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CHAPTER II

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43.01 **DEFINITIONS**

- 43.01-1 **Attending Physician** is a doctor of medicine or osteopathy licensed to practice in the State of Maine (or the state or province in which the services are provided) who provides services within the scope of practice of his or her profession as defined by Maine (or applicable law), identified by the member at the time he or she elects to receive hospice care as having the most significant role in the determination and delivery of the member's medical care.

- 43.01-2 **Department** means the Maine Department of Human Services.

- 43.01-3 **Hospice** is any public, private or non-profit organization, or a subdivision of such an organization, that is primarily engaged in providing pain relief, symptom management, and support services to terminally ill members and their families. For a hospice to receive MaineCare reimbursement, it must be Medicare-certified and licensed under applicable state or provincial law.

- 43.01-4 **Hospice Services** are a range of interdisciplinary services provided twenty four (24) hours a day, seven days a week to a person who is terminally ill and to that person's family. These services are to be delivered in the least restrictive setting possible by volunteers and professionals who are trained to help the member with physical, social, psychological, spiritual and emotional needs related to the terminal illness with the least amount of technology possible. Services are focused on pain relief and symptom management and are not curative in nature.

- 43.01-5 **Interdisciplinary Team** is the team that manages the hospice services provided to the terminally ill member and the member's family. The team includes at least the following individuals: a doctor of medicine or osteopathy, a registered nurse, a medical social worker and a counselor as outlined in Section 43.06-3. All individuals must be employees of the hospice, except the physician who may be a contractor of the hospice.

- 43.01-6 **Medical Director** must be a hospice employee or contractor who is a doctor of medicine or osteopathy licensed in the state or province in which services are provided, who has overall responsibility for the medical component of patient care at the hospice.

- 43.01-7 **Representative** is an individual authorized under state or provincial law to end medical care or to elect or revoke the election of hospice care on behalf of a terminally ill member who is mentally or physically incapacitated. For purposes of making health care decisions, a member's representative may also be a "guardian," "agent" or "surrogate," as these terms are defined in 18-A MRSA Sec. 5-801.

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43.01 **DEFINITIONS** (cont.)

43.01-8 **Terminal Illness** is a medical condition resulting in a prognosis that a member has a life expectancy of six (6) months or less if the illness runs its normal course.

43.02 **MEMBER ELIGIBILITY FOR CARE**

A member is eligible for covered hospice services if he or she meets both the General MaineCare financial eligibility requirements and the Hospice Services Eligibility Requirements, with the exception of the following: those members deemed eligible for coverage under Medicare hospice benefits, however, shall not be eligible for services which would be duplicative under this Section.

43.02-1 General MaineCare Eligibility Requirements

Individuals must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

43.02-2 Hospice Services Eligibility Requirements

- A. A member must be certified by a physician as having a terminal illness as set forth in Section 43.03-1, Certification of Terminal Illness; and
- B. The member or his or her Representative must elect hospice benefits in lieu of other MaineCare covered services as specified in Section 43.03-2 by completing an election statement as set forth in that section. Members under age 21 making said election do not waive any MaineCare covered services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.

43.03 **MEMBER ELIGIBILITY PROCEDURE**

43.03-1 Certification of Terminal Illness

- A. No later than two (2) calendar days after the initiation of hospice care the hospice must get verbal certification of terminal illness from the Medical Director or the physician on the hospice's Interdisciplinary Team and the member's attending physician, if the member has an attending physician. The hospice must obtain written certification prepared by both the Medical Director or the physician on the hospice's Interdisciplinary Team and the member's attending physician (if he/she has one) and submit a copy of the certification to: Bureau of Medical Services, Classification Review, 11 State House Station, Augusta, ME 04333-0011, before submitting the claim for payment.

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43.03 **MEMBER ELIGIBILITY PROCEDURE** (cont.)

- B. With respect to any subsequent election of hospice benefits, the hospice must obtain written certification of the member's terminal illness from the Medical Director or the physician on the hospice's Interdisciplinary Team before submitting the claim for payment.
- C. The certification must include:
 - 1. The statement that the member's life expectancy is six (6) months or less if the terminal illness runs its normal course; and
 - 2. The signature(s) of the physician(s).

The hospice must keep the certification statement(s) in the member's record.

43.03-2 Election/Revocation of Hospice Benefits

A member or his/her Representative must choose hospice care by filing an election statement. An election will remain effective as long as the member remains in the care of the hospice and does not revoke the election, regardless of the number of benefit periods elapsed. A new election statement must be filed if the member seeks to obtain hospice care after such benefits have been revoked. A member may designate the effective date for hospice benefits as the first or any subsequent day of hospice care, but the effective date may not be earlier than the date of election.

A. Contents of Election Statement

The election statement must include:

- 1. Identification of the hospice that will provide care to the member;
- 2. The member's or Representative's acknowledgment that he or she fully understands the palliative rather than curative nature of the hospice care related to the terminal illness;
- 3. The member's or Representative's acknowledgment that he or she understands that the MaineCare services listed in Section 43.03-2(B) and Section 43.05-4 are waived (or subject to limitations) by the election and that the member may be held financially liable for obtaining said services;
- 4. The effective date of the election; and

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43.03 **MEMBER ELIGIBILITY PROCEDURE** (cont.)

5. The signature of the member or Representative.

The hospice must keep the election statement(s) in the member's record.

The hospice must ensure that the member and/or Representative is adequately educated with regard to services waived by the hospice election and financial responsibility of the member for obtaining services that may duplicate services covered under this Section. This education should inform members under the age of 21 or their representatives that medically necessary services are not waived when electing hospice services provided that these services are not duplicative of hospice services.

B. Waiver of Other MaineCare Benefits

For the duration of the election of hospice care a member waives all rights to MaineCare payments for the following services only:

1. hospice care provided by a hospice other than the one designated by the member (unless provided under arrangements made by the designated hospice, or when transferring to another hospice program, see Section 43.03-3);
2. any MaineCare services related to the treatment of the terminal condition for which hospice care was elected, or services that are determined to be related to the treatment of the member's condition (with respect to which a diagnosis of terminal illness has been made); and
3. any MaineCare services equivalent to hospice care, except for services:
 - * provided either directly or arranged by the designated hospice;
 - * provided by the member's attending physician if he or she is not employed by the designated hospice or does not receive payment from the hospice for those services; or
 - * provided as room and board by a nursing facility if the member is a resident.

See Section 43.05 for additional provisions related to covered and non-covered services.

C. Revoking the Election of Hospice Care

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43.03 MEMBER ELIGIBILITY PROCEDURE (cont.)

A member or representative may revoke the election of hospice care at any time by filing a revocation statement with the hospice which includes a signed statement that: a) the member revokes the election for MaineCare coverage of hospice care for the remainder of that benefit period and b) the effective date of the revocation. The effective date may not be earlier than the revocation. Any days that are remaining in that benefit period are forfeited as of the effective date of the revocation. The member may re-elect hospice care at any time. He/she does not have to wait until the previous benefit period would have been completed if the revocation had not occurred.

Upon revoking hospice care, the member resumes coverage of MaineCare benefits waived upon election of hospice care. A person may elect/revoke hospice care as many times as he or she chooses as long as he or she continues to meet the eligibility standards in Section 43.02. The hospice must forward a copy of the completed revocation statement and the Notice of Consumer Transfer/Death BMS/CS 34 to: Classification Review Unit, Bureau of Medical Services, 11 State House Station, Augusta, ME 04333-0011. The hospice must keep the revocation statement(s) in the member's record. Even if a member has revoked hospice care one or more times, the member is only eligible for a lifetime total of two ninety (90)-day benefits periods (followed by an unlimited number of subsequent sixty (60)-day periods).

43.03-3 Changing From One Hospice to Another

- A. A member may change hospice providers once in each benefit period. The change of hospice is not considered a revocation of the election of hospice services.
- B. To change hospice providers, a member shall file a signed statement with the hospice where the member was initially enrolled and with the new hospice. If appropriate, the hospice shall assist the member with preparation of the statement. The statement shall include:
 - 1. The hospice from which the member received hospice services;
 - 2. The hospice from which the member will receive services; and
 - 3. The date the change is effective.
- C. In order to change providers, notification must be sent to the Department on the Notice of Consumer Transfer/Death BMS/CS 34 by the hospice to which the member is transferring.

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43.04 **DURATION OF CARE**

The hospice benefit has two (2) ninety (90)-day benefit periods, followed by an unlimited number of subsequent sixty (60)-day benefit periods. At the beginning of each benefit period the hospice must obtain a new Certification of Terminal Illness.

43.05 **COVERED SERVICES**

43.05-1 Covered Services

Covered hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. To be covered, all services must be in accordance with the plan of care and approved by the Interdisciplinary Team. Services unrelated to the terminal illness which affect the plan of care must be reflected in the plan in order to assure coordination and non-duplication of services.

The following are considered covered hospice services. Unless noted otherwise, reimbursement shall be based on a per diem or hourly rate, and in accordance with the provisions described in Section 43.07.

- A. Physician Services (see Section 43.07-3 for further details).
- B. Nursing Services provided by or under the supervision of a registered nurse.
- C. Medical Social Services provided by a medical social worker working under the supervision of a physician.
- D. Counseling Services must be available to the member and family members or others caring for the member at home, including dietary, spiritual and other counseling. Counseling may be given both for the purpose of training caregivers to provide care, and for the purpose of helping the member and those caring for him or her to adjust to the member's approaching death.
- E. Home Health Aide Services furnished by certified home health aides and certified nursing assistants. Home health aides may provide personal care and household services essential to the comfort and cleanliness of the member and maintaining a safe and healthy environment to allow implementation of the plan of care. Aide services must be provided under the general supervision of a registered nurse.

Home health aide services can include the provision of homemaker services. Homemaker services include maintenance of a safe and healthy environment and services that enable the member to carry out the plan of care.

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43.05 **COVERED SERVICES** (cont.)

- F. Medical Supplies, Drugs and Biologicals are only covered when used primarily for the relief of pain and symptom control related to the member's terminal illness are covered. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to relief or management of the terminal illness. Equipment is provided by the hospice for use in the member's home while under hospice care. Medical supplies include those that are part of the written plan of care.
- G. Short-Term Inpatient Care provided in a participating hospice inpatient unit or a participating hospital or nursing facility which meets the special hospice standards regarding staffing and patient areas. Participating facilities are defined as those with which the hospice has a contract that provides for all requirements contained within the Medicare Hospice conditions of participation. Inpatient services must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot be provided in other settings. Inpatient care may also be furnished to provide respite for individuals caring for the member at home.
- H. Physical, Occupational and Speech/Language Therapy provided for symptom control or to allow the member to perform daily living activities and basic functional skills.
- I. Special Modalities, including chemotherapy, radiation therapy, and other modalities that may be used for palliative purposes if it is determined that these services are needed for palliation. This determination is based on the member's condition and philosophy of care giving of the hospice. No additional MaineCare reimbursement shall be provided, regardless of the cost of the services.
- J. Ambulance Services, when the medical condition requiring ambulance transport is a result of the member's terminal illness.
- K. Other Items and Services specified in the plan of care for which payment may otherwise be made. This item reflects the hospice's responsibility for providing any and all services in the plan of care necessary for the relief and management of the terminal illness and related conditions.

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43.05 **COVERED SERVICES** (cont.)

43.05-2 Special Coverage Requirements

Bereavement counseling consists of counseling services provided to the member's family for up to one (1) year after the member's death. It is a required hospice service but is not separately billable.

43.05-3 Room and Board Services for Nursing Facility Residents

The following services shall be included as room and board services and shall be provided by the nursing facility for those MaineCare members who elect to receive hospice while residing in the nursing facility:

- * performance of personal care services;
- * assistance in activities of daily living;
- * administration of medication;
- * maintaining cleanliness of resident's room; and
- * supervising and assisting with the use of durable medical equipment and prescribed therapies.

43.05-4 Coverage Restrictions During Hospice Election

A. Medically Necessary/Non-Duplicative Services

Medically necessary services (as defined by the Department) which are not duplicative of hospice services or unrelated to a member's terminal illness may be obtained by a MaineCare member receiving hospice services. The services provided must be appropriately documented in the member record, in accordance with Department specifications. These services are subject to the same coverage provisions, limitations, prior authorization requirements and conditions applied to services available to non-hospice MaineCare members. (All services, related to and unrelated to the terminal illness, must be consistent with the plan of care.) These services are reimbursable by MaineCare outside of the hospice rate.

The services include:

- * Ambulance Services - Chapter II, Section 5, when the medical condition requiring ambulance transport is unrelated to the terminal illness for which the member is receiving services under this Section.
- * Audiology Services - Chapter II, Section 10
- * Consumer Directed Attendant Services - Chapter II, Section 12, subject to additional restrictions that may be outlined in that Section

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43.05 **COVERED SERVICES** (cont.)

- * Chiropractic Services - Chapter II, Section 15
- * Family Planning Agency Services - Chapter II, Section 30
- * Hearing Aids & Services - Chapter II, Section 35
- * Home Health Services - Chapter II, Section 40 subject to additional restrictions that may be outlined in that Section
- * Optional EPSDT/Non-traditional EPSDT Treatment Services - Chapter V, Section 4, or its successor Chapter II, Section 94.
- * Transportation Services - Chapter II, Section 113
- * Podiatric Services - Chapter II, Section 95
- * Private Duty Nursing and Personal Care Services - Chapter II, Section 96, subject to additional restrictions that may be outlined in that Section
- * Licensed Clinical Social Worker Services - Chapter II, Section 58
- * Medical Supplies and Durable Medical Equipment - Chapter II, Section 60
- * Psychological Services - Chapter II, Section 100
- * Genetic Testing and Clinical Genetic Services - Chapter II, Section 62
- * Medical Imaging Services - Chapter II, Section 101
- * Occupational Therapy Services - Chapter II, Section 68
- * Physical Therapy Services - Chapter II, Section 85
- * Speech Pathology Services - Chapter II, Section 110
- * Speech and Hearing Agencies - Chapter II, Section 105

B. Continuation of Services

In order to maintain activities of normal life for as long as possible, certain MaineCare services may be continued after the hospice election for those members who have been receiving these services for a substantial period of time prior to the hospice election.

These services include:

- * Case Management Services - Chapter II, Section 13
- * Community Support Services - Chapter II, Section 17
- * Developmental & Behavioral Evaluation Clinic Services - Chapter II, Section 23
- * Day Habilitation Services for Persons with Mental Retardation - Chapter II, Section 24
- * Day Health Services - Chapter II, Section 26
- * Early Intervention Services - Chapter II, Section 27
- * Day Treatment Services - Chapter II, Section 41

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43.05 **COVERED SERVICES** (cont.)

- * Rehabilitative Services - Chapter II, Section 102
- * Home Based Mental Health Services - Chapter II, Section 37
- * Mental Health Clinic Services - Chapter II, Section 65
- * Psychiatric Facility Services - Outpatient services only, Chapter II, Section 46
- * Private Non-Medical Institution Services - Chapter II, Section 97
- * Substance Abuse Treatment Services - Chapter II, Section 111

There may be instances where it is appropriate to allow individual hospice members to receive these services even if they did not receive them prior to electing the hospice benefit. However, the provider must show that services are medically necessary given the member's terminal condition, and are coordinated with the hospice plan of care. These services are reimbursable by MaineCare outside of the hospice rate.

C. Home and Community Benefits

Eligibility for and limits on home and community benefits for members of hospice care are delineated in the relevant section of Chapter II of the MaineCare Benefits Manual (MBM).

43.06 **POLICIES AND PROCEDURES**

43.06-1 Member Service Provision Rights

Receipt of hospice services in no way affects the rights afforded to residents of a nursing facility under Chapter II, Section 67, including those relating to transfer and discharge, status change notification and hearings and appeals.

The election of hospice by a member, however, in no way diminishes the responsibility of the member or nursing facility to obtain required prior authorization, or to comply with eligibility requirements for nursing facility placement.

43.06-2 Member Status Change

A. Notification of the following changes in consumer status must be provided to the Department:

- * Admission to or discharge from a nursing facility
- * Transfer from one nursing facility to another
- * Entry into or exit from hospice status

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43.05 **COVERED SERVICES** (cont.)

- * Transfer from one hospice to another
- * Member death.

B. As applicable, the following forms must be used:

- * Notice of Consumer Transfer/Death BMS/CS 34
- * Election/Revocation of Hospice
- * Certification of Terminal Illness

C. Hospice enrollee in a nursing facility (NF):

This section delineates who is responsible for submitting notification for hospice members who are in a NF.

1. When the change of status involves only the nursing facility, the NF must submit information as outlined in Chapter II, Section 67, of the MBM.
2. When the change of status involves only the hospice (including, but not limited to, election/ revocation) the hospice must submit the appropriate election or revocation form.
3. When the change of status is a transfer from one hospice to another, the hospice to which the member is moving must submit the BMS 34 form.
4. When the change of status involves both the hospice and the nursing facility (e.g. member death) the NF is responsible for submitting the BMS 34 form.

D. Members who are in hospice only.

When the change of status is a transfer from one hospice to another, the hospice to which the member is moving must submit the BMS 34 form.

43.06-3 Professional and Other Qualified Staff

The hospice is responsible for the verification of appropriate licensure, certification or other qualifications of hospice staff, and for monitoring service providers. The hospice must maintain documentation of qualifications of service providers.

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43.06 **POLICIES AND PROCEDURES** (cont.)

Staff must meet orientation and training requirements outlined in hospice licensing regulations.

A. The following professionals, employed directly or by contract with a hospice, by virtue of possession of a current license to practice their discipline in the State of Maine or state or province in which the service is provided, may provide hospice services within the scope of their license:

1. Physician
2. Registered Nurse
3. Practical Nurse
4. Clinical, Dietary and Pastoral Counselors
5. Physical Therapist
6. Physical Therapist Assistant
7. Occupational Therapist Registered (OTR)
8. Certified Occupational Therapy Assistant (COTA)
9. Medical Social Worker
10. Speech-Language Pathologist
11. Speech-Language Pathology Assistant

B. The following staff, employed directly or by contract with a hospice, may provide hospice services within the scope of their license or certification when they meet the following requirements:

1. Certified Home Health Aide and Certified Nursing Assistant (CNA)

A CNA or home health aide must be listed on the Maine Registry of Certified Nursing Assistants. A CNA or home health aide must be supervised as required by licensing regulations.

2. Other Qualified Staff

Other qualified staff are staff members, other than those defined above, who have been determined competent by a health care professional and documented by the hospice to have appropriate education, training and experience for the task in the plan of care for which they have been hired.

43.06-4 **Written Plan of Care**

A plan of care must be established before services are provided. The plan of care must be established by the member's attending physician, the hospice

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43.06 **POLICIES AND PROCEDURES** (cont.)

physician, and the Interdisciplinary Team. Services must be consistent with the plan of care to be reimbursed. The hospice must designate a registered nurse, whose responsibility it is to coordinate the implementation of the plan, and to provide assurance that the member receives necessary care and services on a 24-hour basis. The plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care.

43.06-5 Member Record

All hospices must maintain a clinical record for each member receiving care and services. The clinical record must include the following information:

- A. The plan of care;
- B. The member's name, MaineCare ID, address, sex, age, and next of kin;
- C. Election/Revocation forms;
- D. Pertinent medical history;
- E. Certification of Terminal Illness; and
- F. Complete documentation of all services and events, including: assessments, progress notes and reviews of the plan of care. Progress notes must be maintained in conformance with Medicare conditions of participation.

43.06-6 Surveillance and Utilization Review

The Department's Bureau of Medical Services shall perform the Surveillance and Utilization Review activities set forth in Chapter I, General Administrative Policies and Procedures, of the MBM.

Upon request, the provider will furnish to the Department, with no additional charge, the clinical records, or copies thereof, corresponding to and substantiating services billed by that provider.

43.07 **REIMBURSEMENT**

43.07-1 Levels of Care

There are four levels of care into which each day of care is classified:

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43.07 **REIMBURSEMENT** (cont.)

- * Routine Home Care
- * Continuous Home Care
- * Inpatient Respite Care
- * General Inpatient Care

For each day a member receives hospice care, the hospice will be reimbursed an amount applicable to the type and intensity of the services provided to the member for that day. For continuous home care, payment is determined based on the number of hours of continuous care furnished that day. A description of each level of care follows.

- A. Routine Home Care rate is billed for each day the member is under the care of the hospice and not receiving one of the other categories of hospice care. This rate is paid regardless of the volume and intensity of routine home care services provided on any given day and is also paid when the member is receiving hospital care for a condition unrelated to the terminal condition.

In-home respite care may also be billed as Routine Home Care, as long as the respite providers are qualified to perform Routine Home Care services under this Section.

- B. Continuous Home Care is to be provided only during a period of crisis. A period of crisis is a period in which a member requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or licensed practical nurse, and a nurse must be providing care for more than half of the period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day beginning at midnight. This care need not be continuous. For example, four (4) hours could be provided in the morning and another four (4) hours that evening. Homemaker and home health aide services may also be provided to supplement the nursing care. Continuous care is covered when it is provided to maintain a member at home during a medical crisis. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.
- C. Inpatient Respite Care is a day of care in which the member receives care in an approved facility for short-term respite only when necessary to relieve the family members or others caring for the member at home. Respite care may be provided only occasionally and may not be reimbursed at the inpatient respite care rate for more than five (5) consecutive days at a time. Payment for the sixth (6th) and any subsequent day is at the routine home care rate.

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43.07 **REIMBURSEMENT** (cont.)

Respite care may not be provided when the member is in a nursing home or any other residential facility. For in-home respite care, refer to Section 43.07-1(A), Routine Home Care.

- D. General Inpatient Care is a day of care when a member receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

43.07-2 Reimbursement Policy

Reimbursement for covered services shall be made on the basis of a per diem or hourly rate and shall be the lowest of:

- A. The amount established by the Department and listed in Chapter III, Section 43 of the MaineCare Benefits Manual (MBM); or
- B. The lowest amount allowed under the Medicare Hospice benefit for covered services with the following exception: For Routine Home Care only, as is described in Section 43.07-1(A) of this rule, that is rendered on or after April 1, 2002, the lowest rate of MaineCare reimbursement shall be equal to 123% of the Medicare rate.

In accordance with Chapter I of the MaineCare Benefits Manual, the provider must seek payment from any other available sources before billing MaineCare. MaineCare shall not provide differential payments to hospices that have entered into reimbursement agreements with other payers.

43.07-3 Payment for Physician Services

The basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the member's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of, or working under arrangements with the hospice. These activities would generally be performed by the Medical Director and the physician on the Interdisciplinary Team. Team activities would include participation in developing plans of care, supervision of care and services, periodic review and update of plans of care and establishing governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care and inpatient respite care.

Payment will be made to the hospice, when it also meets the provider enrollment requirements for services described in the MaineCare Benefits

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43.07 **REIMBURSEMENT** (cont.)

Manual under Section 90, Physician Services, for other physician's services not included in the reimbursement rates for routine home care, continuous home care and inpatient respite care. These include direct member care services, furnished to individual members by hospice employees and under arrangements made by the hospice, unless the member care services were furnished on a volunteer basis. The hospice will be reimbursed in accordance with the usual MaineCare reimbursement policy for Physician Services in Chapter III, Section 90 of the MaineCare Benefits Manual. This reimbursement is in addition to the daily rates.

43.07-4 Payment for Inpatient Care

Payment for inpatient care is limited. During the twelve (12) month period beginning November 1 of each year and ending October 31 of the following year, the aggregate number of reimbursable inpatient days (both for inpatient general care and respite care) shall be capped. The aggregate number of reimbursable inpatient days may not exceed twenty (20) percent of the aggregate days of hospice care provided to all MaineCare members during that twelve (12) month period by the hospice provider. Days of inpatient care provided to members with AIDS (acquired immunodeficiency syndrome) may be excluded from the days counted toward the twenty (20) percent limit.

If the total number of days of inpatient hospice care furnished to MaineCare members is less than or equal to the maximum, no adjustment shall be made. If the total number of days of inpatient care exceeds the maximum allowable number, excess payments must be refunded by the hospice to the Department.

If requested, the hospice shall report to the Department the aggregate number of inpatient days (both for inpatient general care and inpatient respite care) and the aggregate number of days of hospice care provided to all MaineCare members during the "cap" period. The report shall be sent by January 1st following the end of the period (October 31 of the previous year) to:

Hospice Benefits
Division of Financial Services-Long Term Care Reimbursement
Bureau of Medical Services
11 State House Station
Augusta, ME 04333-0011

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43.07 **REIMBURSEMENT** (cont.)

43.07-5 Payment Based on Location Where Care is Provided

Hospice providers must submit claims for payment for hospice care furnished in a member's home or a nursing facility based on the place of service, rather than the location of the hospice.

43.08 **BILLING**

Billing must be accomplished in accordance with the Department's billing requirements as set forth in "Billing Instructions for Hospice Services."