

## Chapter 28

# Hospice Services

The hospice benefit is a comprehensive package of services offering palliative care support to terminally ill members and their families. Hospice care is palliative, with a focus on holistic support and relieving pain and other symptoms of the terminal illness. Members electing the hospice benefit agree to receive only palliative care for their terminal illness or condition. When a member voluntarily elects the hospice benefit, he/she agrees to forego curative care for his/her terminal diagnosis. In exchange, the member receives the hospice package of services. Effective January 1, 2011, an IMCare member under age 21 who elects to receive hospice care does not waive coverage for services related to the treatment of the condition for which a diagnosis of terminal illness has been made.

The hospice benefit is available to members who have been certified by a physician as terminally ill. A member is considered to be terminally ill if he/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 six months. Members who meet these requirements may elect the hospice benefit. Dually eligible members who elect the Medicare hospice benefit must also elect the Medicaid hospice benefit. Members with a terminal illness must be informed of all Medical Assistance (Medicaid) services and support options including the hospice benefit. Hospice care is entirely optional and the member may revoke his/her election at any time.

The Medical Assistance (Medicaid) hospice benefit follows the same rules and regulations as the Medicare hospice benefit, which was designed to supplement the care provided by primary caregivers such as family (as the member defines family), friends, and neighbors. The hospice benefit is not intended to replace the supportive role of the member's informal support network of primary care givers. As such, Medical Assistance (Medicaid)-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 caregivers include the following:

1. Coordinating the member's care
2. Performing personal care
3. Assisting with activities of daily living (ADL), assisting with incidental activities of daily living
4. Providing nutrition
5. Assisting with medications

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

1. Adult foster care services
2. Personal care assistant services
3. Home delivered meals
4. Lifeline
5. Community Alternative Care (CAC), Community Alternatives for Disabled Individuals (CADI), Brain Injury (BI), Elderly Waiver (EW), Developmental Disabilities (DD) waiver services, and the Alternative Care (AC) program

## Definitions

**Cap Amount:** The limit on overall hospice payment.

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

**Continuous Home Care Day:** A day in which the member 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 member at home.

More than half the care during the crisis must be nursing care provided by a registered nurse (RN) or licensed practical nurse (LPN). 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 member receives general inpatient care in a hospital, Skilled Nursing Facility (SNF), or inpatient hospice unit for control of pain or management of acute or chronic symptoms that cannot be managed in the home.

**Home:** The member's place of residence.

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

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

**Inpatient Facility:** A hospital, LTCF, 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 members 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 member because the terminally ill member is mentally or physically incapacitated.

**Palliative Care:** Care affording relief, but not cure, providing an alleviating medicine. Palliative care includes managing the symptoms experienced by the hospice member with the intent to enhance the quality of life for the hospice member and his/her family, but not directed at curing the disease.

**Respite Care:** Short-term inpatient care provided to the member only when necessary to relieve the family members or other people caring for the member.

**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 an IMCare hospice provider if it is licensed and certified for Medicare as a hospice by the Minnesota Department of Health (MDH). 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 patient loads or other extraordinary circumstances. The hospice remains responsible for the quality of services provided by contracted staff.

## Eligible Members

To be eligible for hospice services, a member must meet the following criteria:

1. Be eligible for Medical Assistance (Medicaid) or MinnesotaCare
2. Be certified as terminally ill by the medical director of the hospice or a physician member of the interdisciplinary group and the member's attending physician, if he/she has one

Medical Assistance (Medicaid) members who may be eligible for Medicare must be directed to the Social Security Administration for Medicare application. MinnesotaCare members must be directed to their local county human services agency for Medical Assistance (Medicaid) eligibility determination.

Dually eligible members who elect Medicare hospice must also elect Medical Assistance (Medicaid) hospice. The Medicare hospice election form must be sent to the Minnesota Department of Human Services (DHS) on the day of election.

A member may receive hospice care until one of the following occurs:

1. He/she is no longer certified as terminally ill
2. The member or his/her representative revokes the election of hospice care

## Service Authorization

IMCare members require a Service Authorization (*Prior Authorization Form*) before starting hospice services. Provide a statement from the physician about the member's terminal illness and life expectancy. Service Authorization is not required for dual-eligible members when Medicare will be covering the hospice needs.

## Covered Services

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

1. Physician services
2. Nursing services
3. Medical social services
4. Counseling
5. Medical supplies and equipment
6. Outpatient drugs for symptom and pain control
7. Dietary and other counseling
8. Short-term inpatient care
9. Respite care
10. Home health aide (HHA) and homemaker services
11. Physical therapy (PT), occupational therapy (OT), and speech therapy (ST)

12. Volunteer services
13. Other items and services included in the plan of care that are otherwise covered medical services

## **Hospice Care Provided in Conjunction with Other Medical Assistance (Medicaid)-Covered Services**

IMCare understands that members 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 pre-existed their terminal condition or arise during the course of their terminal condition but are unrelated to their terminal condition. A member should never be asked to make an “either/or” choice between an otherwise Medical Assistance (Medicaid)-covered, medically necessary service that is not related to the terminal condition and a covered, medically necessary hospice benefit service that is related to the terminal condition.

### **Pre-Existing Health Care Needs**

Due to the member’s pre-existing medical conditions or disability, some Medical Assistance (Medicaid)-covered services may already be needed and/or in place before the member seeks hospice. 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, amyotrophic lateral sclerosis (ALS), arthritis, cardiac conditions, Acquired Immune Deficiency Syndrome (AIDS), or high blood pressure.

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

### **Medical Needs that Arise during the Period of the Hospice Benefit but that are Unrelated to the Terminal Illness**

Sometimes members need new health care services in addition to the services that are offered as part of the hospice benefit. Medical Assistance (Medicaid)-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 an Medical Assistance (Medicaid)-Covered Service Duplicates 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 that are outside of the hospice benefit.

Because some hospice benefit services and Medical Assistance (Medicaid)-covered services may be similar, this determination process should focus on the purpose, rather than the type of service—that is, what member need is the service addressing?

The following considerations may be helpful in approaching the determination:

1. Is the purpose of a service to address a pre-existing condition or a pre-existing need?

2. Is the purpose of a service to address a health care problem that would have existed even without the terminal illness?
3. Is the purpose of a service to facilitate the member'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 Medical Assistance (Medicaid)-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 member'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 [Hospice Transaction Form \(DHS-2868\)](#).

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, email, or a face-to-face visit. Documentation such as this should be included in the member's hospice record.

The case manager will be invited to participate in the hospice interdisciplinary care team meetings for a member receiving HCBS.

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

When the member is receiving "traditional Medical Assistance (Medicaid)" home care and no case manager is involved, the hospice must coordinate care and communicate with the home care agency involved with the member, rather than through a county case manager.

### **Seeking Home and Community Based Services (HCBS) after Hospice Election**

When a member is receiving concurrent HCBS and hospice services, the HCBS are usually in place before the hospice services began.

There may be situations where a member 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 caregiver. 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 member. The member 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**

Following coordination with the hospice provider agency, county case managers must add comments on the IMCare electronic care plan 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 service agreement line items within the IMCare electronic care plan must be

adjusted as needed to reflect the type and amount of services required. Changes to services continue to require a 10-day notice to members to allow for continuity of care, patient rights, and transitional needs.

When continuing care waiver provider claims are received by IMCare, 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, IMCare will manually review HCBS provider claims to determine if payment is appropriate. Case management notes in the Medicaid Management Information System (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 eligible members and Medical Assistance (Medicaid) if the member has Medical Assistance (Medicaid) only.

### **Billing for Consulting Physician Services**

When billing for the services of a consulting physician for a Medical Assistance (Medicaid)-only member (no Medicare or other third party payer involved), break out the technical portion and bill IMCare for the physician portion only. Services provided to dually eligible members are first billed to Part B Medicare and cross-over for Medical Assistance (Medicaid) payment of copays 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 do the following:

1. Include an assessment of the member's needs
2. Identify services, including the management of discomfort and symptom relief
3. Detail the scope and frequency of services needed to meet the member's and family's needs

The hospice must designate a RN to coordinate the implementation of the plan of care for each member.

### **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 (LTCFs)**

Medical Assistance (Medicaid)-eligible residents of intermediate care facilities for the developmentally disabled

(ICF/DDs) 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 Medical Assistance (Medicaid) payments are made to the hospice provider both for 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 percent 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/DD                        | ICF/DD               | 100%                   |                  | 95% * [(B)*(C)]                      |
| NF                            | NF Case-Mix          | 100%                   |                  | 95% * [(B)*(C)]                      |
| NF                            | NF Case-Mix          | 100%                   | 111.5%           | 95% * {[(B)*(D)]*(C)}                |
| NF First 30 Days <sup>1</sup> | NF Case-Mix          | 120%                   |                  | 95% * [(B)*(C)]                      |
| NF First 30 Days <sup>1</sup> | NF Case-Mix          | 120%                   | 111.5%           | 95% * {[(B)*(D)]*(C)}                |
| Out-of-State NF               | NF Rate              | 100%                   |                  | 95% * [(B)*(C)]                      |

<sup>1</sup>Begins with date of NF admission, not Medical Assistance (Medicaid) eligibility date

The hospice must contract with and negotiate a rate with the LTCF for members who reside in the facility and elect hospice care. The LTCF must coordinate all of the member's services and care with the hospice. The hospice may negotiate with the LTCF for the LTCF to continue to collect the member's spenddown.

The hospice must notify the local county human services agency of the member's hospice election by sending (or faxing) a copy of the front page of the [Hospice Transaction Form \(DHS-2868\)](#) 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 member's medical spenddown.

Residents of ICF/DDs 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 people with terminal illness by making internal staffing adjustments, by also purchasing the specialized services, or by making staff additions. ICF/DDs 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 NF is eligible for bed-hold days. Bed-hold days are available up to 18 consecutive days per hospital admission and 36 days annually for therapeutic leave days when the facility occupancy rate is 96 percent or greater. Bed-hold rates are 30 percent of the case-mix rate, of which the agency is entitled to 95 percent of the adjusted case-mix rate for that LTCF.

**Example:** If stay is May 1 – 10 with May 1 – 7 in a nursing home, submit 0658 revenue code with the case-mix for May 1 – 7; for May 8 – 10 (hospital), submit 0185 revenue code separate for bed-hold with just the rate of charges billed.

**For hospice billing only:** Revenue code 0185 will pay only what is submitted and can be used for hospital and/or therapeutic leave days.

## Hospice Transaction Form (HTF)

The [Hospice Transaction Form \(DHS-2868\)](#) is a multipurpose form that is a tool for hospice providers to report hospice election, certification, revocation of hospice services, change of hospice provider, and member death.

For DHS notifications, use the [Hospice Transaction Form \(DHS-2868\)](#).

### Submitting the HTF

IMCare must be notified within **two days** of members who are enrolled in hospice (regardless of whether Medical Assistance [Medicaid] is the primary payer).

The Medicare- and Medical Assistance (Medicaid)-approved criteria on the hospice agency's election form are to be submitted to IMCare immediately upon enrolling with Medicare hospice. This election form must be completed with all the required/appropriate information (e.g., Personal Member Identifier [PMI], date of birth [DOB], National Provider Identifier [NPI], *International Classification of Diseases, 9<sup>th</sup> Revision, Clinical Modification [ICD-9-CM]* code, and patient's signature). IMCare must receive the information within two days of election.

Dual-eligible Medicare and Medical Assistance (Medicaid) members may submit the Medicare-approved hospice election criteria plus the IMCare required elements to IMCare in place of the IMCare HTF.

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 members enrolled in IMCare who are residing in an LTCF, submit their hospice election forms to IMCare and DHS.

DHS must also be notified when the member is no longer receiving hospice care. Fax or mail the HTF to:

Attn: Hospice Notification  
Minnesota Department of Human Services  
PO Box 64993  
Saint Paul, MN 55164-0993

Fax: **1-651-431-7433**

Hospice overpayments for spenddowns may be sent back to the following address. A copy of the original remittance advice (RA) must be included for correct claim credit. Mail to:

Attn: Benefit Recovery/Hospice  
Minnesota Department of Human Services  
PO Box 64994  
Saint Paul, MN 55164-0994

## Member Information

Enter the following member information on the HTF: member's name, address, IMCare identification (ID) number, and date of birth. If the member is Medicare/Medicaid eligible, he/she must elect Medicare hospice care in addition to Medicaid hospice care. Federal guidelines prohibit members from choosing hospice care through one program and not the other when they are Medicare/Medicaid eligible.

## Election of Hospice Services

The member or a legal representative (if the member 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. Effective January 1, 2011, an IMCare member under age 21 who elects to receive hospice care does not waive coverage for services related to the treatment of the condition for which a diagnosis of terminal illness has been made. A witness signature and date are required only if the member is unable to sign. The hospice must do the following:

1. Explain the benefits the member will receive
2. Explain the benefits the member is waiving
3. Give the member or legal representative a copy of the signed HTF
4. Retain the signed HTF in its files

The election statement must include:

1. The date hospice services are to begin
2. Name and NPI of the hospice that will provide the care
3. Member's acknowledgement that the member fully understands that the hospice provides palliative care rather than curative care with respect to the member's terminal illness
4. Member's signature

IMCare will not use the physician certification dates on the [\*Hospice Transaction Form \(DHS-2868\)\*](#), unless it was not signed in accordance with the guidelines stated in the *Certification of Terminal Illness* section. **IMCare and DHS must receive the form within two days of the member's signature.** Diagnoses such as "failure to thrive" or "weakness" are invalid hospice election diagnoses.

## Election by representative

A representative of the member may make the election and sign and submit the election statement to the hospice for the recipient according to [MN Rules part 9505.0297, subp. 6](#).

## Hospice Discharge

In most situations, discharge from hospice will occur as a result of one of the following:

1. The member decides to revoke the hospice benefit
2. The member moves away from the geographic area that the hospice defines as its service area
3. The member transfer to another hospice
4. The member's conditions improves and he/she is no longer considered terminally ill
5. The member dies

There may be extraordinary circumstances in which a hospice would be unable to continue to provide hospice care to a patient. These situations would include issues where patient safety or hospice staff safety is compromised. The hospice must make every effort to resolve these problems satisfactorily before it considers discharge an option. All efforts by the hospice to resolve the problem(s) must be documented in detail in the patient's clinical record and the hospice must notify the Medicare contractor and State Survey Agency of the

circumstances surrounding the impending discharge. The hospice may also need to make referrals to other relevant state/community agencies (e.g., Adult Protective Services) as appropriate.

### **Discharge Statement**

Complete the discharge statement if a member is no longer considered to have a life expectancy of six months or less or the member 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 member may elect, at any time, to receive curative care and terminate hospice services. The member 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 member may change hospice providers while receiving hospice services. Enter the names and NPIs of both the new and replaced hospice providers. Both hospice providers must retain copies of the HTF. IMCare, DHS, and the county, if applicable, must be notified of the change.

### **Member Date of Death**

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

### **Non-Covered Services**

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

1. Other forms of health care for treatment of:
  - a. The terminal illness for which hospice care was elected; or
  - b. A condition related to the terminal illness
2. Other hospice services or hospice services equivalent to hospice care, except those provided by the designated hospice or its contractors; and
3. Services provided under HCBS 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 an LTCF.

IMCare will pay a hospice for each day a member 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 members 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 an LTCF and certain payments to the member's attending physician are not considered when the cap amount is calculated.

## Billing Hospice Services

1. Use the 837I claim format.
2. Type of bill:
  - a. 811 Non-hospital based hospice (817 for non-hospital based hospice replacement claims)
  - b. 821 Hospital based hospice (827 for hospital based hospice replacement claims)
3. For home care, bill one of the following revenue codes:
  - a. 0651 Routine care day (less than 8 hours)
    - i. Enter the appropriate Healthcare Common Procedure Coding System (HCPCS) code (Code range Q5001 – Q5009), identifying the level of care provided for each service line
    - ii. Report units as days (1 day = 1 unit; 30 days = 30 units)
  - b. 0652 Continuous home care day, 8 or more hours of nursing care each day up to 24 hours per day
    - i. Enter the appropriate HCPCS code (code range Q5001 – Q5009), identifying the level of care provided for each service line
    - ii. Report units in 15 minute increments. (8 hours = 32 units, 24 hours = 96 units)

When billing routine home care or continuous home care (revenue codes 0651 and 0652, respectively), enter value code 61 and the appropriate 5 digit core based statistical area (CBSA) code, right justified in the corresponding field on the claim format. CBSA codes are the same for Medicare and Medical Assistance (Medicaid).

### **If the value code or CBSA code is not entered, IMCare will deny the claim.**

1. 0655 Inpatient respite day, billing may include date of admission but not date of discharge, unless discharged deceased.
2. 0656 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 percent of the total days provided to a hospice recipient.

To bill for 0658 LTCF room and board, the member must reside in an LTCF or an ICF/DD and be billed fee-for-service.

IMCare does not pay for discharge day, even upon death, while residing in an LTCF.

## Billing Hospice Physician Services

1. Use the 837P claim form.
2. Use appropriate Current Procedural Terminology (CPT)/HCPCS codes and any applicable modifiers.
3. Enter the rendering physician's individual NPI in the Rendering Provider field.
4. Enter the NPI of the hospice provider in the Billing Provider section.
5. The hospice payment for physician services is the IMCare physician payment rate and is included in the hospice cap amount.
  - a. 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 Chapter 6, Physician and Professional Services, of this manual) and are not part of the hospice cap amount.

- b. Do not submit denied Medicare physician payments that are related to the terminal illness.
- c. 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).

## **Billing Medical Supplies and Equipment**

Claims for medical supplies and equipment outside of the hospice benefit must include a signed statement from the hospice physician indicating why the equipment or supply was not related to the terminal condition.

## **Legal References**

[MN Rules part 9505.0297](#) – Hospice Care Services

[MN Rules part 9505.0446](#) – Hospice Care Payment Rates and Procedures

[Balanced Budget Act of 1997](#)

[Title 42 Code of Federal Regulations \(CFR\) Part 418](#) – Hospice Care

[Title 42 United States Code \(USC\) Section 1396a](#) – State Plans for Medical Assistance