

Administrative Code

Title 23: Medicaid
Part 205
Hospice Services

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Title 23: Division of Medicaid

Part 205: Hospice Services

Part 205 Chapter 1: Program Overview

Rule 1.1: General Provisions and Definitions

A. Admission to hospice and subsequent election periods must be prior authorized through a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designated entity.

B. The hospice provider must provide all required services to meet the needs of the beneficiary related to the terminal illness and related conditions.

C. The Division of Medicaid covers medically necessary hospice services for beneficiaries when the following criteria are met:

1. A written certification specifying the beneficiary's medical prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course and the written certification is in accordance with 42 C.F.R. § 418.22 and the Mississippi State Department of Health (MSDH) Minimum Standards of Operation for Hospice,

2. A beneficiary or a beneficiary's guardian/legal representative has elected hospice care services for the palliation and management of a beneficiary's terminal illness and related conditions,

3. Services are reasonable and necessary for the palliation and management of a beneficiary's terminal illness and related conditions,

4. A plan of care (POC) is established, prior to hospice care services beginning, which requires periodic review by the attending physician, if any, the medical director, and the interdisciplinary group of the hospice program, and

5. The hospice care services are consistent with the beneficiary's established plan of care.

D. Hospice services are only covered for palliative management of a terminal illness except for Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries.

E. The hospice provider must develop and maintain a system of communication and integration. Therefore, the hospice’s own policies and procedures must:

1. Ensure that the interdisciplinary team/interdisciplinary group (IDT/IDG) maintains responsibility for directing, coordinating, and supervising the care and services provided.

2. Ensure that the care and services are provided in accordance with the POC.

3. Ensure that the care and services provided are based on all assessments of the beneficiary and family needs.

4. Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.

5. Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.

F. Persons enrolled in Home and Community-Based Services (HCBS) waivers who elect to receive hospice care may not receive HCBS waiver services which are duplicative of any services rendered through hospice. Persons may receive non-duplicative HCBS waiver services in coordination with hospice services.

G. The Division of Medicaid holds the hospice provider liable for the following circumstances including, but not limited to:

1. Duplicative hospice and/or HCBS waiver services, and/or

2. Failure to fully utilize hospice benefits and palliative services related to the person's terminal illness and related conditions prior to utilizing HCBS waiver services.

H. The Division of Medicaid defines:

1. Terminal illness as an illness/condition with a prognosis of life expectancy of six (6) months or less, if the illness/condition follows its normal course.

2. Hospice as a public agency or private organization or subdivision of either of these that is primarily engaged in providing hospice care to terminally ill beneficiaries and meets Medicare Conditions of Participation for hospices and has a valid Medicaid provider agreement.

3. Hospice care as a comprehensive set of services, described in section 1861(dd)(1) of the Social Security Act, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill beneficiary and/or family members as delineated in a specific plan of care for the beneficiary.

4. Palliative care as beneficiary and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate beneficiary autonomy, access to information, and choice.

5. Hospice physician as a doctor of medicine or osteopathy who is legally authorized to practice medicine in the state of Mississippi and designated by the hospice to provide care

to hospice beneficiaries in coordination with the beneficiary' s attending physician, if the beneficiary has an attending physician.

6. Attending physician as a doctor of medicine or osteopathy who is legally authorized to practice medicine in the state of Mississippi or a nurse practitioner who meets training, education, and experience requirements as described in 42 C.F.R. § 410.75 and in accordance with the Mississippi Nurse Practice Act. The attending physician is identified by the beneficiary, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the beneficiary's medical care.

7. False claims as a term used when a person knowingly makes an untrue statement or claim to gain a benefit or reward.

8. Election statement as a written statement electing hospice care filed by a beneficiary or the beneficiary's guardian/legal representative with a hospice provider.

9. Prior authorization as the process of reviewing a request for services and determining beneficiary eligibility, coverage, medical necessity, and appropriateness of services. Refer to Miss. Admin. Code Part 205, Rule 1.11 for required documentation.

10. Election period as a predetermined timeframe for which a beneficiary may elect to receive Medicaid coverage of hospice care during the beneficiary's lifetime. Election periods consist of:

    a) An initial ninety (90)-day period once in a lifetime,

    b) A subsequent ninety (90)-day period once in a lifetime, and

    c) Subsequent sixty (60)-day periods with unlimited increments which require face-to-face encounters with a hospice physician or hospice nurse practitioner.

11. Reasonable and necessary as safe and effective services which are not experimental or investigational and are appropriate, including the duration and frequency in terms of whether the item or service is:

    a) Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary's condition or to improve the function of a malformed body member,

    b) Ordered and furnished in a setting appropriate to the beneficiary's medical needs and condition, and

    c) One that meets, but does not exceed, the beneficiary's medical need.

12. Period of crisis as a period in which a beneficiary requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms.

13. Bereavement counseling as emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment.

Source: 42 C.F.R. Part 418; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2018.

Rule 1.2: Provider Enrollment Requirements

Providers of hospice must comply with all federal, state, and local laws and regulations related to the health and safety of beneficiaries and:

A. Meet the conditions of participation set forth in 42 C.F.R. Part 418, Subpart D,

B. Be licensed and certified for participation by the Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification (HFLC), and meet all requirements in accordance with the rules and regulations as defined in the Minimum Standards of Operation for Hospice per the MSDH,

C. Enter into a provider agreement with the Mississippi Division of Medicaid,

D. Satisfy all requirements set forth in Part 200, Rule 4.8 and must provide to the Division of Medicaid:

    1. A National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

    2. Written confirmation from the Internal Revenue Service (IRS) confirming the provider's tax identification number and legal business name,

    3. A copy of the provider's current Medicare certification or Tie-In Notice from the Medicare Intermediary. An Explanation of Medicare Benefits (EOMB) is not acceptable, and

    4. A copy of the provider's current license or certification letter from the state of the servicing location.

Source: 42 C.F.R. Part 418; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2018.

Rule 1.3: Certification and Recertification of Terminal Illness

A. Only a Medicaid enrolled medical doctor or doctor of osteopathy can certify or recertify a terminal illness.

B. A beneficiary who reaches a point of stability and no longer meets the definition of terminally ill must not be recertified and must return to Medicaid benefits, if eligible.

C. The physician(s) signing the written certification/recertification statement can be held liable for causing false claims to be submitted.

D. Certifications/recertifications of terminal illness are based on the clinical judgment of the certifying physician(s) regarding the normal course of the beneficiary's terminal illness and must conform to the following requirements:

1. The certification/recertification must specify that the beneficiary's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course.

2. Clinical information and other documentation that support the medical prognosis of six (6) months or less must accompany the certification including, but not limited to,

    a) Terminal diagnosis and related diagnoses,

    b) Specific clinical findings, prognostic indicators, functional ability scales, symptom management scales, and other pertinent medical documentation,

    c) Coordinating national or local coverage determinations, if any,

    d) Laboratory reports,

    e) Radiology reports, and/or

    f) Pathology reports.

3. The certifying physician must complete a brief narrative explanation of the clinical findings that supports a life expectancy of six (6) months or less on the certification/recertification form, or as an attachment to the certification/recertification form.

    a) If the narrative exists as an attachment to the certification/recertification form, in addition to the physician's signature on the certification/recertification form, the physician must also sign immediately following the narrative in the addendum.

    b) The narrative must include a statement directly above the physician signature attesting that by signing, the narrative is based on his/her review of the beneficiary's medical record or, if applicable, his/her examination of the beneficiary.

    c) The narrative must reflect the beneficiary's individual clinical circumstance and cannot contain check boxes or standard language used for all beneficiaries.

d) The narrative associated with the third election period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of six (6) months or less.

4. The physician or nurse practitioner who performs the face-to-face encounter with the beneficiary must attest in writing that he or she had a face-to-face encounter with the beneficiary, including the date of the visit. The attestation of the nurse practitioner or a non-certifying hospice physician must state the clinical findings of that visit were provided to the certifying physician for use in determining continued eligibility for hospice care.

5. All certifications/recertifications of terminal illness must be signed, dated, and must include the election period dates to which the certification or recertification applies.

E. The hospice must obtain written certification of terminal illness for each election period, even if a single election continues in effect.

1. For the initial ninety (90) day election period, the hospice must obtain written certification statements from:

a) The medical director of the hospice or the physician member of the hospice interdisciplinary group, and

b) The beneficiary's attending physician, if the beneficiary has an attending physician.

2. For subsequent election periods, the only requirement is recertification by the hospice medical director or physician member of the hospice interdisciplinary group.

F. The hospice provider must obtain written certification of terminal illness within two (2) calendar days, after the initiation of hospice care.

1. If the hospice cannot obtain the written certification of terminal illness within two (2) calendar days, after the initiation of hospice care, the hospice must obtain a verbal certification of terminal illness within two (2) calendar days. The hospice must obtain the written certification/recertification of terminal illness no later than eight (8) days after care is initiated and before submitting a claim for payment.

2. For recertifications, the hospice must obtain, no later than two (2) calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group.

G. Certifications/recertifications of terminal illness cannot be completed more than fifteen (15) calendar days prior to the effective date of the election period.

H. As of January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter to gather clinical findings to determine continued eligibility for hospice care

services for each hospice beneficiary whose total stay across all hospices is anticipated to reach the third benefit period. The face-to-face encounter must:

1. Occur no more than thirty (30) calendar days prior to the third election period recertification, and

2. Occur every election period recertification, thereafter.

Source: 42 C.F.R. Part 418; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2018.

Rule 1.4: Hospice Eligibility, Election, Transfer, Revocation, and Discharge

A. A beneficiary must meet eligibility requirements for hospice care services. For the duration of an election of hospice care services, a beneficiary waives all rights to Medicaid State Plan services for treatment related to the terminal illness and related conditions. In order to be eligible to elect hospice care services under Medicaid, a beneficiary must:

   1. Be Medicaid eligible for full benefits,

   2. Be certified by a physician as terminally ill in compliance with 42 C.F.R. § 418.22,

   3. Require medically necessary treatment for the palliation and management of a terminal illness and related conditions,

   4. The beneficiary or legal guardian/representative must elect hospice care in accordance with 42 C.F.R. § 418.24.

B. A beneficiary that meets hospice care eligibility requirements, and chooses the Medicaid hospice benefit must file an election statement with a Mississippi Medicaid enrolled hospice provider. For dual eligible beneficiaries, refer to Rule 1.10.

C. The Medicaid enrolled hospice provider must submit the following to the Utilization Management / Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity within five (5) calendar days of a beneficiary's admission to hospice which includes the following:

   1. The beneficiary's election statement, which includes the following:

      a) Identification of the particular hospice that will provide care to the beneficiary,

      b) The beneficiary's acknowledgment or legal guardian's/representative's acknowledgment, if applicable, that the beneficiary has been given a full understanding of hospice care, particularly the palliative rather than curative nature of treatment,

c) The beneficiary’s acknowledgement or legal guardian's/representative’s acknowledgment, if applicable, that the beneficiary understands that certain Medicaid State Plan services are waived by the election of hospice,

d) An effective date of the election period which cannot be earlier than the date of the election statement,

e) The name of the beneficiary's attending physician, if any, along with the following information including, but not limited to, the attending physician's:

1) Full name,

2) Office address,

3) National Provider Identification (NPI) number, and

4) Other detailed identifying information.

f) The beneficiary's acknowledgement or legal guardian's/representative's acknowledgment, if applicable, that the designated attending physician is the beneficiary's or legal guardian's/representative's choice.

g) The signature of the beneficiary or signature of the legal guardian/representative, if applicable, and date signed.

2. Prior authorization requests must include the following for the initial ninety (90) day election period:

a) Signed notice of election form,

b) Signed Physician Certification/Recertification of Terminal Illness Form,

c) Clinical/medical information supporting terminal prognosis,

d) Physician orders,

e) Current medication list, and

f) Hospice provider plan of care.

D. The Medicaid hospice provider must submit prior authorization for any subsequent ninety (90) day election period and subsequent sixty (60) day hospice election periods five (5) calendar days prior to the end of the current election period.

1. The following prior authorization documentation is required:

a) Signed Physician Certification/Recertification of Terminal Illness Form (DOM 1165 C),

b) Updated clinical/medical information supporting terminal prognosis,

c) Updated physician orders,

d) Updated medication record,

e) Updated plan of care,

f) Beneficiary's current weight, vital sign ranges, lab tests, and

g) Any other documentation supporting continuation of hospice services.

2. An election to receive hospice care services is considered to continue through the initial election period and through subsequent election periods without a break in service as long as the beneficiary:

a) Remains in the care of a hospice,

b) Does not revoke the election,

c) Is not discharged from the hospice, and

d) Continues to meet Medicaid eligibility requirements.

E. Additional documentation that is requested by the UM/QIO that is not received within the time period outlined in the Notice of Pending or Suspended Review will result in the effective date beginning when completed required documentation is received.

1. The Division of Medicaid may waive the consequences of failure to submit timely documentation for exceptional circumstances. Exceptions to notice within five (5) calendar days:

a) Fire,

b) Floods,

c) Embargoes,

d) War, acts of war, insurrections, riots,

e) Strikes, lockouts or other labor disturbances,

f) Or acts of God.

2. A provider so affected shall use reasonable commercial efforts to avoid or remove such causes of nonperformance, and shall provide proper notice hereunder immediately whenever such causes are removed. Changes to the scope of available services or reimbursement methodology for the provision of certain services through legislative or regulatory action shall not constitute an unforeseeable circumstance within the meaning of this section.

F. A beneficiary or legal guardian/representative may change, once per election period, the designation of the particular hospice from which hospice care will be received. The change of the designated hospice is not considered a revocation of the election or discharge from hospice services, but is a transfer.

1. The beneficiary or legal guardian/representative must file, with the hospice from which hospice care has been received and with the newly designated hospice, a signed statement that includes the following information:

a) The name of the hospice from which the beneficiary currently receives hospice care,

b) The name of the hospice the beneficiary chooses to transfer to, and

c) The effective date of the transfer.

2. The new hospice provider chosen by the beneficiary or legal guardian/representative must file the transfer notice and complete all assessments as required by the hospice Conditions of Participation and any federal and state laws.

G. A beneficiary or legal guardian/representative may revoke the election of hospice care services at any time which results in forfeiture of any remaining days in that election period.

1. The revocation must be in writing and filed with the hospice provider and must include:

a) A signed statement that the beneficiary revokes the election for hospice care services for the remainder of that election period, and

b) The effective date of the revocation which cannot be earlier than the date that the revocation is made.

2. Verbal revocation of hospice care services is not acceptable.

3. Upon revoking hospice care services, the beneficiary's waived Medicaid benefits will resume.

4. The provider must file a revocation of hospice services notice to the UM/QIO Division of Medicaid or designee within five (5) calendar days after the effective date of the revocation.

5. The beneficiary or legal guardian/representative may, at any time after a revocation, elect to receive hospice coverage for any other hospice election periods the beneficiary is eligible to receive.

H. The hospice provider must notify the Division of Medicaid of any discharge by filing a discharge notice within five (5) calendar days after the effective date of discharge.

1. A hospice provider can only discharge a beneficiary as a result of one (1) of the following:

a) The beneficiary or guardian/legal representative transfers to another hospice provider,

b) The beneficiary moves out of the geographic area that the hospice defines in its service area,

c) The beneficiary's condition improves and he/she is no longer considered terminally ill,

d) Discharge for cause which is extraordinary circumstances in which the hospice provider would be unable to continue to provide hospice care services. Before seeking a discharge for cause of a beneficiary, the hospice provider must:

1) Advise the beneficiary that a discharge for cause is being considered,

2) Make a serious effort to resolve the problem(s) presented by the beneficiary's behavior or situation, and

3) Ascertain that the beneficiary's proposed discharge is not due to the beneficiary's use of necessary hospice services,

4) Document the problem(s) and efforts made to resolve the problem(s) in the beneficiary's medical records, and

5) Notify the UM/QIO Division of Medicaid or designee of the circumstances surrounding the impending discharge.

e) Beneficiary or guardian/legal representative decides to revoke the hospice benefit, or

f) The beneficiary dies,

2. The hospice provider, prior to discharging a beneficiary for any reason other than revocation, transfer, or death, must obtain a written physician's discharge order from the hospice medical director. If a beneficiary has an attending physician involved in his or her care, this physician should be consulted before discharge and the physician's review and decision included in the discharge note.

3. A beneficiary, upon discharge from a hospice provider during a particular election period for reasons other than immediate transfer to another hospice, is no longer covered under Medicaid for hospice care and:

    a) Resumes Medicaid coverage of the benefits waived, if eligible, and

    b) May at any time elect to receive hospice care if he or she is again eligible to receive the benefit.

4. The hospice provider must have in place a discharge planning process that takes into account the prospect that a beneficiary's condition might stabilize or otherwise change such that the beneficiary cannot continue to be certified as terminally ill. Prior to discharging a beneficiary who is no longer certified as terminally ill, the discharge planning process must include planning for any necessary:

    a) Family counseling,

    b) Beneficiary education, and/or

    c) Other services.

I. Hospice providers cannot automatically or routinely discharge a beneficiary at its discretion, even if the hospice care is costly or inconvenient.

Source: 42 C.F.R. Part 418; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2022; Revised eff. 04/01/2018; Revised Miss. Admin. Code Part 205, Rule 1.4.E. eff. 06/01/2016.

Rule 1.5: Hospice Plan of Care (POC)

A. The hospice provider must ensure each beneficiary has an individualized written plan of care (POC) established by the hospice interdisciplinary team/interdisciplinary group (IDT/IDG) in collaboration with the attending physician, if any, beneficiary, family and/or primary care giver that specifies the hospice care and services necessary to meet the beneficiary's and family's specific needs identified in the initial, comprehensive, and updated comprehensive assessments.

B. The hospice provider must ensure that each beneficiary and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the POC.

C. The IDT/IDG must be designated by the hospice and be composed of representatives from all the core services and include, at a minimum:

    1. A doctor of medicine or osteopathy,

2. A registered nurse (RN) designated to provide coordination of care and to ensure continuous assessment of each beneficiary's and family's needs and implementation of the interdisciplinary POC,

3. A social worker, and

4. A pastoral or other counselor.

D. The POC must be developed for each beneficiary/family by a minimum of two (2) IDT/IDG members and must be approved or revised by the full IDT/IDG and the hospice medical director at the next IDT/IDG meeting. The IDT/IDG is responsible for:

1. Participation in the establishment of the POC within forty-eight (48) hours of admission to hospice,

2. Periodic review and revision of the most current beneficiary/family assessment, evaluation of care needs and updating the POC as frequently as the beneficiary's condition requires but no less than every:

   a) Fourteen (14) calendar days for home care, and

   b) Seven (7) calendar days for general inpatient care,

3. Direction, coordination and supervision of the hospice care and services provided in accordance with the POC and comprehensive assessments, and

4. Signing initial, periodic, and revisions of the POC.

D. The POC must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:

1. Interventions to manage pain and symptoms,

2. A detailed statement of the scope and frequency of services necessary to meet the specific beneficiary and family needs,

3. Measurable outcomes anticipated from implementing and coordinating the POC,

4. Drugs and treatment necessary to meet the needs of the beneficiary,

5. Medical supplies and appliances necessary to meet the needs of the beneficiary,

6. The IDT's/IDG's documentation of the beneficiary's or guardian's/legal representative's level of understanding, involvement, and agreement with the POC in accordance with the hospice's own policies, in the medical record.

E. The POC of a resident of a long-term care facility receiving hospice care should be coordinated between the long-term care facility and the hospice provider to ensure continuity of care.

F. The POC of a waiver participant receiving hospice care should be coordinated between the hospice provider and the waiver provider to ensure continuity of care. Waiver participants who elect to receive hospice care may not receive waiver services which are duplicative of any services rendered through hospice.

Source: 42 C.F.R. Part 418; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2018.

Rule 1.6: Covered Services

The Division of Medicaid covers hospice services in accordance with the hospice plan of care (POC), when prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designated entity and provided in a manner that is consistent with accepted standards of practice and complies with all federal and state laws in addition to Medicare's Conditions of Participation and includes the following:

A. Core services, with the exception of physician services, must be provided directly by hospice employees on a routine basis. The following are hospice core services:

1. Physician services,

2. Nursing services by a registered nurse (RN),

3. Medical social services by a licensed social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician,

4. Counseling services which includes, but not limited to:

a) Bereavement counseling services provided to the beneficiary's family before and up to one (1) year after the beneficiary's death and the hospice provider must:

1) Have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling.

2) Counsel residents of a skilled nursing facility/nursing facility (SNF/NF) or an intermediate care facility for individuals with intellectual disabilities (ICF/IID) when appropriate and identified in the bereavement plan of care (POC).

3) Ensure that bereavement services reflect the needs of the bereaved.

4) Develop a bereavement POC that notes the kind of bereavement services to be offered and the frequency of service delivery.

b) Spiritual counseling, and

c) Dietary counseling by a registered dietician, RN, or other qualified professionals.

B. Non-core services which include:

1. Physical therapy, occupational therapy, and speech-language pathology services,

2. Hospice aide and homemaker services furnished by qualified personnel, and

3. Volunteer services used in defined roles and under the supervision of a designated hospice employee.

C. Routine Home Care (RHC) which is a day when a beneficiary who has elected to receive hospice care is at home and is not receiving Continuous Home Care.

D. Continuous Home Care which is a day when a beneficiary who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home.

1. The hospice must provide a minimum of eight (8) aggregate hours of care by an RN, hospice aide and/or homemaker during a twenty-four (24) hour day that begins and ends at midnight. Homemaker or hospice aide services or both may supplement the nursing care during periods of crisis but care during these periods must be predominantly nursing care provided by an RN, which means more than half of the hours of care are provided by an RN.

2. Continuous Home Care may not be provided when the hospice beneficiary is a long-term care facility resident or an inpatient of a free-standing hospice.

E. Inpatient Respite Care which is a day when a beneficiary who has elected hospice care receives care in an approved facility on a short-term basis for respite when necessary to relieve the family members or other persons who normally care for the beneficiary at home and must not be:

1. Greater than five (5) consecutive days at a time.

2. Long-term care facility resident, assisted living (AL) waiver participant, or an inpatient of a free-standing hospice, or

3. Provided when services are duplicated or any other like services are being delivered to the beneficiary.

F. General Inpatient Care which is a day when a beneficiary who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings and provided in a participating hospice inpatient unit, hospital, or a participating skilled nursing facility (SNF) or nursing facility (NF) that additionally meets the special hospice standards regarding patient and staffing areas.

G. Medical supplies and appliances, drugs and biologicals related to the palliation and management of the beneficiary's terminal illness and related conditions as identified in the hospice POC.

H. Concurrent hospice and home and community based-services (HCBS) waiver services only if:

1. Hospice benefits which address the person's terminal illness are fully utilized prior to waiver service utilization in instances of potential duplication including, but not limited to:

a) Hospice aide/homemaker and HCBS waiver personal care attendant services,

b) Hospice in-patient respite and HCBS waiver institutional respite,

c) Hospice medical appliances/supplies and HCBS waiver specialized medical equipment/supplies,

d) Hospice physical therapy, speech-language pathology, occupational therapy and HCBS waiver physical therapy, speech therapy, occupational therapy, and

e) Hospice nursing care and HCBS waiver home health skilled nurse visits.

2. A face-to-face person centered planning (PCP) conference with both providers is held within five (5) business days of a person receiving concurrent services. If the face-to-face conference cannot be held within five (5) business days due to justifiable logistical reasons, a conference call must be held:

a) Within five (5) business days of a person receiving concurrent services, and

b) A face-to-face conference with both providers must be held within thirty (30) days of the person receiving concurrent services.

3. A face-to-face PCP conference is conducted within five (5) business days of a significant change in the person's condition that warrants changes to the person's services on the hospice POC and/or HCBS plan of services and supports (PSS).

4. The following persons are in attendance at the face-to-face PCP conference:

a) The person and/or the person's designated representative,

b) The hospice provider, and

c) The HCBS waiver case manager/support coordinator.

5. The hospice POC and an HCBS PSS:

a) Are maintained by both providers in the medical record,

b) Identify the services the person receives,

c) Designate which provider is responsible for delivering each service,

d) Indicate the frequency of each service,

e) State a reason each service performed by a waiver is not covered by hospice,

f) Meet the standard requirements of the hospice POC and the applicable requirements of the HCBS waiver program's PSS,

g) Are signed by both the hospice provider and HCBS waiver case manager/support coordinator, and

h) Are approved by the Division of Medicaid.

Source: Miss. Code Ann. §§ 41-85-1 through 25, 43-13-121.

History: Revised eff. 04/01/2018.

Rule 1.7: Transportation

A. The hospice provider must:

1. Provide transportation for medical services relating to the terminal illness and related conditions after the admission to the hospice,

2. Provide transportation from the hospital to the beneficiary's residence or to a freestanding hospice facility during a period of hospitalization after election of the hospice benefit.

3. Arrange for non-emergency transportation through the non-emergency transportation (NET) broker program when the hospice beneficiary requires or requests transportation for services that are not palliative in nature or for transportation services unrelated to the terminal illness and related conditions.

B. Transportation is not covered under the hospice benefit when:

1. The hospice beneficiary calls 911 for ambulance/medical assistance for the terminal illness or related conditions, or

2. The hospice beneficiary requires or requests transportation for medical services that are not palliative in nature or are unrelated to the terminal illness or related conditions.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2018.

Rule 1.8: Reimbursement

A. A hospice provider must obtain written certification/recertification of terminal illness before billing for hospice services.

B. The Division of Medicaid reimburses hospice providers at one (1) of the four (4) following predetermined rates for each day that the beneficiary is under the care of the hospice based on the level of care required to meet the beneficiary's and family's needs:

   1. Routine Home Care (RHC):

      a) Is reimbursed for each day the beneficiary is under the care of the hospice provider and not receiving one of the other categories of hospice care. This rate is reimbursed without regard to the volume or intensity of routine home care services provided on any given day, and is also reimbursed when the beneficiary is receiving outpatient hospital care for a condition unrelated to the terminal condition.

      b) Beginning January 1, 2016 is reimbursed:

         1) At a higher payment rate for the first sixty (60) days of hospice care, and

         2) At a reduced payment rate for hospice care for sixty-one (61) days and over, and

      c) Includes a service intensity add-on (SAI) payment in addition to the per-diem RHC rate for the actual direct patient care hours provided by a registered nurse (RN) or social worker, up to four (4) hours total per day, during the last seven (7) days of a beneficiary's life when discharged due to death. The SAI payment is equal to the continuous home care hourly payment rate multiplied by the amount of direct care actually provided by an RN and/or social worker.

   2. Continuous Home Care:

      a) Is reimbursed only during a period of crisis, defined as a period in which the beneficiary requires continuous care to achieve palliation and management of acute medical symptoms, and only as necessary to maintain the terminally ill beneficiary at home.

b) Must be a minimum of eight (8) aggregate hours of predominantly nursing care during a twenty-four (24) hour day, which begins and ends at midnight, and:

1) Nursing care must be provided for more than half of the period of care, and

2) Must be provided by a registered nurse.

c) Is reimbursed at the hourly rate up to twenty-four (24) hours per day.

d) Is not reimbursed during a hospital, long-term care facility, or inpatient free-standing hospice facility stay.

3. Inpatient Respite Care:

a) Is reimbursed on any day on which the beneficiary is an inpatient in an approved facility for inpatient respite care.

b) Is limited to a maximum of five (5) consecutive days at a time.

c) Is not reimbursed when the hospice beneficiary is a long-term care facility resident, assisted living (AL) waiver participant, or an inpatient of a free-standing hospice.

4. General Inpatient Care:

a) Is reimbursed at the general inpatient care rate for each day such care is consistent with the beneficiary's plan of care.

b) Is reimbursed on any day on which the beneficiary is an inpatient in an approved facility for general inpatient care.

c) Is reimbursed at the general inpatient care rate for the date of admission and all subsequent inpatient days, except the day on which the beneficiary is discharged.

C. The Division of Medicaid reimburses the hospice for respite and general inpatient days. The hospice must reimburse the facility that provides respite inpatient care.

D. The Division of Medicaid does not reimburse for the date of discharge or the date of death.

E. Payment for physician services provided in conjunction with the hospice benefit is based on the type of service performed.

F. Payment for physicians' administrative and general supervisory activities is included in the hospice payment rates which include:

1. Participating in the establishment, review and updating of plans of care,

2. Supervising care and services, and

3. Establishing governing policies.

G. The Division of Medicaid reimburses the hospice provider for beneficiaries in a long-term care facility at ninety-five percent (95%) of the long-term care facility's Medicaid per-diem rate.

1. If the hospice provider fails to submit the required documentation to the UM/QIO within five (5) calendar days of the hospice election, the effective date will be the date when the completed documentation is received.

a) The Division of Medicaid will not reimburse the hospice or nursing facility providers for days prior to the effective date of the election statement.

b) The hospice and/or nursing facility cannot seek payment from the beneficiary.

2. The Division of Medicaid does not reimburse the hospice provider for long-term care bed-hold days.

H. Hospice providers must report all diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual.

I. The Division of Medicaid reimburses drugs not related to the beneficiary's terminal illness or related conditions to the dispensing pharmacy through the Medicaid Pharmacy Program.

J. The Division of Medicaid reimburses disease specific drugs as well as other drugs related to the palliation and management of the beneficiary's terminal illness and related conditions in the hospice per diem rates and are not be reimbursed through the Medicaid Pharmacy Program.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2022; Revised eff. 04/01/2018.

Rule 1.9: Documentation Requirements

A. The hospice provider must maintain medical records for each beneficiary at the hospice site which corresponds to the address associated with the provider license and Division of Medicaid provider number and must include, but not limited to, the following:

1. The Division of Medicaid's specific hospice related forms which must be complete and accurate:

a) Terminal illness certification/recertification form with supporting documentation,

b) Hospice notice of election form,

c) Hospice discharge/Hospice revocation form, if applicable,

d) Hospice transfer form, if applicable,

e) Hospice discharge/Hospice revocation form including the discharge summary for a hospice beneficiary which must include the following:

1) A summary of the beneficiary's stay including treatments, symptoms, and pain management,

2) The beneficiary's current plan of care (POC),

3) The beneficiary's current physician orders, and

4) Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility.

The hospice must forward to the receiving facility for any beneficiary transferred to another hospice provider, the following:

(1) The hospice discharge summary, and

(2) The beneficiary's clinical record, if requested.

(b) The hospice must forward to the beneficiary's attending physician for any beneficiary that revokes hospice election or is discharged the following:

(1) The hospice discharge summary, and

(2) The beneficiary's clinical record, if requested.

2. An interdisciplinary POC including the initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes that support each hospice service rendered including needs, care, services and goals.

3. A copy of a waiver participant's plan of services and supports (PSS) when the hospice beneficiary is also receiving waiver services.

4. The certifying physician's election period face-to-face encounter and date of encounter with clinical findings to support a life expectancy of six months or less. If a non-certifying hospice physician or nurse practitioner performs the face-to-face encounter, documentation must show:

a) An attestation in writing of the face-to-face encounter that the clinical findings of the visit were provided to the certifying physician for use in determining continued eligibility for hospice care, and

b) The date of the face-to-face encounter.

5. Treatment rendered including:

a) Each discipline's visit or contact of the treatment or intervention rendered at the frequency ordered on the POC.

b) Documentation to show relationship of the treatment plan and medications to the terminal illness and related conditions,

c) Responses to medications, symptom management, treatments, and services, and

d) Appropriate discipline's signature or initials on all medical records.

6. A current medication list for each month of certification that clearly indicates the medications the hospice paid related to the terminal illness and related conditions. The list must contain the name, strength, dosage, and route of the drugs administered to the hospice beneficiary and the name and address of the pharmacies that provided the medications to the hospice beneficiary.

7. A current list of medical appliances and supplies related to the terminal illness and related conditions paid for by the hospice and the names and address(s) of the providers paid.

B. Documentation must be maintained in accordance with requirements set forth in Part 200, Chapter 1, Rule 1.3. and all hospice providers must retain medical records for a minimum of six (6) years after death or discharge of a beneficiary, unless State law stipulates a longer period of time.

C. Concurrent providers of hospice services and home and community-based (HCBS) waiver services must maintain medical records in accordance with requirements set forth in Miss. Admin. Code Part 200, Rule 1.3 and must include, but not limited to:

1. Additional documentation requirements included in Miss. Admin. Code Part 205, Rule 1.8 for hospice providers and in Miss. Admin. Code Part 207 for HCBS waiver providers.

2. All person centered planning (PCP) conferences, including but not limited to:

a) Time and date of conference,

b) Persons in attendance,

c) Any applicable notes, and

d) Signatures of the hospice provider and HCBS case manager/support coordinator.

3. The hospice plan of care (POC) and the HCBS plan of services and supports (PSS) which must include, but not limited to:

a) A list of all hospice and HCBS waiver services the person receives,

b) The provider responsible for providing each listed service,

c) The frequency of each service, and

d) An explanation when a service is provided by a HCBS waiver provider instead of a hospice provider.

e) Monthly communication between the hospice provider and the HCBS waiver provider must be documented in the person's medical record including, but not limited to:

1) Date and time of the communication,

2) Staff included in the communication,

3) Method of communication, and

4) Topics discussed.

Source: 42 C.F.R. Part 418; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2018.

Rule 1.10: Dual Eligibles

A. The hospice benefit must be used simultaneously under Medicare and Medicaid with Medicare providing primary coverage for dual eligible beneficiaries.

B. The Division of Medicaid requires the hospice provider to submit the Notice of Hospice Election or Discharge for Dual Eligible Beneficiaries (Form DOM 1166C) to the Division of Medicaid's Utilization Management/Quality Improvement Organization (UM/QIO) within five (5) calendar days of the beneficiary's hospice election or discharge date.

1. If the hospice provider fails to submit Form DOM 1166C to the UM/QIO within five (5) calendar days of the election period, the effective date will be the date when the completed Form DOM 1166C is received.

a) The Division of Medicaid will not reimburse the hospice or nursing facility providers for days prior to the effective date of the election statement.

b) The hospice and/or nursing facility cannot seek payment from the beneficiary.

2. The UM/QIO will issue a prior authorization number once Form DOM 1166C is received to be notated on the claim by the hospice provider for nursing facility room and board reimbursement.

3. If the beneficiary elects the hospice benefit in a home setting, the UM/QIO will issue a prior authorization number once Form DOM 1166C is received.

C. The Division of Medicaid may waive the consequences of failure to submit timely documentation for exceptional circumstances.

1. Exceptions to notice within five (5) calendar days:

a) Fire,

b) Floods,

c) Embargoes,

d) War, acts of war, insurrections, riots,

e) Strikes, lockouts or other labor disturbances,

f) Or acts of God.

2. A provider so affected shall use reasonable commercial efforts to avoid or remove such causes of nonperformance, and shall provide proper notice hereunder immediately whenever such causes are removed. Changes to the scope of available services or reimbursement methodology for the provision of certain services through legislative or regulatory action shall not constitute an unforeseeable circumstance within the meaning of this section.

Source: 42 C.F.R. § 418.24; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2022; Revised eff. 03/01/2021; Revised eff. 04/01/2018.

Rule 1.11: Prior Authorization

A. Prior authorization is required for the initial and all subsequent hospice election periods.

B. All prior authorization requests must be submitted within ten (10) calendar days of the effective date of the election period and must include the following:

1. For the initial ninety (90) day election period:

a) Signed notice of election form,

b) Signed certification/recertification of terminal illness form,

c) Clinical/medical information supporting terminal prognosis,

d) Physician orders,

e) Current medication list, and

f) Hospice provider plan of care.

2. For subsequent ninety (90) day election period and subsequent sixty (60) day election periods:

a) Signed certification/recertification of terminal illness form,

b) Updated clinical/medical information supporting terminal prognosis,

c) Updated physician orders,

d) Updated medication record,

e) Updated plan of care,

f) Beneficiary's current weight, vital sign ranges, lab tests, and

g) Any other documentation supporting continuation of hospice services.

C. All required documentation must be submitted with the prior authorization requests. Documentation that is incomplete or not received within fifteen (15) calendar days of the election period effective date will result in the effective date beginning when completed required documentation is received.

Source: Miss. Code Ann. § 43-13-121.

History: New Rule eff. 04/01/2018.