and one pastoral or other counselor.

Legal Representative: A person who, under Minnesota law, may execute or revoke an election of hospice care on behalf of the recipient because the terminally ill recipient is mentally or physically incapacitated.

Palliative Care: Care affording relief, but not cure. Providing an alleviating medicine. Managing the symptoms experienced by the hospice recipient with the intent to enhance the quality of life for the hospice recipient and his/her family, but not directed at curing the disease.

Respite Care: Short-term inpatient care provided to the recipient only when necessary to relieve the family recipients or other persons caring for the recipient.

Social Worker: A person who has at least a bachelor's degree in social work from a program

accredited or approved by the Council on Social Work Education and who complies with the Minnesota statutes related to social work licensure.

Terminally Ill: A medical prognosis with a life expectancy of six months or less, given that the terminal illness runs its normal course.

Eligible Providers

A hospice organization may enroll as a PrimeWest Health hospice provider if it is licensed and certified for Medicare as a hospice by the Minnesota Department of Health. In order for hospice services to be covered, a plan of care must be established.

A hospice may use contracted staff to supplement hospice employees during periods of peak recipient loads or other extraordinary circumstances. The hospice remains responsible for the quality of services provided by contracted staff.

Eligible Recipients

To be eligible for hospice services, a recipient must be:

- MA (Medicaid) or MinnesotaCare eligible; and
- Certified as terminally ill by the medical director of the hospice, or a physician member of the interdisciplinary group, and the recipient's attending physician, if he/she has one.

MA recipients who may be eligible for Medicare must be directed to the Social Security Administration for Medicare application. MinnesotaCare recipients must be directed to their local county human services agency for MA eligibility determination.

Dually eligible recipients who elect Medicare hospice must also elect MA hospice. The Medicare hospice election form must be sent to DHS on the day of election.

GAMC recipients who are terminally ill are not eligible for hospice care and should be referred to their county human services agency for MA eligibility determination.

A recipient may receive hospice care until:

- They are no longer certified as terminally ill; or
- The recipient or their representative revokes the election of hospice care.

Covered Services

The hospice benefit includes coverage for the following services, when provided directly in response to the terminal illness:

- Physician services
- Nursing services
- Medical social services
- Counseling
- Medical supplies and equipment
- Outpatient drugs for symptom and pain control

- Dietary and other counseling
- Short-term inpatient care
- Respite care
- Home health aide and homemaker services
- Physical, occupational, and speech therapy
- Volunteers
- Other items and services included in the plan of care that are otherwise covered medical services

Hospice Care Provided In Conjunction with Other MA-Covered Services

Prime West Health understands that recipients facing death may have a complex set of health care needs. These needs often stem from their terminal condition. These needs may also stem from other medical conditions that either (a) pre-existed their terminal condition, or (b) arise during the course of their terminal condition but are unrelated to their terminal condition. A recipient should never be asked to make an “either/or” choice between an otherwise MA-covered, medically necessary service which is not related to the terminal condition, and covered, medically necessary hospice benefit service that is related to the terminal condition.

Pre-existing health care needs

Some MA-covered services may already be needed and/or in place before the recipient seeks hospice, due to the recipient’s pre-existing medical conditions or disability. The hospice benefit is not intended to duplicate health services or supports that relate to a pre-existing condition. Examples include continuing care services such as home care related to a previous stroke, waiver services related to a disability, or adult foster care related to a disability such as elderly dementia. Examples of pre-existing medical care include services for conditions such as diabetes, ALS, arthritis, cardiac conditions, AIDS, or high blood pressure.

Pre-existing continuing care services may need to be adjusted during the period that the recipient is receiving the hospice benefit. Recipients with pre-existing needs, such as quadriplegia or stroke, may have more intensive physical needs due to the terminal illness compared to persons without such pre-existing conditions. The resulting higher needs are an interaction of the two conditions together; some of which may need to be addressed through increased continuing care services.

Medical needs that arise during the period of the hospice benefit but which are unrelated to the terminal illness

Sometimes recipients need new health care services in addition to the services that are offered as part of the hospice benefit. MA-covered services may be provided in response to conditions not related to the terminal condition. Examples of this include treatment for a hip fracture unrelated to the terminal diagnosis, or the development of a new condition or symptom unrelated to the terminal diagnosis.

How to Determine When a MA-Covered Service Duplicates of a Hospice Benefit Service

Generally, the determination about whether a service duplicates a hospice benefit service will be made as part of the hospice provider's general responsibility to provide care coordination. The hospice care coordinator must assume the lead responsibility for collaborating with the county case manager, home care agency, physician, or other provider providing the services, which are outside of the hospice benefit.

Because some hospice benefit services and MA-covered services may be similar, this determination process should focus on the purpose, rather than the type of service -- that is, what recipient need is the service addressing?

The following considerations may be helpful in approaching the determination:

- Is the purpose of a service to address a pre-existing condition or a pre-existing need?
- Is the purpose of a service to address a health care problem that would have existed even without the terminal illness?
- Is the purpose of a service to facilitate the recipient's ability to live in the community setting rather than an institution, and would that need have been present with or without the terminal illness?

Documentation Requirements When A Case Manager is Involved

When the MA-covered service is the type that includes county-based home and community based services (HCBS) case management, the hospice must notify the case manager in writing of the recipient's election of hospice and the anticipated start date. Written notification via fax, mail, or hand delivery must be given to the case manager within two business days using the AHCA Form 5000-25, Notice of Hospice Election.

The hospice agency staff must assume lead responsibility for collaboration and documentation of that collaboration with the case manager. The hospice staff must forward the documentation within eight calendar days of the effective date of hospice services. Collaboration may be completed via telephone, fax, e-mail, or a face-to-face visit. Documentation such as this should be included in the recipient's hospice record.

The case manager will be invited to participate in the hospice interdisciplinary care team meetings for a recipient receiving home and community-based services.

The case manager will keep a copy of the cooperative agreement in the recipient's record. (This is not a mandated form but to be used as a tool for preventing duplication of services.)

When the recipient is receiving "traditional MA" home care and no case manager is involved, the hospice must coordinate care and communicate with the home care agency involved with the recipient, rather than through a county case manager.

Seeking HCBS After Hospice Election

When a recipient is receiving concurrent HCBS and hospice services, the HCBS are usually in

place before the hospice services began.

There may be situations where a recipient seeks case-managed HCBS or an increase in HCBS, after electing the hospice benefit. Example: An adult with a disability is living with an aging mother, who is the primary care giver. The aging mother experiences a decline in health status, and has to cut back on the amount of primary care she is able to provide the recipient. The recipient therefore applies for HCBS to access available services and supports that the primary caregiver can no longer provide. In situations where the initial HCBS is added or increased after the hospice benefit is elected, county case management documentation must justify the addition/increase of the HCBS services.

County Case Manager Approval of Services that are Concurrent with the Hospice Benefit

An MMIS informational edit will appear on the HCBS service agreement to alert counties that the recipient has elected the hospice benefit. Following coordination with the hospice provider agency, county case managers must add comments on the county DHS Comment Screen of the MMIS service agreement, documenting the coordination of services. The notes must indicate why continuing care services are necessary. (Either they are pre-existing, or they are new but treated as a condition not related to the terminal condition.) The MMIS service agreement line items must be adjusted as needed to reflect the type and amount of services required. Changes to services continue to require a ten-day notice to recipients to allow for continuity of care, recipient rights, and transitional needs.

When continuing care waiver provider claims are received by DHS, a claim edit suspends the claim when the date of service overlaps with the hospice benefit period. Because the hospice provider becomes the primary payer of services, DHS will manually review HCBS provider claims to determine if payment is appropriate. Case management notes in MMIS will be reviewed at that time to ensure hospice provider coordination with the county case manager has occurred. If it appears that the coordination by the hospice provider has not occurred, the claim will remain in suspense until the coordination process is completed. If it appears that the coordination process has occurred, then the claim will be paid. When payment appears appropriate, the claim will be paid as requested. The informational edit and manual review of claims will remain in place temporarily to encourage consistent coordination between the provider areas.

Physician Services

An attending physician's services are separately billable as long as the attending physician is not an employee of or under contract with the hospice. Bill Medicare Part B for dual eligibles and MA if the person has MA only.

Billing for Consulting Physician Services

When billing for the services of a consulting physician for an MA-only recipient (no Medicare or other third party payer involved), break out the technical portion and bill PrimeWest Health for the physician portion only. Services provided to dual eligibles are first billed to Part B

Medicare and cross-over for MA payment of co-pays and deductibles.

Establishing the Plan of Care

The attending physician, the hospice medical director or physician designee, and the interdisciplinary group must establish a written plan of care for providing hospice services. The care provided by the hospice must follow the established plan of care.

Content of Plan of Care

The written plan of care must:

- Include an assessment of the recipient's needs;
- Identify services, including the management of discomfort and symptom relief; and
- Detail the scope and frequency of services needed to meet the recipient's and family's needs.

The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each recipient.

Review of Plan of Care

The plan of care must be reviewed and updated at intervals specified in the plan by the attending physician, the hospice medical director or physician designee, and the interdisciplinary group. The reviews must be documented.

Hospice Services for Residents of Long Term Care Facilities

MA eligible residents of Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) and Nursing Facilities (NFs) who also meet hospice service eligibility may elect to receive hospice services where they live. The hospice provider becomes the primary provider of the service, and authorizes and funds the hospice benefits. Medicare and MA payments are made to the hospice provider for both the hospice services it provides, and for the residential services provided by the facility. Current law requires a payment, to the hospice provider, of at least 95% of the rate that would have been paid for facility services for the individual. Effective July 1, 2001, payments to be made by DHS are indicated in column (E):

Facility Type (A)	DHS Payment Rate (B)	Percentage of Rate (C)	Private Room (D)	Hospice Payment For Room & Board (E)
ICF/MR	ICF/MR	100%		95% * [(B)*(C)]
NF	NF Case Mix	100%		95% * [(B)*(C)]
NF	NF Case Mix	100%	115%	95% * {[(B)*(D)]*(C)}
NF First 30 Days ❶	NF Case Mix	120%		95% * [(B)*(C)]
NF First 30 Days ❶	NF Case Mix	120%	115%	95% * {[(B)*(D)]*(C)}
out-of-state NF	NF Rate	100%		95% * [(B)*(C)]

❶ Begins with date of NF admission on or after July 1, 2003 (not MA eligibility date).

The hospice must contract with and negotiate a rate with the long term care facility for the recipients who reside in the facility and elect hospice care. The long term care facility must coordinate with the hospice all of the recipient’s services and care. The hospice may negotiate with the long-term care facility for the long-term care facility to continue to collect the recipient’s spenddown.

The hospice must notify the local county human services agency of the recipient’s hospice election by sending (or faxing) a copy of the front page of the [PrimeWest Health Hospice Transaction Form](#) to the county. The hospice will become the designated provider for the medical spenddown, and the payment to the hospice for the room and board will exclude the amount of the recipient’s medical spenddown.

Residents of ICF/MRs and NFs may receive end-of-life care from their residential provider without making the hospice election. Facilities may be able to arrange for the specific care needs of persons with terminal illness by making internal staffing adjustments, or by also purchasing the specialized services, or making staff additions. ICF/MR facilities may apply through their host counties for a variable rate adjustment in order to accommodate the increased needs of a person with terminal illness.

Bed-hold Billing

When a hospice patient resides in a nursing home and is absent from the nursing home for hospitalization, home visits, etc., the hospice agency must verify that the nursing facility is eligible for bed-hold days. Bed-hold days are available up to 18 days per occurrence when the facility occupancy rate is 93% or greater. Bed-hold rates are 60% of the case-mix rate (as of July 1, 2003), of which the agency is entitled to 95% of the adjusted case-mix rate for that LTC facility.

Example: If stay is May 1-10 with May 107 in NH, submit 0658 revenue code with the case-mix; and May 8-10 hospital, submit 0185 revenue code separate for bed-hold with just the rate of charges billed.

Hospice Transaction Form

The PrimeWest Health [Hospice Transaction Form](http://edocs.dhs.state.mn.us/lfserver/legacy/DHS-2868-ENG) (HTF) (DHS-2868, 8/02) <http://edocs.dhs.state.mn.us/lfserver/legacy/DHS-2868-ENG> is a multipurpose form which is a tool for hospice providers to report hospice election, certification, revocation of hospice services, change of hospice provider, and recipient death.

Submitting the Hospice Transaction Form

DHS must be notified of recipients who are enrolled in hospice (regardless of whether MA is the primary payer).

The Medicare and Medicaid (MA) approved criteria on hospice agency's election form is to be submitted to DHS immediately upon enrolling with Medicare hospice. This election form must be completed with all the required/appropriate information (e.g., PMI, DOB, PrimeWest Health provider number, ICD-9, and patient's signature). DHS must receive the information within two days of election.

Dual eligible Medicare and MA recipients may submit the Medicare approved hospice election criteria plus the DHS required elements to DHS in place of the DHS hospice transaction form.

Page one of the election form must also be sent to the county financial worker when a spenddown is involved. State staff will make the institutional to medical change in the system if the change has not been made by the county.

For recipients enrolled in a prepaid health plan, only submit their hospice election forms to DHS if they are residing in a long-term care facility.

DHS must also be notified when the recipient is no longer receiving hospice care.

Fax or mail the HTF to:

Minnesota Department of Human Services
Attention: Hospice Notification
P.O. Box 64993
St. Paul, MN 55164-0993
Fax (651) 431-7433

Hospice overpayments for spenddowns may be sent back to the following address. A copy of the original RA must be included for correct claim credit.

Minnesota Department of Human Services
Attention: Benefit Recovery/Hospice
P.O. Box 64994
St. Paul, MN 55164-0994

Recipient Information

Enter the recipient's name, address, PrimeWest Health ID number, and date of birth. If the recipient is Medicare/Medicaid eligible, he or she must elect Medicare hospice care in addition to

Medicaid hospice care. Federal guidelines prohibit recipients from choosing hospice care through one program and not the other when they are Medicare/Medicaid eligible.

Election of Hospice Services

The recipient or a legal representative (if the recipient is physically or mentally unable) must sign and date the HTF to elect hospice care and waive rights to any other medical services related to the treatment of the terminal condition. A witness signature and date are required only if the recipient is unable to sign. The hospice must:

- Explain the benefits the recipient will receive;
- Explain the benefits the recipient is waiving;
- Give the recipient or legal representative a copy of the signed HTF; and
- Retain the signed HTF in its files.

The election statement must include the date hospice services are to begin, and the name and PrimeWest Health provider ID number of the hospice that will provide the care. DHS will not use the physician certification dates unless the HTF was not signed in accordance with the guidelines stated in the Certification of Terminal Illness section below. **DHS must receive the form within two days of the recipient's signature.** Diagnoses such as “failure to thrive” or “weakness” are invalid hospice election diagnoses.

Discharge Statement

Complete the discharge statement if a recipient is no longer considered to have a life expectancy of six months or less or the recipient is no longer eligible to receive hospice services and is discharged from the hospice program. The hospice medical director or designee and attending physician must sign and date the statement.

Revocation of Hospice Services

A hospice recipient may elect, at any time, to receive curative care and terminate hospice services. The recipient or a legal representative must sign and date revocation of hospice services. The effective date of the revocation must be on or after the date the form is signed.

Change of Designated Hospice Provider

A recipient may change hospice providers while receiving hospice services. Enter the names and PrimeWest Health ID numbers of both the new and replaced hospice providers. Both hospice providers must retain copies of the HTF. DHS and county, if applicable, must be notified of the change.

Recipient Date of Death

The hospice must enter the recipient's date of death. DHS must receive a copy of the HTF within two days of the recipient's date of death.

Non-covered Services

The following services are not covered and must be waived while the recipient is in hospice care:

- Other forms of health care for treatment of:
 - The terminal illness for which hospice care was elected; or
 - A condition related to the terminal illness;
- Other hospice services or hospice services equivalent to hospice care, except those provided by the designated hospice or its contractors; and
- Services provided under home and community based waivers that are related to the terminal illness.

Hospice Payments/Limits

Hospice providers are paid at one of the four fixed daily rates that apply to all services except certain physician services, and room and board in a long-term care facility.

PrimeWest Health will pay a hospice for each day a recipient is under the hospice's care. The payment methodology and amounts are the same as used by the Medicare program.

The limits and cap amounts are the same as used in the Medicare program except that the inpatient day limit on both inpatient respite days and general inpatient days do not apply to recipients afflicted with AIDS.

Additional payment is not made for bereavement counseling.

The hospice may be paid for an amount that does not exceed the hospice cap payment. Room and board payments for a long term care facility and certain payments to the recipient's attending physician are not considered when the cap amount is calculated.

Billing Hospice Services

- Use the UB-92
- Type of bill:
 - 811 Non-hospital based hospice (817 for non-hospital based hospice replacement claims)
 - 821 Hospital based hospice (827 for hospital based hospice replacement claims)
- Use one of the following revenue codes:
 - 0651 Routine home care day, bill number of days
 - 0652 Continuous home care day, 8 or more hours of nursing care each day up to 24 hours per day, bill hourly rate for each date of service

When billing routine home care or continuous home care (revenue codes 0651 and 0652, respectively), enter value code 61 and the appropriate MSA code in form locator (FL) 39-41, right justified. MSA codes are the same for Medicare and MA. **If the value code or MSA code is not entered, DHS will deny the claim.**

- 655 Inpatient respite day, billing may include date of admission but not date of discharge, unless discharged deceased
- 656 General inpatient day, billing may include date of admission but not date of discharge, unless discharged deceased
- The total number of general inpatient care days and inpatient respite care days may not exceed 20% of the total days provided to a hospice recipient.
- 659 Long term care facility room and board, the recipients must:
 - Reside in a long-term care facility; or
 - ICF/MR; and
 - Billed fee-for-service.

(DHS does not pay for discharge day, even upon death, while residing in a LTC facility.)

Billing Hospice Physician Services

- Use the CMS-1500.
- Use appropriate CPT/HCPCS codes and any applicable modifiers.
- Enter the physician's PrimeWest Health provider ID number in box 24K or the Rendering Provider field on the Services Tab in MN-ITS.
- Enter the hospice PrimeWest Health provider ID number in box 33, GRP#, or as the Billing Provider in MN-ITS.
- The hospice payment for physician services is the PrimeWest Health physician payment rate, and is included in the hospice cap amount.
- Patient care services not related to the terminal illness rendered by an independent attending physician (a physician who is not considered employed or under contract with the hospice) must be billed using physician billing guidelines (refer to the [Physician & Professional Services chapter](#) [Ch. 5] of this manual), and are not part of the hospice cap amount.
- Do not submit denied Medicare physician payments that are related to the terminal illness.
- Denied Medicare payments for physician services must have an attachment stating the reason(s) Medicare denied the services. (Services must not be related to the terminal illness).

Hospice Transaction Form

PDF document available at: <http://edocs.dhs.state.mn.us/lfserver/legacy/DHS-2868-ENG>

Legal References

Minnesota Rules [9505.0297](#); [9505.0446](#)

Balanced Budget Act of 1997

[42 CFR 418](#)

42 CFR 1396a