

# Hospice Services Table of Contents

**John R. Kasich, Governor**

**John B. McCarthy, Director**

## Ohio Department of Medicaid

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<i>Please send comments to <a href="mailto:ePubs_updates@jfs.ohio.gov">ePubs_updates@jfs.ohio.gov</a></i>	
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# Medical Assistance Letters (MAL)

# MAL 596 (Rule Changes Affecting Medicaid Hospice Services)

## Medical Assistance Letter (MAL) 596

May 19, 2015

To: Interested Hospice Parties  
From: John B. McCarthy, Director  
Subject: Rule Changes Affecting Medicaid Hospice Services

Aligning Medicare and Medicaid Hospice Benefit Periods

This Medical Assistance Letter (MAL) is being released as a result of the recent rule amendments affecting Medicaid hospice for both Medicaid-only hospice recipients and dually eligible (Medicaid/Medicare) hospice recipients. The MAL reiterates the requirement for hospices to serve individuals who are discharged or choose to revoke hospice *during* a benefit period. The MAL also serves to clarify how providers are to proceed with a re-election of hospice when discharge or revocation occurs.

### Policy Statement

Rule [5160-56-03](#) of the Administrative Code, as amended on April 1, 2015, states the reasons that an individual may be discharged from the Medicaid hospice benefit or that they may choose to revoke the election of hospice care once during each benefit period. An individual may choose to re-elect the Medicaid hospice benefit *at any time* after discharge or revocation, provided the individual meets all hospice eligibility. However, the rule does not state whether or not a new benefit period will begin after an individual has revoked hospice, and then re-elects hospice.

The Ohio Department of Medicaid is hereby clarifying that, after an individual is discharged from hospice or revokes hospice and then re-elects it, the current benefit period ends at the point of discharge or revocation and a new benefit period will begin at the time that the individual is eligible to re-elect hospice benefits. This policy will align Medicaid policy with Medicare policy and eliminate inconsistency between the two programs.

### Access to Rules and Related Material

The Ohio Department of Medicaid maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this letter page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

This transmittal letter may be viewed as follows:

eManuals Home >> Medicaid - Provider >> Hospice Services >> Medical Assistance Letters (MAL) and Hospice Services - Ohio Administrative Code Rules.

From the "eManuals" page, providers may view documents online by following these steps:

- (1) Select the *Medicaid - Provider* folder;
- (2) Select the appropriate subfolder (i.e., *Hospice Services*);
- (3) Select the appropriate topic (i.e., *Medical Assistance Letters*) from the document list; and
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

### Additional Information

Questions pertaining to this MAL should be addressed to:

Ohio Department of Medicaid

Bureau of Long Term Care Services and Supports

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTCSS@medicaid.ohio.gov

(614) 466-6742

# **MAL 577 (Patient Liability Change)**

## **Medical Assistance Letter (MAL) 577**

December 1, 2011

TO: Providers, Hospice Agencies  
Directors, County Departments of Job and Family Services  
Director, Ohio Council for Home Care and Hospice  
Director, Midwest Care Alliance

FROM: Michael B. Colbert, Director

SUBJECT: Patient Liability Change

The purpose of this Medical Assistance Letter (MAL) is to supersede MAL No. 544 regarding billing guidance for a consumer who resides in a long-term care facility (LTCF) and has a patient liability. With the implementation on August 2, 2011 of the new Medicaid Information Technology System (MITS), the way patient liability is entered into the system has changed and the previous method discussed in MAL No. 544 no longer works.

The MITS requirements for patient liability are different from those under the previous Medicaid Management Information System (MMIS). For portal claims, the patient liability is entered in the "Patient Amount Paid" field, which is on the first portal panel; for hospice room and board claims (T2046), the amount for the entire month should be applied. For Electronic Data Interchange (EDI) claims, the patient liability amount must be reported in the AMT Segment of Loop 2300 with an F5 qualifier. Prior to MITS implementation, some hospice providers and/or their trading partners used a different segment and loop that does not work in MITS. Please note that paper claims will no longer be accepted on or after January 1, 2013.

### **Web Pages:**

Billing instructions for professional claims are available on the Ohio Department of Job and Family Services web page for Medicaid providers. The URL is as follows:

<http://jfs.ohio.gov/ohp/provider.stm>

Billing instructions applicable to hospice providers may be viewed as follows:

- (1) Under the "Billing" heading, select "Billing Instructions".
- (2) Under "Professional Claims", select "click here" to view either the Web Portal Billing Guide, the EDI Companion Guide for Professional Claims, or the ODJS Instructions for Completing the CMS-1500 Paper Claim Form.

### **Questions:**

Questions about this MAL should be addressed to:

Ohio Department of Job and Family Services  
Bureau of Long-Term Care Services and Supports  
P.O. Box 182709  
Columbus, Ohio 43218-2709

<http://jfs.ohio.gov/ohp>

(614) 466-6742

# **MAL 574 / MHTL 3336-11-01 (Rule Changes Affecting Home Health Services and Hospice Services)**

**Medicaid Handbook Transmittal Letter (MHTL) No. 3336-11-01**

**Medical Assistance Letter (MAL) 574**

January 21, 2011

TO:

- Director, Ohio Department of Aging
- Director, Ohio Department of Mental Retardation and Developmental Disabilities
- Director, Ohio Department of Mental Health
- Director, Ohio Department of Alcohol and Drug Addiction Services
- Providers, ODJFS-Administered Home and Community-Based Services
- Providers, Home Health Agencies
- Providers, Hospice Agencies
- Providers, Otherwise-accredited Agencies
- Providers, Independent Private Duty Nursing
- Case Managers and Administrators, CareStar
- Directors, County Departments of Job and Family Services
- Directors, Area Agencies on Aging
- Directors, County Boards of Mental Retardation and Developmental Disabilities
- Directors, Centers for Independent Living
- Ohio Long Term Care Ombudsmen
- Director, Brain Injury Association of Ohio
- Directors, Members, HOME Choice Planning and Advisory Group
- Chairperson, Ohio Olmstead Task Force
- Director, Ohio Council for Home Care and Hospice
- Director, Ohio Home Care Organization
- Director, Ohio Hospice and Palliative Care Organization
- Vice-President, SEIU District 1199, WV/KY/OH
- President, Ohio State Medical Association
- President, Ohio Osteopathic Association
- All Eligible General Practice Physicians
- Providers, Family Practice Physician
- Providers, Pediatrician
- Providers, Internal Medicine Practitioner
- Providers, Obstetrician
- Providers, Physician Services
- Comprehensive Clinics
- Public Health Department Clinics
- Outpatient Health Facilities

Rural Health Clinics  
Federally Qualified Health Centers  
Managed Care Plans

FROM: Michael B. Colbert, Interim Director

SUBJECT: Rule Changes Affecting Home Health Services and Hospice Services

The Ohio Department of Job and Family Services (ODJFS) has amended rules [5101:3-12-01](#), [5101:3-56-02](#), [5101:3-56-04](#), and [5101:3-56-06](#) of the Administrative Code (OAC). The amendments to these rules will 1) require a face-to-face encounter (between the consumer and the consumer's physician, advanced practice nurse in collaboration with the qualifying treating physician, or physician assistant under the supervision of the qualifying treating physician), prior to the supervising physician certifying medical necessity for home health services in order to align these rules with the implementation of Section 6407(d) of the federal Patient Protection and Affordable Care Act (PPACA) of 2010 and 2) specify that a child under age twenty-one who completes a hospice election form does not waive any rights to be provided with, or to have payment made for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made in order to align these rules with the implementation of Section 2302 of the federal Patient Protection and Affordable Care Act (PPACA) of 2010. A description of these rules follows below.

**OAC rule [5101:3-12-01](#), Home health services: provision requirements, coverage and service specification**, explains the services available through the home health benefit for Medicaid consumers and providers. The proposed amendment to this rule set forth the following: 1) a requirement for a face-to-face encounter as described above must occur within ninety days prior to the start of home health services start of care date, or within thirty days following the start of care date inclusive of the start of care date, preceding certification of medical necessity of home health services in order to align this rule with the implementation of Section 6407(d) of the federal Patient Protection and Affordable Care Act (PPACA) of 2010, 2) a change from the Ohio Department of Mental Retardation and Developmental Disabilities to the Ohio Department of Developmental Disabilities and 3) correction of citations.

**OAC rule [5101:3-56-02](#), Hospice services: eligibility and election requirements**, explains hospice eligibility requirements for consumers. The proposed amendment to this rule sets forth that when a child voluntarily elects hospice, he or she does not waive the right to be provided with, or have payment made for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made in order to align this rule with the implementation of Section 2302 of the federal Patient Protection and Affordable Care Act (PPACA) of 2010.

**OAC rule [5101:3-56-04](#), Hospice services: provider requirements**, explains responsibilities of hospice providers. The proposed amendment to this rule sets forth the following additional requirements: 1) facilitation of concurrent care for children under age twenty-one with other Medicaid providers, 2) documentation about how services are coordinated between the hospice provider and other Medicaid providers, 3) provision of a copy of the consumer's advance directive and hospice election form to other Medicaid providers, 4) notification to consumers of their responsibilities to report to the hospice provider the names of their other Medicaid providers and 5) correction of citations. These amendments are part of the implementation of Section 2302 of the federal Patient Protection and Affordable Care Act (PPACA) of 2010, and provide for the assurance of continuity of care and coordination to avoid duplication of equivalent services.

**OAC rule [5101:3-56-06](#), Hospice services: reimbursement**, explains the requirements for the reimbursement of hospice providers. The proposed amendment to this rule sets forth the following: 1) specification that the Ohio Department of Job and Family Services will reimburse only non-hospice providers for curative treatments delivered to consumers under age twenty-one for the consumer's terminal illness, and that Medicaid providers who provide curative treatments for these consumers must comply with all the requirements for Medicaid providers in Chapter 5101:3-1 of the Administrative Code and not bill hospice organizations and 2) correction of citations.

**Instructions:**

[Remove and File as Obsolete](#)

[Insert Replacement](#)

5101:3-12-01 (effective 11/8/2007)	<a href="#">5101:3-12-01</a> (effective 2/1/2011)
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**Instructions:**

<b>Remove and File as Obsolete</b>	<b>Insert Replacement</b>
5101:3-56-02 (effective 3/2/2008)	<a href="#">5101:3-56-02</a> (effective 2/1/2011)
5101:3-56-04 (effective 3/2/2008)	<a href="#">5101:3-56-04</a> (effective 2/1/2011)
5101:3-56-06 (effective 3/2/2008)	<a href="#">5101:3-56-06</a> (effective 2/1/2011)

**Web Pages:**

ODJFS maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Physician Services" (right column).
- (3) Select "Medicaid Handbook Transmittal Letters (in the "Physician Services Table of Contents" dropdown).

It may also be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Hospice Services" (right column).
- (3) Select "Medical Assistance Letters", "Hospice Rules" (in the "Hospice Services Table of Contents" dropdown).

**Questions:**

Questions about this MAL and MHTL should be addressed to:

Ohio Department of Job and Family Services  
 Bureau of Long-Term Care Services and Supports  
 P.O. Box 182709  
 Columbus, Ohio 43218-2709  
<http://ifs.ohio.gov/ohp>  
 (614) 466-6742



# MAL 544

## Medical Assistance Letter (MAL) No. 544

February 26, 2008

TO: All Hospice Providers  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Patient Liability

The purpose of this Medical Assistance Letter (MAL) is to provide billing guidance to hospice agencies when billing for a consumer that resides in a long-term care facility (LTCF) and has a patient liability. This guidance is applicable for room and board charges submitted on both the CMS 1500 claim form (i.e., a hard copy paper claim) and the EDI 837P claim (i.e., an electronic claim). To ensure correct payment for room and board services (T2046 - Hospice long term care, room and board only; per diem), hospice agencies must not bill for room and board days covered by the patient liability amount. The following are examples of several scenarios that hospice agencies may encounter.

If the consumer enrolled in hospice resides in a LTCF for a month (i.e., 30 days) with a patient liability amount of \$1,300 and 95% of the per-diem is \$100, the hospice agency should not bill for the first 13 days of the month (i.e., the days that the patient liability covers the charges). The hospice agency should only bill for the room and board days not paid by the patient liability amount, days 14-30.

If the consumer enrolled in hospice resides in a LTCF for a month (i.e., 30 days) with a patient liability amount of \$525 and 95% of the per-diem is \$100, the hospice agency should not bill for the first five days of the month (i.e., the days that the patient liability covers the charges). The hospice agency must reduce the charges (i.e., \$100) for the sixth day by the remaining \$25. Therefore on day six, the hospice agency should bill \$75.

If the consumer becomes enrolled in hospice in the middle of the month and resides in a LTCF, the hospice agency must request the unpaid patient liability amount from the LTCF. Any unpaid patient liability should be treated according to the above examples.

The above examples are applicable for claims submitted on both the CMS 1500 claim form (i.e., a hard copy paper claim) and the EDI 837P claim (i.e., an electronic claim). Hospice agencies that submit CMS 1500 claim forms directly to the Ohio Department of Job and Family Services (ODJFS) at P.O. Box 7965 Akron, Ohio 44306 can only submit six lines on a single claim. Conversely, hospice agencies that submit EDI 837P claims to ODJFS directly, through a billing agent, or through a Trading Partner in a CMS 1500 format, may submit up to 50 lines on an EDI claim. ODJFS greatly encourages hospice agencies to ensure that EDI claims submitted to bill the unpaid charges are in a single electronic claim transaction rather than billing six lines at a time.

Currently, ODJFS' claims payment system does not capture the patient liability amounts reported in the EDI 837P claim. Therefore, the patient liability amount is not being deducted from the total charges. However, ODJFS intends to capture all hospice room and board dates of service and the deducted patient liability amount reported on the EDI 837P claim in the future. Again, when billing for hospice room and board (T2046 - Hospice long term care, room and board only; per diem), do not bill for the room and board days covered by the patient liability if the consumer resides in a long-term care facility (LTCF) and has a patient liability amount. ODJFS will notify all hospice agencies and Trading Partners of any changes to the billing instructions.

Any EDI 837P claim that has been submitted for hospice room and board charges with a patient liability amount reported must be adjusted. Overpayments are not an option and hospice agencies are responsible to make sure that the claims with room and board services are not overpaid with respect to the patient liability amount per the instructions in this letter. Upon discovery, hospice agencies are required to return or adjust any previous overpayments using the paper JFS 06767 Adjustment Request Form. Hospice agencies, billing

agents or Trading Partners may complete the overpayment adjustments for hospice agencies, but ultimately the hospice agencies are responsible to ensure proper payment.

Finally, please note that all third party commercial insurance and Medicare coordination of benefits EDI Loops are working properly and all prior payments must be reported according to the paper claim form billing instructions or the ODJFS 837 Companion Guides. The patient amount paid reported in the 837P is the only item not working properly.

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, letters, forms and handbooks. The URL for this is "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "Hospice Services"; and
- (3) Selecting the MAL 544 from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar>) is a quick reference for finding documents that have been recently published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans  
Provider Services Section  
P.O. Box 1461  
Columbus, OH 43216-1461  
Toll Free Telephone Number 1-800-686-1516

# MAL 541

## Medical Assistance Letter (MAL) No. 541

March 5, 2008

TO: All Hospice Providers  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Hospice Rules Five-Year Review

This Medical Assistance Letter (MAL) announces the rules for Hospice Services (5101:3-56-01 through 5101:3-56-06 of the Administrative Code). These rules were revised as part of the five year rule review and replace rules 5101:3-56-01 through 5101:3-56-06.2 of the Administrative Code. Note that rule 5101:3-56-3.3 of the Administrative Code effective September 1, 2007 is still in effect. These rules became effective on March 2, 2008.

Ohio Administrative Code (OAC) rule 5101:3-56-01 titled *Hospice services: definitions* provides definitions for terms used in the Chapter 5101:3-56 rules. This rule replaces rescinded rule 5101:3-56-01 and part of rescinded rule 5101:3-56-04.1 with new language regarding hospice definitions. Definitions new to the hospice chapter include the definition of advance practice nurse, core hospice services, counseling services, home and community based services waiver, interdisciplinary group, intermediate care facility for the mentally retarded, inpatient facility, licensed occupational therapist, licensed occupational therapy assistant, licensed physical therapist, licensed physical therapy assistant, licensed speech-language pathologist, licensed speech-language pathology aide, medical director, Medicare, non-core hospice services, nursing facility, nursing services, and registered nurse.

OAC rule 5101:3-56-02 titled *Hospice services: eligibility and election requirements* sets forth eligibility, certification, and elections requirements the consumer must meet to be eligible to enroll in the hospice benefit. This rule replaces part of rescinded rule 5101:3-56-02, 5101:3-56-03, 5101:3-56-03.2, and 5101:3-56-05. The provisions of this rule are not different from the rules it replaces. Only the organization and structure have changed.

Ohio Administrative Code (OAC) rule 5101:3-56-03 titled *Hospice services: discharge requirements* sets forth the discharge requirements for the consumer termination of the hospice benefit. This rule replaces part of rescinded rules 5101:3-56-03.1 and 5101:3-56-03.2. Again, the provisions of this rule are not different from the rules it replaces. Only the organization and structure have changed.

OAC rule 5101:3-56-04 titled *Hospice services: provider requirements* defines the criteria a hospice provider must meet to be eligible to provide services, and requirements a hospice provider must follow when providing care to a Medicaid consumer. This rule replaces rescinded rule 5101:3-56-04.2 and part of rescinded rules 5101:3-56-02, 5101:3-56-03, 5101:3-56-03.1, 5101:3-56-05, 5101:3-56-06 and 5101:3-56-06.1. The provisions of this rule are not different from the rules it replaces. Only the organization and structure have changed.

OAC rule 5101:3-56-05 titled *Hospice services: covered services* sets forth covered hospice services that are provided and professionally managed by the hospice agency. The rule outlines coverage for all consumers including those who reside in a nursing facility or intermediate care facility for the mentally retarded (ICR-MR) and those who are enrolled in a home and community based waiver. This rule replaces part of rescinded rules 5101:3-56-02, 5101:3-56-03, 5101:3-56-03.2, 5101:3-56-05, 5101:3-56-06, 5101:3-56-06.1, and 5101:3-56-06.2. The provisions of this rule are not different from the rules it replaces. Only the organization and structure have changed.

OAC rule 5101:3-56-06 titled *Hospice services: reimbursement* sets reimbursement specifications for hospice services. This rule replaces part of rescinded rules 5101:3-56-02, 5101:3-56-03.2, 5101:3-56-04, 5101:3-56-06, 5101:3-56-06.1, and 5101:3-56-06.2. The provisions of this rule are not different from the rules it replaces. Only the organization and structure have changed.

### Web Page and Paper Distribution:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>

Providers may view documents online by:

- (1) Selecting "Ohio Health Plans - Provider" folder;
- (2) Selecting "Hospice"; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

Providers may view current reimbursement rates online by:

- (1) The URL for provider fee schedules and rates page is <http://jfs.ohio.gov/ohp/bhpp/FeeSchdRates.stm>
- (2) Selecting "Hospice Rates."

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans  
Provider Services Section  
P.O. Box 1461  
Columbus, OH 43216-1461  
1-800-686-1516

## **MAL 532**

**Medical Assistance Letter No 532** (June 7, 2007 - Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid), is maintained in the Ambulatory Surgery Center Services e-book.

[Click here to view MAL 532, Information Providers Must Know about the National Provider Identifier \(NPI\) in Order to Get Paid.](#)

## **MAL 522**

**Medical Assistance Letter No 522** (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516), is maintained in the General Information e-book.

[Click here to view MAL 522, August, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516.](#)

# MAL 521

## Medical Assistance Letter (MAL) No. 521

August 31, 2007

To: Providers of Hospice Services Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: Entry of hospice service spans into the IVR System

This Medical Assistance Letter (MAL) transmits rule 5101:3-56-03.3, *Hospice services: reporting requirements*, which will become effective on September 1, 2007.

This new rule enables the recording of the hospice service span of every consumer receiving Medicaid hospice services. For each consumer, a hospice provider will be required to enter certain pieces of information (such as the hospice provider number, the consumer's recipient identification number, the beginning date of service, and the ending date of service) into the ODJFS Interactive Voice Response (IVR) System. Although the requirement does not take effect until September, hospice providers will be permitted and encouraged to enter information into the IVR System before the effective date.

Providers will receive one printed copy of this transmittal letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form. Or they may view ODJFS transmittal letters, rules, manuals, forms, and handbooks online at the ODJFS "electronic manuals" web page, <http://emanuals.odjfs.state.oh.us/emanuals/>.

Questions pertaining to this MAL should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, Ohio 43215-1461

Toll Free Telephone Number (800) 686-1516

## **MAL 516**

**Medical Assistance Letter No 516** (Date - Employee Education About False Claims Recovery), is maintained in the General Information e-book.

[Click here to view MAL 516, Employee Education About False Claims Recovery.](#)



# **MAL 489**

## **Medical Assistance Letter (MAL) No. 489**

October 13, 2005

TO: All Providers of Hospice Services  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Change in billing requirements for Hospice providers.

### **Ending December 31, 2005**

The paper JFS 06780 form will no longer be allowed to be used for billing purposes.

### **Beginning January 1, 2006**

Hospice providers will be required to bill on the CMS 1500 form (formerly called the HCFA 1500), if not already doing so. This change is to assist the billing system to become more uniform and efficient. The new billing instruction guide is available online and will assist you in filling out the CMS 1500, specific to Ohio's Medicaid Hospice program.

The new billing instruction guide is included with this MAL and is also located on the website in the Billing Instructions handbook, which can be found in their entirety on our website at: <http://emanuals.odjfs.state.oh.us/emanuals> click on: Ohio Health Plans - Provider, then on the right column click on Billing instructions, then click on BIN 1001, then click on [BIN 1001.2](#) Instructions for completing the CMS 1500. Or if you do not have internet access you may request a paper copy of this notice and billing instructions by completing the attached JFS 03400.

**Questions pertaining to this MAL should be addressed to:**

**Bureau of Plan Operations**

**The Provider Network Management Section**

**P.O. Box 1461**

**Columbus, Ohio 43216**

**In-state toll free telephone number 1-800-686-1516**

# **MAL 485A**

## **Medical Assistance Letter (MAL) No. 485 A**

July 13, 2005

**TO:** All Providers of Hospice Services  
Directors, County Department of Job and Family Services  
Medical Assistance Coordinators

**FROM:** Barbara E. Riley, Director

**SUBJECT:** Hospice Election for Individual Options and Level One HCBS Waiver Enrollees

Effective July 1, 2005

For Individual Options (IO) and Level One HCBS Waivers

On July 1, 2005 the enrollees of MR/DD administered HCBS waivers may elect the hospice benefit. This new policy is being implemented as a result of collaborative efforts between the Ohio Department of Job and Family Services (ODJFS), Ohio Department of Aging, Ohio Department of MR/DD, Ohio Council for Home Care, and the Ohio Hospice & Palliative Care Organization.

Beginning in July hospice providers for MR/DD will have to provide services in accordance with the rules listed in MAL 485 including Rule 5101: 3-56-02 Hospice Eligibility, and 5101:3-1-39 Verification rule of the Administrative Code. Rule 5101:3-56-02 of the Administrative Code requires the collaboration of hospice and waiver case managers for care coordination and defines the responsibilities of hospice and waiver case managers. Please note that the rule does not allow those individuals who have elected the hospice benefit to subsequently apply for enrollment in a MR/DD waiver program.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216

In-state toll free telephone number 1-800-686-1516

# MAL 485

## Medical Assistance Letter (MAL) No. 485

April 18, 2005

TO: All Providers of Hospice Services  
Directors, County Department of Job and Family Services  
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Hospice Election and Home and Community Based Services (HCBS) Waiver Enrollees

### **Effective April 1, 2005**

For Ohio Home Care, Transitions, PASSPORT, and Choices HCBS Waivers

### **Proposed Effective for July 1, 2005**

For Individual Options (IO) and Level One HCBS Waivers

On April 1, 2005 providers of Hospice services may begin to render services to consumers enrolled on HCBS waivers administered by ODJFS or ODA. On July 1, 2005 or the new effective date of rule 5101: 3-40-01 of the Administrative Code, enrollees of MR/DD administered HCBS waivers may elect the hospice benefit. This new policy is being implemented as a result of collaborative efforts between the Ohio Department of Job and Family Services (ODJFS), Ohio Department of Aging, Ohio Department of MR/DD, Ohio Council for Home Care, and the Ohio Hospice and Palliative Care Organization. The policy transmitted with this MAL was constructed using the following principles:

- To avoid duplicative payments between programs as required by federal directive.
- To keep costs neutral within the ODJFS budget.
- To keep the HCBS waivers cost effective as required by federal mandate.

#### 5101:3-56-02 Eligibility for Medicaid Hospice Services.

Rule 5101:3-56-02 of the Administrative Code was amended to define which provider would provide medically necessary services to the HCBS waiver enrollee who has elected hospice. The rule also requires the collaboration of hospice and waiver case managers for care coordination and defines the responsibilities of hospice and waiver case managers. Please note that the rule does not allow those individuals who have elected the hospice benefit to subsequently apply for enrollment in a HCBS waiver program.

- Providers of waiver services will continue to provide:
- Waiver services such as adult day care, center based day care, home delivered meals, chore, home modification, independent living assistant, interpreter, supported employment, and emergency response installation/rental etc.
- Durable medical equipment, medical supplies, and adaptive assistive devices that are unrelated to the terminal illness.
- Waiver services such as aide, homemaker, personal care, attendant or companion care, and/or waiver nursing at the amount, scope and/or duration as provided prior to the initial hospice enrollment.
- Providers of Hospice services will provide:
- Hospice Services as specified in Chapter 5101: 3-56 of the Administrative Code.
- Any home health services or private duty nursing service to the extent that they are covered under state plan.
- Social Work, nutritional counseling, or out-of-home respite.

- Durable medical equipment, medical supplies, and adaptive assistive devices that are related to the terminal illness.
- Aide, homemaker, personal care, attendant or companion care, and/or waiver nursing if the amount, scope and/or duration that waiver service is increased after hospice enrollment.

Note: These services are all a part of the per diem payment and not billed separately.

Care coordination between the hospice case manager and waiver case manager shall be a collaborative effort that ensures a continuum of the overall care provided to the individual.

- Case management of hospice services is provided by the hospice case manager.
- Case management of waiver services is provided by the waiver case manager.

Waiver Case Managers as the ODJFS designee will:

- Review and approve a comprehensive plan for the simultaneous provision of waiver services by waiver and hospice providers
- Resolve any issues resulting from the comprehensive plan.

ODJFS will resolve any issues of interpretation or exceptions.

### 5101: 3-1-39 Verification of Home Care Service Provision to Home Care Dependant Adults

Because providers of hospice services are now serving individuals who are enrolled on a HCBS waiver, Hospice providers are considered a home care service provider in accordance with 5101: 3-1-39 of the Administrative Code. Rule 5101: 3-1-39 requires special employee verification systems for home care dependent adults. This rule is mandated by section 121.36 of the Revised Code. This rule requires verification of an employee as follows.

1. The provider of Hospice services must verify employee is present at the beginning and end of each visit if the consumer:
  - Resides in a private home or other non-institutional, unlicensed living arrangement without a parent or guardian present.
  - Requires, due to health and safety needs, regularly scheduled home care services to remain in the home or other living arrangement.
  - Is sixty years of age or older, or is at least twenty-one years of age but less than sixty years of age and has a physical disability or mental impairment.
  - Has a mental impairment or life-threatening condition:
    - Mental Impairment: A consumer has a diminished capacity of judgment where if the consumer was left alone it would place the consumer at risk of permanent impairment.
    - Life-threatening condition: A health condition that will place the consumer at risk of permanent impairment if the home care service is not provided.
2. The provider of Hospice services must verify employees have provided services at the end of each working day if the consumer:
  - Resides in a private home or other non-institutional, unlicensed living arrangement without a parent or guardian present.
  - Requires, due to health and safety needs, regularly scheduled home care services to remain in the home or other living arrangement.
  - Is sixty years of age or older, or is at least twenty-one years of age but less than sixty years of age and has a physical disability.
    - Physical disability: A consumer's physical condition of severe functional limitations.

The verification system does not apply to consumers who are:

- Children
- Adults without physical disability or mental impairment that are under sixty.
- Adults that have a parent or guardian in the home.
- Adults that do not require, due to health and safety, regularly scheduled home care services to remain in the home or other living arrangement.

Other Effected Administrative Code Rules

Rules 5101:1-39-83 Medicaid Hospice, 5101: 3-12-04 Consumer Eligibility for Ohio Home Care Benefits, and 5101: 3-31-03, Eligibility for Enrollment in PASSPORT have also been altered to allow those enrolled on HCBS waivers to elect the hospice benefit. Please note: the paper copy of this notice will not include Rules 5101:1-39-83, 5101:3-12-04, and 5101:3-31-03 since the alteration was a short paragraph. Please view these documents on our website on the emanuals pages.

The rules announced in this Medical Assistance Letter (MAL) can be found on our website at: <http://emanuals.odjfs.state.oh.us/emanuals> or if you do not have internet access you may request a paper copy of this notice and the rules by completing the attached JFS 03400.

**Questions pertaining to this MAL should be addressed to:**

**Bureau of Plan Operations**

**The Provider Network Management Section**

**P.O. Box 1461**

**Columbus, Ohio 43216**

**In-state toll free telephone number 1-800-686-1516**

# **MAL 458A**

## **Medical Assistance Letter (MAL) No. 458A**

January 21, 2004

TO: All Hospice Providers  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Thomas Hayes, Director

SUBJECT: Hospice Services: Advanced Practice Nurses

The purpose of this MAL is to correct information transmitted in MAL 458 regarding new rule 5101:3-56-04.1 titled, Hospice Services: Advanced Practice Nurses. The previous MAL stated that the rule would be effective on January 1, 2004, **however the rule will not be effective until February 16, 2004**. The effective date has been changed because the rule was re-filed to include a revised definition of an advanced practice nurse (APN). The previous definition of an APN referred to a section in the Ohio Board of Nursing rules, which will be rescinded effective January 17, 2004. Therefore the department has changed the citation to reference a different portion of the Ohio Board of Nursing Rules.

The re-filed version of rule 5101:3-56-04.1 can be found on the reverse side of this MAL. To find other hospice rules and transmittals, please go to URL: <http://emanuals.odjfs.state.oh.us/emanuals/medicaid>, and scroll down to Hospice Services on the right side.

**Questions pertaining to this MAL should be addressed to:**

**The Bureau of Plan Operations  
Provider Network Management Section  
P.O. Box 1461  
Columbus, Ohio 43216-1461  
Toll-Free Phone Number: 1-800-686-1516**

# MAL 458

## Medical Assistance Letter (MAL) No. 458

December 9, 2003

TO: All Hospice Providers  
Directors, County Departments of Job and Family Services  
Medical Assistance Coordinators

FROM: Thomas Hayes, Director

SUBJECT: HIPAA Compliant Hospice Codes and Hospice Policy

This MAL transmits three new rules, HIPAA compliant coding changes. The new rules are scheduled to be effective January 1, 2004.

Rule 5101:3-56-03.2, Hospice services: third-party coverage and election, revocation and termination of benefit, was created to clarify the role of third-party coverage when a Medicaid eligible individual elects hospice.

Rule 5101:3-56-04.1, Hospice services: advanced practice nurses, was created to clarify the role of advanced practice nurses in providing hospice services. This clarification aligns us with current Medicare guidelines concerning APNs.

New rule, 5101:3-56-06.2 Hospice services: procedure codes, contains the five HIPAA compliant codes for hospice services that will replace the local codes. For your convenience, the following table contains a crosswalk of local codes and the corresponding new HIPAA codes.

Description	ODJFS Local Code	New Code Effective 1/1/04
Routine Care	X0101	T2042
Continuous Home Care	X0102	T2043
Inpatient Respite Care	X0103	T2044
General Inpatient Care	X0104	T2045
Room and Board	X0105	T2046

### To obtain a copy of the rules and future program updates:

The rules that are announced in this Medical Assistance Letter (MAL) can be found at on our website at: <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid> or if you do not have internet access you may request a paper copy of the rules by completing the attached JFS 03400. If you have received ONLY a paper copy of this MAL and you wish to be notified in the future by e-mail of program updates the week that they are published, please send an email to: [provider\\_subscribe@odjfs.state.oh.us](mailto:provider_subscribe@odjfs.state.oh.us) and include your provider number.

Questions pertaining to this MAL should be addressed to:

The Bureau of Plan Operations  
Provider Network Management Section  
P.O. Box 1461  
Columbus, Ohio 43216-1461

In-State: 1-800-686-1516 (toll-free) or (614) 728-3288 or Out-of-State:(614) 728-3288

# Hospice Services - Ohio Administrative Code Rules



**5160-1-39**      **Verification of Home Care Service Provision to Home Care Dependent Adults**

**\*Formerly\* 5101:3-1-39**      **Verification of Home Care Service Provision to Home Care Dependent Adults**

[Click here to view OAC 5160-1-39, Verification of Home Care Service Provision to Home Care Dependent Adults](#)

This rule is maintained in the ODJFS Ohio Administrative Code eManual, located in the Legal Services collection.

**LTCSTL 15-10**

**Effective Date: April 1, 2015**

**Most Current Prior Effective Date: March 2, 2008**

Hospice care is end-of-life care provided by health professionals and volunteers. Hospice care is an approach to caring for terminally ill consumers individuals that stresses palliative care as opposed to curative care. Hospice care incorporates an interdisciplinary team approach to meet the consumer's individual's physical, psychological, social, and spiritual needs, as well as the psychosocial needs of the consumer's individual's family.

Paragraphs (A) to ~~(GG)~~(HH) of this rule define terms used in the rules governing the medicaid hospice program as contained in Chapter ~~5101:3-56~~5160-56 of the Administrative Code.

- (A) "Advance directive" means a written instruction, such as a living will, a declaration, as defined in Chapter 2133. of the Revised Code, or a durable power of attorney for health care, as defined in Chapter 1337. of the Revised Code, which is recognized under state law and relates to the provisions of health care when the individual is incapacitated.
- (B) "~~Advance~~ Advanced practice registered nurse" means a registered nurse authorized to practice as a certified clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife or certified nurse practitioner in accordance with section 4723.43 of the Revised Code.
- (C) "Attending provider" is:
  - (1) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery as authorized under Chapter 4731. of the Revised Code in which he or she performs that function or action. This provider is identified by the consumer individual or the representative, at the time he or she elects the hospice benefit, as having the most significant role in the determination and delivery of the consumer's individual's medical care; or
  - (2) An advanced practice registered nurse who meets the training, education, and experience requirements in accordance with section 4723.43 of the Revised Code. Advanced practice registered nurses are prohibited from certifying or recertifying a terminal diagnosis. This provider is identified by the consumer individual or the representative, at the time he or she elects the hospice benefit, as having the most significant role in the determination and delivery of the consumer's individual's medical care.
- (D) "Bereavement counseling" means counseling services provided to the ~~consumer's~~ individual's family or caregivers after the consumer's individual's death.
- (E) "Core hospice services" are nursing care, medical social services, counseling services, and physician services that must routinely be provided directly by the employees of the hospice.
- (F) "Counseling services" are services provided for the purpose of counseling or training the caregiver and helping the beneficiary individual and the family members and/or caregiver with adjustment to the approaching death.
- (G) "Dietary counseling" means intervention and education regarding appropriate nutritional intake that is provided to the consumer individual and/or the consumer's individual's family by a qualified professional including, but not limited to, a registered nurse, a dietitian and/or a physician.
- (H) "Dietitian" means a person licensed to practice dietetics who meets the criteria set forth in Chapter 4759. of the Revised Code.
- (I) "Election period" is a period for which the consumer individual is enrolled in the hospice benefit. The election period is subject to the conditions set forth ~~is in~~ in this chapter and are listed below in sequential order:
  - (1) An initial ninety-day period (limited to one during the consumer's individual's lifetime).

- (2) A second subsequent ninety-day period (limited to one during the ~~consumer's~~ individual's lifetime).
- (3) An unlimited number of subsequent sixty-day periods.
- (J) "Home and community based services (HCBS) waivers" are operated in accordance with Section 1915 (c) of the Social Security Act (the Act), 42 U.S.C. 1396n(c) (as in effect January 1, 2015). The HCBS waiver programs include those waivers operated by the Ohio department of ~~job and family services (ODJFS)~~ medicaid (ODM), the Ohio department of aging (ODA), and the Ohio department of ~~mental retardation and~~ developmental disabilities (ODMRDD) (DODD).
- (K) "Home health aide" means a person who meets the training, aptitude and skill requirements to provide home care services for the hospice ~~consumer~~ individual and his or her family in accordance with rule 3701-19-16 of the Administrative Code.
- (L) "Hospice" is a public agency or private organization or a subdivision of either that is licensed in the state of Ohio and is primarily engaged in providing care to terminally ill ~~consumers~~ individuals.
- (M) "Interdisciplinary group (IDG)" is composed of ~~individuals~~ persons who provide or supervise the care and the services offered by the hospice. The group must include a physician, a registered nurse, a social worker, and a spiritual or another counselor who are employees of the hospice in accordance with ~~the 42 CFR 418.68 (November 1, 1983)~~ 42 C.F.R. 418.56 (October 1, 2014).
- (N) "Intermediate care facility for ~~the mentally retarded~~" (ICF-MR) individuals with intellectual disabilities (ICF-IID) means an intermediate care facility for ~~the mentally retarded~~ individuals with intellectual disabilities certified as in compliance with applicable standards for the medical assistance program by the director of health in accordance with Title XIX of the Social Security Act (as in effect January 1, 2015).
- (O) "Inpatient facility" means a facility that either is operated by or under contract with a hospice for the purpose of providing inpatient care to the ~~consumer~~ individual.
- (P) "Licensed occupational therapist" means a person holding a valid license under Chapter 4755. of the Revised Code as an occupational therapist.
- (Q) "Licensed occupational therapy assistant" means a person holding a valid license under Chapter 4755. of the Revised Code as an occupational therapy assistant (OTA).
- (R) "Licensed physical therapist" means a person holding a valid license under Chapter 4755. of the Revised Code as a physical therapist.
- (S) "Licensed physical therapy assistant" means a person holding a valid license under Chapter 4755. of the Revised Code as a physical therapist assistant (PTA).
- (T) "Licensed speech-language pathologist" means a person holding a valid license under Chapter 4753. of the Revised Code as a speech-language pathologist and who is eligible for or meets the educational requirements for a certificate of clinical competence in speech language pathology granted by the "American Speech-Language-Hearing Association."
- (U) "Licensed speech-language pathology aide" means a person holding a valid license under Chapter 4753. of the Revised Code as a speech-language pathology aide.
- (V) "Medical director" must be a hospice employee or contracted employee who is a doctor of medicine or osteopathy who assumes overall responsibility for the medical component of the hospice's patient care program.
- (W) "Medicare" is the federally financed medical assistance program determined under Title XVIII of the Social Security Act (as in effect January 1, 2015).
- (X) "Non-core hospice services" are hospice services that are the responsibility of the hospice to ensure are provided directly to the ~~consumer~~ individual by hospice employees or under a contractual arrangement made by the hospice.

- (Y) "Nursing facility" (NF) means a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX of the Social Security Act (as in effect January 1, 2015), and is not an ~~intermediate care facility for the mentally retarded (ICF-MR)~~ ICF-IID.
- (Z) "Nursing services" are services that require the skills of a registered nurse, or a licensed practical nurse under the supervision of a registered nurse. Services provided by an advanced practice registered nurse who is not the patient's attending provider or are not provided by a physician in the absence of an advanced practice registered nurse are included under nursing services.
- (AA) "~~ODJFS~~ODM" means Ohio department of ~~job and family services~~ medicaid.
- (BB) "Palliative care" seeks to prevent or relieve the symptoms produced by a life-threatening medical condition or its treatment, to help patients with such conditions and their families lives as normally as possible, and to provide them with timely and accurate information and support in decision making.
- (CC) "Physician" means a person who is authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.
- (DD) "Physician services" means services provided by a person as defined in ~~rules 5101:3-4-01 to 5101:3-4-05~~ Chapter 5160-4 of the Administrative Code.
- (EE) "Registered nurse" means a person licensed to practice nursing as a registered nurse who meets the criteria set forth in Chapter 4723. of the Revised Code.
- (FF) "Representative" means an adult, eighteen years or older, who has been authorized under Ohio law to make health care decisions on behalf of the ~~consumer~~ individual who is mentally or physically incapacitated, or at the request of the terminally ill ~~consumer~~ individual. These decisions may include the termination of medical care, the election of the hospice benefit, or the revocation of election of the hospice benefit on behalf of a terminally ill ~~consumer~~ individual. Documentation of the authorization must be maintained in the ~~consumer's~~ individual's hospice record.
- (GG) "Social worker" means a person registered under Chapter 4757. of the Revised Code to practice as a social worker or independent social worker.
- (HH) "Terminally ill" means that a physician has certified that the ~~consumer~~ individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

Effective: 04/01/2015

Five Year Review (FYR) Dates: 12/19/2014 and 04/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.70, 5166.01

Prior Effective Dates: 4/16/90, 12/1/91, 4/1/94, 9/26/02, 2/16/04, 3/2/08

**LTCSTL 15-10**

**Effective Date: April 1, 2015**

**Most Current Prior Effective Date: February 1, 2011**

The purpose of this rule is to outline the criteria that must be met for the consumer individual to be eligible to enroll in the hospice benefit.

- (A) In order to be eligible to elect the hospice benefit under medicaid, the consumer individual must meet the following criteria:
- (1) The consumer individual must be eligible for medicaid in accordance with Chapters ~~5101:1-37~~5160:1-1 to ~~5101:1-42~~5160:1-6 of the Administrative Code.
  - (2) The consumer individual must be certified as being terminally ill by his or her attending physician and the hospice medical director or physician member of the interdisciplinary group.
  - (3) If the consumer individual is enrolled or becomes enrolled in medicare, the consumer individual must elect the medicare hospice benefit at the same time that the medicaid hospice benefit is elected in order to assure that medicaid is the secondary payor. If the consumer individual revokes his or her medicare hospice benefit, the medicaid hospice benefit must be revoked at the same time.
  - (4) If the consumer individual has or later obtains third-party coverage of the hospice benefit, the consumer individual must elect the third-party coverage hospice benefit at the same time that the medicaid hospice benefit is elected in order to assure that medicaid is the secondary payor. If the consumer individual revokes his or her third-party coverage of the hospice benefit, the medicaid hospice benefit must be revoked at the same time.
  - (5) If the consumer individual is a participant in the program of all-inclusive care for the elderly (PACE), the consumer individual must access hospice services through the PACE site's network of providers.
  - (6) If the consumer individual is enrolled in a medicaid managed care plan (MCP), the consumer individual must access hospice services through the MCP's network of providers.
  - (7) ~~If the consumer is enrolled in an HCBS waiver program, the consumer may subsequently be enrolled in the hospice benefit. However, if the consumer is enrolled in the hospice benefit and is not also enrolled in an HCBS waiver, the consumer is not subsequently eligible for HCBS waiver program enrollment.~~ Individuals enrolled in hospice may be enrolled concurrently on a home and community based services (HCBS) waiver.
- (B) If the consumer individual is eligible to elect the hospice benefit based on paragraph (A) of this rule, the consumer individual may elect to receive hospice care during one or more of the election periods as long as the consumer individual continues to meet the eligibility requirements.
- (C) At the time of election of hospice care, the consumer individual must, in a written statement, elect the hospice benefit with the hospice.
- (1) The consumer individual or representative must acknowledge that he or she has been given a full explanation of the palliative rather than curative nature of hospice care as it relates to the consumer's individual's terminal illness and the provisions and limitations of services as specified in this chapter.
  - (2) The consumer individual or representative must sign and date an election form that specifies the type of care and services that may be provided during the course of the illness. The effective date of the election may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement.
  - (3) When the consumer individual under age twenty-one voluntarily elects hospice care, he or she does not waive any rights to be provided with, or to have payment made for, services that are

related to the treatment of the condition for which a diagnosis of terminal illness has been made, in addition to the hospice palliative care.

- (D) For the duration of the election of hospice care, the ~~consumer~~individual must waive medicaid services if the services:
- (1) Are provided by a hospice other than the hospice designated by the ~~consumer~~individual, unless provided under arrangement made by the designated hospice;
  - (2) Are related to the curative treatment of the terminal condition for which hospice care was elected or a related condition, except for the ~~consumer~~individual under age twenty-one; or
  - (3) Are equivalent to hospice care.

Effective: 04/01/2015

Five Year Review (FYR) Dates: 12/19/2014 and 04/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.70

Prior Effective Dates: 5/15/90, 5/16/90, 12/1/91, 4/1/94, 9/26/02, 1/1/04, 4/1/05, 3/2/08, 2/1/11

**LTCSTL 15-10**

**Effective Date: April 1, 2015**

**Most Current Prior Effective Date: March 2, 2008**

The purpose of this rule is to detail circumstances in which the consumerindividual would no longer receive the medicaid hospice benefit.

(A) Discharge from hospice care:

- (1) The hospice shall discharge the consumerindividual from hospice care when the consumerindividual:
  - (a) Expires;
  - (b) No longer meets the enrollment criteria;
  - (c) No longer is terminally ill;
  - (d) Moves out of the service area;
  - (e) Enters a non-contracted facility;
  - (f) Revokes the hospice benefit according to paragraph (B) of this rule;
  - (g) Transfers to another hospice; or
  - (h) Compromises the safety of the consumerindividual or the safety of the hospice staff.
- (2) The hospice shall complete a written statement of discharge, retain the original for its records and provide the consumerindividual or representative with a copy. The written statement of discharge must clearly state the reason for discharge except when the patient expires. A written statement of discharge should not be provided to the consumer's individual's representative when the consumerindividual expires, unless requested from the representative.

(B) Revocation of the election of hospice care:

- (1) The consumerindividual receiving the medicaid hospice benefit may choose to revoke the election of hospice care once during each benefit period. Upon revocation of the medicaid hospice benefit, regular medicaid coverage resumes ~~and any rights to additional hospice care coverage through the medicaid program for the remaining days of that benefit period are forfeited~~. The individual may choose to re-elect the hospice benefit at any time.
- (2) The hospice must obtain a written statement of revocation signed and dated by the consumerindividual or representative, retain the original for its records, and provide the consumerindividual or the representative with a copy. The written statement of revocation must clearly state the reason for the revocation.

(C) The consumerindividual who voluntarily revoked the hospice benefit, or who has been discharged from hospice care, may elect the benefit at a later date if the consumerindividual qualifies as terminally ill and otherwise meets the requirements of the medicaid hospice benefit as follows:

- (1) The consumerindividual who revoked the hospice benefit or who was discharged from the hospice benefit during the initial ninety-day period would enroll in the hospice program in the second ninety-day benefit period; or
- (2) The consumerindividual who revoked the hospice benefit or who was discharged from the hospice benefit during the second ninety-day benefit period, or any subsequent sixty-day benefit period, would begin the new enrollment in a new sixty-day benefit period.

(D) Transfer to another hospice:

- (1) The consumerindividual or the representative may change the designation of the particular hospice from which hospice care is received once during each benefit period. The change of the



designated hospice is not considered a revocation of the election from the period in which it is made.

- (2) To change the designated hospice, the ~~consumer~~individual or the representative must file, with the hospice from which the ~~consumer~~individual has received care and the newly designated hospice, a signed statement that includes the following information:
- (a) The name of the hospice from which the ~~consumer~~individual has received care;
  - (b) The name of the hospice from which the ~~consumer~~individual plans to receive care; and
  - (c) The date the change is to be effective.
- (E) The ~~consumer~~individual who has elected the hospice benefit and decided to revoke, terminate, or transfer his or her hospice benefit must do so on the same effective date for both the third-party covered or medicare hospice benefit and the medicaid hospice benefit.
- (F) Any denial or termination of hospice care which is the result of an ~~ODJFS~~Ohio department of medicaid (ODM) decision shall be subject to the notice and hearing rights contained in Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.

Effective: 04/01/2015

Five Year Review (FYR) Dates: 12/19/2014 and 04/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.70

Prior Effective Dates: 5/16/90, 12/1/91, 4/1/94, 9/26/02, 1/1/04, 3/2/08



**LTCSTL 15-10**

**Effective Date: April 1, 2015**

**Most Current Prior Effective Date: September 1, 2007**

- (A) The purpose of this rule is to enable recording of the hospice service span of every ~~consumer~~individual receiving medicaid hospice services in accordance with Chapter ~~5101:3-56~~5160-56 of the Administrative Code, even if the ~~consumer~~individual is covered by third-party insurance, which includes medicare.
- (B) In this rule, the following definitions apply:
- (1) "Beginning date of service" means the first date on which a provider delivers hospice services to ~~a~~an ~~consumer~~individual.
  - (2) "~~Consumer~~Individual" means a person who:
    - (a) Is eligible for medicaid;
    - (b) Has satisfied applicable spenddown; and
    - (c) Has elected to receive the hospice benefit.
  - (3) "~~Consumer~~Individual election date" means the date on which a ~~consumer~~individual elects, in writing, to receive hospice services in accordance with Chapter ~~5101:3-56~~5160-56 of the Administrative Code.
  - (4) "Ending date of service" means the date on which a provider stops delivering hospice services to the ~~consumer~~individual because of revocation of the medicaid hospice benefit, discharge from the hospice benefit, change by the ~~consumer~~individual of the designated hospice, or death of the ~~consumer~~individual in accordance with Chapter ~~5101:3-56~~5160-56 of the Administrative Code.
  - (5) "Hospice service span" means the period of time, delimited by the beginning date of service and the ending date of service, during which ~~a~~an ~~consumer~~individual receives hospice services from a hospice provider in accordance with Chapter ~~5101:3-56~~5160-56 of the Administrative Code.
  - (6) "Interactive Voice Response system" or "IVR system" means the telephone-based system maintained by ODJFS that gives authorized entities access to data such as medicaid eligibility, claim status, payment status, prior authorization, drug and procedure codes, and provider information.
  - (7) "Oral physician certification date" means the date on which an oral physician certification statement that the ~~consumer~~individual is terminally ill is obtained in accordance with Chapter ~~5101:3-56~~5160-56 of the Administrative Code.
  - (8) "Written physician certification date" means the date on which a written physician certification statement that the ~~consumer~~individual is terminally ill is obtained in accordance with Chapter ~~5101:3-56~~5160-56 of the Administrative Code.
- (C) Each provider of hospice services shall enter the following information into the IVR system:
- (1) Within thirty days after the beginning date of service, the provider of hospice services shall enter:
    - (a) The hospice provider number;
    - (b) The ~~consumer's~~individual's recipient identification number (also referred to as the medicaid billing number) as shown on the ~~consumer's~~individual's medicaid card;
    - (c) The beginning date of service;
    - (d) Either:

- (i) The written physician certification date or
  - (ii) The oral physician certification date;
  - (e) The ~~consumer~~individual election date; and
  - (f) At least one but not more than three terminal diagnosis codes for the ~~consumer~~individual.
- (2) No earlier than the beginning date of service and no later than thirty days after the ending date of service, the provider of hospice services shall enter:
- (a) The written physician certification date;
  - (b) The ending date of service; and
  - (c) The date of death, if applicable.
- (3) No earlier than the beginning date of service and no later than thirty days after the ending date of service, the provider of hospice services may change or update:
- (a) The oral physician certification date;
  - (b) The written physician certification date;
  - (c) The ~~consumer~~individual election date;
  - (d) Not more than three terminal diagnosis codes for the ~~consumer~~individual, so long as at least one diagnosis code remains entered in the IVR system;
  - (e) The ending date of service; or
  - (f) The date of death.
- (D) The information specified in paragraph (C) of this rule shall be submitted only through the IVR system in accordance with the requirements of that system.
- (E) The information specified in paragraph (C) of this rule shall be submitted for all ~~consumers~~individuals receiving medicaid hospice services, without regard to the payer.
- (F) No provider of hospice services shall be entitled to payment on a claim before the information specified in paragraph (C)(1) of this rule has been submitted.

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**LTCSSTL 15-10**

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The hospice assumes full responsibility for professional management of the ~~consumer's~~ individual's hospice care in accordance with the hospice conditions of participation. To be eligible to provide medicaid hospice services, a hospice must meet the criteria in paragraphs (A) to ~~(R)~~ of this rule.

- (A) Be eligible to participate in the Ohio medicaid program upon execution of a provider agreement in accordance with rule ~~5101:3-1-17.2~~5160-1-17.2 of the Administrative Code.
- (B) Meet the medicare guidelines in accordance with 42 C.F.R. part 418 (~~September 22, 2006~~)(October 1, 2014).
- (C) Be licensed under Ohio law in accordance with Chapter 3712. of the Revised Code by the Ohio department of health.
- (D) Comply with all requirements for medicaid providers in Chapter ~~5101:3-1~~5160-1 of the Administrative Code.
- (E) Assure that all hospice employees who provide services are licensed, certified, or registered in accordance with federal and state law.
- (F) Not discontinue nor diminish the hospice care it provides to the ~~consumer~~individual because of the inability of the ~~consumer~~individual to pay or receive medicaid reimbursement for such care pursuant to the medicare requirements at Section 1861 (dd)(2)(D) of the Social Security Act, 42 U.S.C. 1395x(dd)(2)(D) (~~December 8, 2003~~)(as in effect January 1, 2015).
- (G) Inform the county department of job and family services (CDJFS) in writing of any change in the ~~consumer's~~ individual's address.
- (H) Arrange for another individual or entity to furnish services to the hospice's ~~consumers~~individuals in accordance with 42 C.F.R. 418.56 (~~June 5, 2008~~)(October 1, 2014) when the hospice cannot provide services to the ~~consumer~~individuals. This arrangement must include a signed agreement and this agreement must remain on file at the hospice agency.
- (I) Facilitate concurrent curative treatment for children under age twenty-one with other medicaid providers to assure that continuity of care is maintained and coordinated to avoid duplication of equivalent services. The provider must document the delineation of the manner in which services and the assessment process are coordinated between medicaid providers.
- (J) Provide a copy of the hospice election form that specifies the type of hospice care and services in accordance with rule ~~5101:3-56-02~~5160-56-02 of the Administrative Code to other medicaid providers, including providers of concurrent curative treatment.
- (K) Provide a copy of the ~~consumer's~~ individual's advance directive to other medicaid providers, including providers of concurrent curative treatment.
- (L) Have a signed agreement with the nursing facility, the ~~ICF-MR~~intermediate care facility for individuals with intellectual disabilities (ICF-IID), the general inpatient facility, and/or the inpatient respite care facility in which the ~~consumer~~individual resides and/or receives services. The terms of the agreement must not violate the medicaid provider agreement as set forth in rule 5160-1-17.2 of the Administrative Code and must not violate the individual's freedom of choice of providers. This agreement must remain on file at the hospice agency and contain, at a minimum, the following:
  - (1) A stipulation that the hospice maintains responsibility for the professional management of the ~~consumer's~~individual's hospice care;
  - (2) A delineation of the manner in which contracted services are coordinated and supervised by the hospice;

- (3) A delineation of the role of the hospice and the facility in the admissions process, patient/family assessments, and the interdisciplinary group (IDG) conferences; and
- (4) A stipulation that the facility must have a valid medicaid provider agreement in accordance with rule ~~5101:3-1-17.2~~5160-1-17.2 of the Administrative Code and accept the payment from the hospice as payment in full as negotiated; ~~and~~.
- ~~(5) The terms of the agreement must not violate the medicaid provider agreement as set forth in rule 5101:3-1-17.2 of the Administrative Code and must not violate the consumer's freedom of choice of providers.~~

(M) The hospice must obtain written certification of terminal illness for each election period:

- (1) For the first ninety-day election period, the hospice must obtain, no later than two calendar days after hospice care is initiated, a written physician certification statement signed by the medical director of the hospice or a physician member of the hospice interdisciplinary group (IDG) and the ~~consumer's~~ individual's attending provider;
- (2) For subsequent benefit periods, the hospice must obtain a written physician certification statement no later than two calendar days after hospice care is initiated in each of the subsequent benefit periods. The written physician certification statement shall be signed and dated by the hospice medical director or a physician member of the IDG;
- (3) If the hospice cannot obtain the written physician certification statement within two calendar days, after a benefit period begins, it must obtain an oral physician certification statement within two calendar days and obtain the signed and dated written physician certification statement ~~signed and dated~~ prior to submission of a claim;
- (4) The hospice must document the oral physician certification statement in the ~~consumer's~~ individual's hospice record and retain the written physician certification statements in the ~~consumer's~~ individual's hospice records;
- (5) The physician certification must include a statement that the ~~consumer~~ individual has a medical prognosis that his or her life expectancy is six months or less if the terminal illness runs its normal course and specific clinical findings and other documentation supporting a life expectancy of six months or less in accordance with 42 C.F.R. 418.22 ~~(August 6, 2009)~~ (October 1, 2014); and
- (6) The hospice must also follow these requirements for those ~~consumers~~ individuals who had been previously discharged and subsequently re-elected hospice care.

(N) At the time of election of the hospice care, the hospice must:

- (1) Assist the ~~consumer~~ individual or representative with the election process;
- (2) Retain a copy of the election form in the ~~consumer's~~ individual's hospice record; and
- (3) On the date of election, provide the ~~consumer~~ individual or the representative with the following materials and written information:
  - (a) Conditions of election of the hospice benefit; including
    - (i) Duration and scope of coverage; and
    - (ii) Notice of the ~~consumer's~~ individual's responsibility for reporting other insurance and for obtaining health care; and
    - (iii) Notice of the ~~consumer's~~ individual's responsibility for reporting other providers of concurrent curative treatment for children under age twenty-one; and
  - (b) Grievance procedures;
  - (c) Procedures for revocation of the hospice benefit; and
  - (d) Information regarding advance directives in accordance with Chapter 2133. of the Revised Code and any policies the hospice has regarding the implementation of advance directives.

- (i) Each ~~consumer~~individual has the right to formulate an advance directive, including a do not resuscitate order; and
- (ii) The hospice must maintain the ~~consumer's~~ individual's advance directive in an accessible part of the ~~consumer's~~ individual's current hospice record and include a notation in the ~~consumer's~~ individual's plan of care.

- (O) Establish a written plan of care for each ~~consumer~~individual prior to providing care, and the care provided to the ~~consumer~~individual must be in accordance with the plan. The plan of care must:
- (1) Be established and maintained in accordance with ~~the~~ 42 C.F.R. 418.56 (~~June 5, 2008~~)(October 1, 2014);
  - (2) Be established by the attending provider, the medical director or physician designee and the IDG;
  - (3) Be reviewed and updated, at intervals specified in the plan, by the attending provider, the medical director or physician designee and IDG. These reviews must be documented; and
  - (4) Include an assessment of the ~~consumer's~~ individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the ~~consumer's~~ individual's and family's needs.
- (P) Designate a registered nurse to coordinate the implementation of the plan of care for each ~~consumer~~individual.
- (Q) Assure that care is coordinated for ~~consumers~~ individuals enrolled in ~~an HCBS~~ a home and community based (HCBS) waiver program. A collaborative effort must occur between the hospice case manager and the waiver case manager or the service and support administrator (SSA) as applicable to maintain a continuum of the overall care provided to the ~~consumer~~individual.
- (1) Case management of hospice services shall be provided by the hospice case manager in accordance with this chapter;
  - (2) Case management of waiver services shall be provided by the waiver case manager; and
  - (3) The hospice must provide services to a waiver ~~consumer~~individual in accordance with a comprehensive plan for the concurrent provision of waiver services by waiver and hospice providers. The administrating agency of the waiver or its designee ~~will~~shall assist in the coordination of care by:
    - (a) Reviewing and approving the comprehensive plan for the concurrent provision of waiver services by waiver and hospice providers;
    - (b) Resolving any issues resulting from the comprehensive plan for the concurrent provision of waiver services by waiver and hospice providers;
    - (c) Resolving any issues of interpretation when implementing the requirements in this chapter; and
    - (d) Applying any exceptions to the requirements of this chapter on a case-by-case basis.
- (R) Each month, the hospice must identify the ~~consumer~~individual as a hospice ~~consumer~~individual by labeling the medicaid card with the name of the hospice next to the ~~consumer's~~ individual's name. This is to indicate that hospice care has been elected and a restriction exists on medicaid coverage. Since the medicaid card lists the names of all medicaid-eligible individuals under a particular case number, the hospice must label the card in such a way as to clearly identify which individual has elected medicaid hospice care.
- ~~(1)~~ ~~Since the medicaid card lists the names of all medicaid-eligible consumers under a particular case number, the hospice must label the card in such a way as to clearly identify which consumer has elected medicaid hospice care;~~
- ~~(2)~~(1) The hospice must label the card no later than the eighth of each month to indicate that the ~~consumer~~individual is enrolled in the hospice program; or

~~(3)~~(2) The hospice must label the card no later than eight days after the ~~consumer~~individual has enrolled in the hospice program.

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~~For services outlined in this rule to be covered, a certification that the consumer is terminally ill must have been completed, and the hospice service must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. The consumer must elect hospice care, and a plan of care must be established before the services are provided.~~

~~A hospice may furnish covered services to consumers who reside in a SNF, NF, ICF-MR, or any residence or facility not certified by medicare or medicaid or at the consumer's home.~~

~~When the consumer elects the hospice benefit, the hospice assumes responsibility for the professional management of the consumer's care. Professional management involves the assessment, planning, monitoring, directing and evaluation of the consumer's care across all settings.~~

(A) For services outlined in this rule to be covered, a certification that the individual is terminally ill must have been completed in accordance with rule 5160-56-04 of the Administrative Code, and the hospice service must be reasonable and necessary for the palliation and management of the terminal illness and related conditions. The individual must elect hospice care, and a plan of care must be established before the services are provided.

(B) A hospice may furnish covered services to individuals who reside in a skilled nursing facility (SNF), a nursing facility (NF), or an intermediate care facility for individuals with intellectual disabilities (ICF-IID), or any residence or facility not certified by medicare or medicaid or at the individual's home.

(C) When the individual elects the hospice benefit, the hospice assumes responsibility for the professional management of the individual's care. Professional management involves the assessment, planning, monitoring, directing and evaluation of the individual's care across all settings.

~~(A)~~(D) The following covered hospice services must be performed by appropriately qualified personnel, and the level of care provided must be based on the ~~consumer's~~ individual's needs:

(1) Core hospice services include the following:

- (a) Nursing care;
- (b) Medical social services, provided by a social worker under the direction of a physician or attending provider;
- (c) Counseling services, provided for the purpose of counseling or training the caregiver and helping the ~~consumer~~individual and the family members and/or caregiver with adjusting to the approaching death, including but not limited to:
  - (i) Dietary;
  - (ii) Bereavement;
  - (iii) Spiritual; and
  - (iv) Additional counseling; and
- (d) Physician services.

(2) Non-core services include the following:

- (a) Short-term inpatient care that can be accessed on an intermittent, nonroutine, occasional basis for pain control and acute or chronic symptom management and/or respite;
- (b) Medical appliances and supplies, including drugs and biologicals;
- (c) Home health aide and homemaker services that enable the ~~consumer~~individual to carry out the treatment plan;

- (d) Physical therapy, occupational therapy, and speech-language pathology provided for symptom control or to enable the ~~consumer~~individual to maintain activities of daily living and basic functional skills;
  - (e) All other medical treatment and diagnostic procedures provided in relation to the terminal condition, when medically indicated; and~~or~~
  - (f) Transportation services must be provided or arranged for by the hospice:
    - (i) If there is no other means to transport the ~~consumer~~individual, and the ambulance service is the safest way of transportation and it is related to the ~~consumer's~~individual's condition, the ambulance service becomes a covered hospice service; or
    - (ii) If the hospice determines that the ~~consumer's~~individual's need for transportation is for other than receiving care related to the terminal illness, the hospice may make arrangements for the appropriate level or type of transportation and the service may be covered under medicaid in accordance with Chapter ~~5104:3-24~~5160-15 or Chapter 5160-24 of the Administrative Code.
- (3) Hospice care for ~~consumers~~individuals residing in a nursing facility or ~~ICF-MR~~ICF-IID:
- (a) The facility has the responsibility to assure that the care outlined in the plan of care is performed by qualified staff and consistent with acceptable professional standards of practice. Those services include:
    - (i) Performing personal care services;
    - (ii) Assisting with activities of daily living;
    - (iii) Administering medication;
    - (iv) Socializing activities;
    - (v) Maintaining the cleanliness of the ~~consumer's~~individual's room; and
    - (vi) Supervising and assisting in use of durable medical equipment and prescribed therapies; and
  - (b) The hospice has the responsibility to cover hospice services outlined in paragraphs ~~(A)(D)~~(D)(1) and ~~(A)(D)~~(D)(2) of this rule.
- (4) Hospice care for ~~consumers~~individuals enrolled in a home and community based services (HCBS) waiver program:
- (a) Waiver services are provided by approved waiver providers if the service is a covered service for that waiver program prior to the election of the hospice benefit; and
  - (b) The hospice has the responsibility to cover hospice services outlined in paragraphs ~~(A)(D)~~(D)(1) and ~~(A)(D)~~(D)(2) of this rule.
- ~~(B)~~(E) For any medicaid services that are unrelated to the treatment of the terminal condition for which hospice care was elected, providers must:
- (1) Follow all applicable medicaid authorization policies and procedures; and
  - (2) Call the hospice before providing any services in order to clarify the ~~consumer's~~individual's restricted status.

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**LTCSTL 15-10**

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~~ODJFS~~The Ohio department of medicaid (~~ODM~~) shall reimburse only the hospice provider directly for the costs of all covered services related to the treatment of the ~~consumer's individual's~~ terminal illness with the exception of reimbursement for physician services that are for direct patient care and, if the ~~consumer individual~~ is under age twenty-one, with the exception of reimbursement for concurrent curative treatment for the ~~consumer's individual's~~ terminal illness. Physician services for direct patient care will be reimbursed according to paragraph (D) of this rule. Providers billing for concurrent curative treatment will be reimbursed according to paragraph (H) of this rule.

(A) Based on the methodology set forth in 42 C.F.R. 418.302 (~~August 6, 2009~~)(October 1, 2014), the medicaid payment for hospice services is made at one of four predetermined rates. Each rate is based on the level of care that is appropriate for the ~~consumer individual~~ for each day while under the care of the hospice.

Each rate covers all services rendered by the hospice (either directly or under contractual arrangement), the administrative services, the technical services, and the general supervisory activities performed by physicians, and travel expenses and supervision provided by other hospice staff.

The medicaid maximum payment rate for each hospice is set forth in the hospice's provider charge file that is specifically assigned to each participating hospice.

(B) The hospice shall bill ~~ODJFS~~~~ODM~~ the appropriate code and unit(s) for the appropriate level of care. The rate paid for the date of service depends on the level of care furnished to the ~~consumer individual~~ on that day.

(1) Routine home care is covered in accordance with 42 C.F.R. 418.302 (~~August 6, 2009~~)(October 1, 2014). Hospice providers must use code T2042 for one unit per day to bill for routine home care.

(2) Continuous care is covered in accordance with 42 C.F.R. 418.302 (~~August 6, 2009~~)(October 1, 2014). Hospice providers must use code T2043 for one unit per hour, minimum of eight hours per day to bill for continuous home care.

(3) Inpatient respite care is covered in accordance with 42 C.F.R. 418.302 (~~August 6, 2009~~)(October 1, 2014). Hospice providers must use code T2044 for one unit per day to bill for inpatient respite care.

(4) General inpatient care is covered in accordance with 42 C.F.R. 418.302 (~~August 6, 2009~~)(October 1, 2014). Hospice providers must use code T2045 for one unit per day to bill for general inpatient care.

(C) When the ~~consumer individual~~ is a resident of a ~~NF~~nursing facility (NF) or an ~~ICF-MR~~intermediate care facility for individuals with intellectual disabilities (ICF-IID), the hospice shall be reimbursed for room and board. This additional per diem amount is reimbursable for routine home care and continuous home care days. Hospice providers shall use code T2046 to bill for room and board. To receive reimbursement, the hospice:

(1) Must bill ~~ODJFS~~~~ODM~~ the amount equal to ninety-five per cent of the medicaid NF or the ~~ICF-MR~~ICF-IID per diem rate as obtained from the NF or the ~~ICF-MR~~ICF-IID.

(2) Must bill only for days that the ~~consumer individual~~ is in the NF or ~~ICF-MR~~ICF-IID overnight and is medicaid eligible.

(3) ~~Can~~Must bill for ~~consumers individuals~~ who ~~have~~are ~~elected the hospice benefit under~~ medicare ~~but are~~and medicaid eligible, medicare for services provided under the medicare

hospice benefit and medicaid for the individual's ~~and reside in a medicaid-reimbursed NF or ICF-MR for the~~ room and board.

- (D) ~~ODJFS will reimburse separately for physician services involving direct patient care, as follows~~ Separate payment may be made to a physician for services involving direct patient care. The physician may be an employee of the hospice, a practitioner under contractual arrangement with the hospice, or an attending practitioner who is not an employee of the hospice but is an eligible medicaid provider. Separate payment cannot be made, however, for the following services:
- (1) ~~Reimbursement for services provided by physicians who are hospice employees or who are under contractual arrangements with the hospice, unless furnished on a volunteer basis, an administrative basis or a technical service, will not be included in any of the predetermined rates, but will be paid to the hospice separately in accordance with Chapter 5101:3-4 of the Administrative Code~~ A physician service furnished on a volunteer basis or on an administrative basis;
  - (2) ~~If the consumer designates an attending physician who is not an employee of the hospice, medicaid will pay the physician directly, if the physician has a valid medicaid provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code. Costs for services such as lab or x-rays are not to be included on the attending physician's bill, but are covered in the predetermined rate paid the hospice. Payment for attending physician services is based on current medicaid rules and regulations for physician services as found in Chapter 5101:3-4 of the Administrative Code.~~ A procedure classified as a technical service; or
  - (3) Laboratory or radiography services performed in connection with the physician service.
- (E) After receipt of ~~the~~ a third-party resource, ~~ODJFS~~ ODM may be billed for the balance. For each day the medicaid eligible ~~consumer~~ individual is enrolled in hospice, the total reimbursement for hospice services cannot exceed the per diem rate for the appropriate code specifying the appropriate level of care.
- (F) Medicaid eligible residents of NFs or ~~ICF-MRs~~ ICF-IIDs who are enrolled in a medicare or medicaid hospice program are not entitled to medicaid-covered bed-hold days. It is the hospice's responsibility to contract with and pay the NF in accordance with rule ~~5101:3-3-16.4~~ 5160-3-16.4 of the Administrative Code. It is the hospice's responsibility to contract with and pay the ~~ICF-MR~~ ICF-IID in accordance with rule ~~5101:3-3-16.8~~ 5123:2-7-08 of the Administrative Code.
- (G) Pursuant to Section 1861(dd)(2)(A)(iii) of the Social Security Act, 42 U.S.C. 1395x(dd)(2)(A)(iii) (~~March 30, 2010~~ as in effect January 1, 2015) there shall be a limitation on reimbursement for inpatient care during the hospice cap period.
- (H) For any services related to the terminal illness, providers must bill the hospice provider directly unless the services were for concurrent curative treatment of the terminal illness for ~~consumers~~ individuals under age twenty-one. Providers billing for concurrent curative treatment must comply with, and will only be reimbursed according to, all the requirements for medicaid providers in Chapter ~~5101:3-15~~ 160-1 of the Administrative Code.

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