

TO: Hospice Agencies

SUBJECT: Hospice Services

EFFECTIVE: September 1, 1992

PURPOSE: The New Jersey Medicaid program is pleased to announce the

BACKGROUND: Reimbursement for hospice services was authorized pursuant to section 1905 (o) of the Social Security Act, codified as 42 U.S.C. 1396 (d). The New Jersey State statute (N.J.S.A 30:4D-6b(20)) authorizes the provision of hospice services in the Title XIX (Medicaid) program.

The New Jersey Register, dated August 17, 1992, (CITE 24 N.J.R. 2778 (a)) contains the proposed regulations governing the hospice services.

NOTE: This newsletter does not apply to hospice care provided as a Medicaid waiver service under the AIDS Community Care Alternatives Program (ACCAP). For information on hospice waiver services under ACCAP, see the New Jersey Health Services Program Newsletter, P-657, dated October 15, 1990.

ACTION: The New Jersey Medicaid program's Hospice Services Manual states hospice agencies as part of the Medicaid training given July 1, 1992. Hospice agency personnel had received a draft Hospice Services Manual at hospice training and this manual should be retained until a new manual is received. A finalized Hospice Services Manual will be sent to Medicaid approved hospice agencies at the time or shortly after adoption of the hospice regulations in the New Jersey Register.

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DISCARD THE DRAFT FISCAL AGENT SUPPLEMENT GIVEN ON JULY 1, 1992 AT TRAINING. A Fiscal Agent Billing Supplement that has been revised since training on July 1, 1992, is enclosed. Please use the billing instructions enclosed in this copy of the Fiscal Agent Billing Supplement.

Revised copies of the forms to be used by the hospice agencies are attached to this Newsletter. Please project your need for a three month's supply of forms and indicate the following when ordering forms:

1. The name of the hospice on hospice letterhead:
2. The specific name(s) of the forms;
3. The number of the form(s). (The number is listed on the lower left-hand corner); and
4. The quantity desired.

Forms may be ordered by writing to the following address:

Division of Medical Assistance and Health Services
General Services
Attention: Forms
CN-712
Trenton, New Jersey 08625-0712

RECIPIENT ELIGIBILITY:

In order to receive hospice services through Medicaid, an individual must be eligible for Medicaid either in the community or in an institution. A new eligibility group is being established consisting of persons residing in the community who would be eligible if they were residing in a nursing facility and were medically qualified for hospice services.

Individuals must be medically and financially eligible for hospice services. Medical eligibility requires that the individual be terminally ill and elects the hospice benefit. "Terminal illness" means having a life expectancy of six months or less as certified, in writing, by a licensed physician (M.D. or D.O.). Applicants should be determined medically eligible by a Medicaid approved hospice. The hospice agency should then refer the applicant to the proper agency - County Welfare Agency (CWA), Medicaid District Office (MDO) or Division of Youth and Family Services (DYFS) District Office for a financial eligibility determination, as applicable.

Financial eligibility is determined by the CWA for all individuals except those eligible for Supplemental Security Income (SSI) and by DYFS for children under foster care who are currently Medicaid eligible. SSI eligibles should be referred to the appropriate MDO so that their records on the Medicaid eligibility file are updated for hospice services. For children under DYFS foster care, the appropriate DYFS District Office should be contacted to update the Medicaid eligibility files for hospice services.

A limited access Medicaid Eligibility Identification Card (MEI) with the statement "Except for hospice and physicians services, check with hospice provider for other services" will be issued to a Medicaid recipient who is eligible for hospice services.

Medicaid eligibles or persons who might be applicants for Medicaid hospice services, already residing in a nursing facility, who express interest in hospice services should be referred to the appropriate MDO or CWA of the county in which the facility is located, as applicable. Persons in the community or waiting for placement in a nursing facility should be referred to the appropriate MDO or the CWA in their county of residence, as applicable.

When providing services to members of the Garden State Health Plan (GSHP), or another HMO which provides authorization for hospice services, an authorization number must be obtained from the applicant's GSHP or other HMO physician case manager prior to providing hospice services. Hospice agencies must use this authorization number when billing for services provided to a GSHP or other HMO member.

COVERED SERVICES:

The New Jersey Medicaid program reimburses hospice providers for an all-inclusive package of covered services on a per diem basis. Hospice services must be reasonable and necessary for the palliation and management of the terminal illness, and consistent with the hospice's plan of care for the recipient. Hospice services include nursing care, medical social services, supervisory physician services, counseling services, durable medical equipment and supplies including drugs and biologicals, homemaker/home health aide services, physical therapy, occupational therapy and speech-language pathology services. Medicaid also reimburses for room and board services for a hospice recipient residing in a nursing facility, for co-payment for inpatient respite care, and for drugs and biologicals for dually eligible Medicare/Medicaid recipients.

PLAN OF CARE:

The hospice's plan of care for the recipient delineates which Medicaid services are approved as medically necessary by the hospice's interdisciplinary group. For Medicaid payment, all Medicaid services (except physician services) provided to a hospice recipient must receive approval from the hospice agency prior to providing services so that those services would be reflected in the plan of care. Denial of payment for services by Medicaid may result if this approval has not been obtained. The provider of services should be informed by the hospice as to whether the service will be paid to the hospice by Medicaid as part of the all-inclusive per diem rate (and thus paid to the provider by the hospice), or whether the provider should submit the claim directly to the Medicaid fiscal agent for reimbursement.

A hospice recipient agrees to waive some regular Medicaid benefits and other services which are duplicative of the hospice benefits by signing an Election of Hospice Benefits Statement. However, under certain limited conditions, other Medicaid approved services may also be provided unrelated to the terminal illness. Providers need approval from the hospice agency for providing any services other than hospice services (except physician services). The specific services must be included in the plan of care.

REIMBURSEMENT

The details about reimbursement are included in the enclosed Fiscal Agent Billing Supplement and the draft Hospice Services Manual (N.J.A.C. 10:53A). For information about the application of the recipient's available income through the completion of the PA-3L, applicable only for billing for hospice services provided to in a nursing facility, please refer to N.J.A.C. 10:53A - 4.1 of the draft Hospice Services Manual that was provided at the Medicaid hospice training.

Any additional information or questions regarding this Newsletter should be directed to Ms. Judith Johnston, Social Work Consultant, Office of Home Care Programs, Division of Medical Assistance and Health Services at (609)-588-2733 or 2751.

ATTACHMENTS: FISCAL AGENT BILLING SUPPLEMENT

FORMS (PACKAGE OF 8)

