HOSPICE POLICY UPDATE

TOPIC
Policy clarification on coordinating home and community based services with the hospice benefit.

PURPOSE
To communicate policy on care coordination for persons receiving home and community based services, who elect the hospice benefit.

CONTACT
Questions from waiver service coordinators, case managers and Medicaid home care providers can be directed to Carol Estrada at 651-582-1936.

Questions from hospice providers can be directed to the Provider Help Desk at 651-282-5545 or 1-800-366-5411.

For TTY, contact Minnesota Relay Service at 1-800-627-3529

Minnesota Department of Human Services
Community Supports for Minnesotans with Disabilities (CSMD)
444 Lafayette Road North
St. Paul, Minnesota 55155-3857

SIGNED

MARIA R. GÓMEZ
Assistant Commissioner
Continuing Care
BACKGROUND

This bulletin replaces all information in DHS Bulletin 98-56-2 and outlines Department of Human Services (DHS) policy on coordinating home and community based support for persons who have elected the hospice benefit. Home and community based support includes Medicaid home care services, Alternative Care program, and waiver services; Elderly Waiver (EW); Community Alternative Care (CAC); Community Alternatives for Disabled Individuals (CADI); Mental Retardation and Related Conditions (MR/RC) and Traumatic Brain Injury (TBI).

The hospice provider is responsible for providing service and support for the terminal illness and conditions related to the terminal illness. They are not responsible for care or treatment of an illness, injury or disability not related to the person’s terminal condition. A person who elects the hospice benefit has the right to receive care and support for health conditions not related to the terminal illness.

This bulletin provides basic information on the hospice benefit, important information on coordination of care, and information on additional resources. Our goal is to improve statewide responsiveness, accountability and support to individuals and families involved in end of life care.

KEY COMPONENTS OF COORDINATION

Agencies and providers must be accountable for responsive service and support to persons with terminal illness and their family members. Family in this context is defined as people living together or in close proximity and caring for each other.

Key policy components:

- Federal law and guidelines prohibit duplication of care and payment.
- People must be informed of support options from which they may choose. Information should be provided to a person and their family well in advance of needing to make decisions.
- People have the right to make informed choices. This does not mean a person must choose between home and community based support or the hospice benefit. Important clarification follows.
- All providers (waiver service coordinators, case managers, home care agencies, hospice providers and others) are accountable for and aware of their roles and responsibilities in end of life care.
HOSPICE SERVICE AND SUPPORT

The hospice benefit:

- Is an option for people who have been certified by a physician as terminally ill
- Is a benefit for which an eligible person can voluntarily enroll and disenroll
- Offers palliative (not curative) service and support for the terminal illness
- Offers support and comfort to the person and their family
- Is available on a 24-hour basis to offer support and care necessary for palliation of the terminal illness
- Continuous care is provided in the home only during brief periods of intense need (attributed to the terminal diagnosis).
- Includes a comprehensive package of services for the terminal illness and conditions related to the terminal illness. Services include:
  - Physician services
  - Nursing
  - Speech, physical and occupational therapy
  - Home health aide
  - Homemaking
  - Medical social services and counseling
  - Medical supplies and equipment
  - Outpatient medications for pain and symptom control (related to the terminal illness)
  - Dietary services
  - Short-term inpatient care
  - Respite care
  - Volunteers

Hospice services are described in more detail in Attachment A: Health Care Programs Provider Update #105 Hospice Update

ROLE OF THE HOSPICE PROVIDER IN COORDINATING CARE

The hospice provider is responsible for:

- Developing an individualized plan of care that identifies a person’s needs related to the terminal illness and how those needs will be addressed.
- Authorizing, coordinating and paying for all services related to the terminal illness that are
covered under the hospice benefit. This applies to care in community and / or institutional settings.

• Notifying the waiver service coordinator or Medicaid home care provider of a person’s election of the hospice benefit and anticipated start date as soon as possible
  Written notification (FAX or mail) to the waiver service coordinator / case manager or Medicaid home care agency must be given within two business days of hospice benefit election.

• Coordinating care
  A care coordination document must be developed by the hospice provider and shared with the waiver service coordinator or the Medicaid home care contact within eight calendar days of hospice benefit election. This document must be maintained in the person’s hospice, home care and waiver files.

SERVICE COORDINATION TEAM

The hospice provider is responsible for leading care coordination. Coordination requires complete and timely communication and collaboration among all team members. Team members may include:

• The person and their legal representative
• Family
• Hospice provider
• Waiver service coordinator, case manager, and/or county PHN’s
• Medicaid home care agency representative
• Medicaid Financial worker
• Others

COORDINATION OF HOME AND COMMUNITY BASED SERVICES WITH THE HOSPICE BENEFIT

Key considerations in coordination of care center around individualized planning. Care coordination must address each of the following.

1. A person’s unique situation. Decisions applicable to one person may not be applicable to another.

2. The type of service a person needs

3. The purpose of the service

4. Potential areas of, and plans to eliminate or avoid, duplication of service and /or payment.
Coordination of care is needed in the following situations:

- When home and community based services support a non-terminal, pre-existing, acute, or other, health care condition or need.
- When home and community based services meet a need for ongoing continuous care that is not covered under the hospice benefit such as foster care or supported living service.
- When home and community based services provide a service that is not duplicative and/or not offered under the hospice benefit.

One example of this may be personal care assistance service.

The Code of Federal Regulations states that home health aids may provide personal care services such as bathing, dressing, grooming, caring for hair, nails, and oral hygiene, changing bed linens for a person who is incontinent, shaving, skin care, assistance with feeding, routine catheter and colostomy care, assistance with ambulation, changing position in bed and assistance with transfers.

Personal care assistance in Minnesota includes a broader array of service and support and may include assistance with the following activities:

- Activities of daily living including assistance with dressing, grooming, bathing, eating, toileting, transfers, mobility and positioning.
- Instrumental activities of daily living including assistance with meal preparation, shopping for essential items, performing essential household chores, assistance with phone calls, arranging transportation and assistance with money management including paying bills.
- Health-related assistance through hands-on service, cueing or supervision
- Behavioral support including monitoring, redirection and intervention

Some other examples of home and community based services not included in the hospice benefit include assisted living, adult foster care and supported living. These are “bundled” packages of service. Careful attention must be paid to reviewing and amending the package of service to assure there is not duplication of a service for the terminal illness.

ROLE OF THE WAIVER SERVICE COORDINATOR, CASE MANAGER, COUNTY PUBLIC HEALTH NURSE OR MEDICAID HOME CARE PROVIDER IN COORDINATING CARE

Waiver service coordinators and case managers are responsible for informing people of community support options. Individuals can benefit from information on hospice in advance of needing to make
decisions. Helpful and important information is available from Hospice Minnesota (phone number and website is included in the resources section of this bulletin). Case managers who work with people residing in institutions (such as ICF-MR facilities) need to inform individuals and their legal representative of the hospice benefit option.

Other responsibilities include:

- Responsive and timely communication and collaboration with the individual, their family, the hospice provider etc.
- Coordination of service and support and assurance that there is no duplication
- Participation in team meetings whenever necessary
- Maintaining a copy of the care coordination document developed by the hospice provider
- Updating the Payer Determination Form (DHS 3273)
- Completing the Notice of Action Home and Community Based Waiver Services (DHS 2828) to provide information on right to appeal following reduction, termination or denial of service
- Timely MMIS updates including:

  1. Screening document - a person may need to have a reassessment if there are changes in overall status.

  2. Service agreement - a person may need to have their service plan adjusted with the addition of the hospice benefit. This may mean a reduction or increase in some services. The service agreement must be updated accordingly.

  3. Service coordinators **must** include comments on the MMIS service agreement comment section, indicating that coordination of services has occurred.

### INDIVIDUALS WHO HAVE NOT PREVIOUSLY RECEIVED HOME AND COMMUNITY BASED SERVICE

Sometimes an individual will need service in addition to the hospice benefit. For example: A person who is diagnosed with terminal lung cancer whose osteoarthritis exacerbates at the same time may need waiver support related to the osteoarthritis. Or, a person with a terminal illness may need care following a hip fracture (that is not due to the terminal condition). The hospice provider is responsible for care and support for the terminal illness. Medicaid covered services may be provided in response to symptoms, conditions and disabilities not related to the terminal condition. Coordination of care must occur as outlined in this bulletin to assure that there is not duplication of care.
MEDICAID MANAGED CARE POLICY

If a person is enrolled in the Prepaid Medical Assistance Program (PMAP), Minnesota Care, Minnesota Senior Health Options (MSHO), or Minnesota Disability Health Options (MnDHO), the prepaid health plan is responsible for hospice services.

Providers may access the Eligibility Verification System (EVS) at 1-800-657-3613 or 651-282-5354 or www.mnevs.state.mn.us, to determine which health plan a person is enrolled in. Hospice providers must notify the PMAP, MinnesotaCare, MSHO or MnDHO health plan of a person’s election of either Medicaid or Medicare hospice benefit and the anticipated start date. All hospice services provided to these enrollees must be coordinated and may need to be authorized through their health plan. For people enrolled in MSHO and MnDHO, the health plans authorize and pay for home and community based services.

If a person has elected hospice and resides in a nursing facility, MA fee-for-service pays the room and board directly to the hospice provider and the Hospice provider pays the nursing facility. Nursing facility (NF) days occurring during hospice election periods do not count toward the PMAP 90-Day Nursing Facility Benefit or the MSHO and MnDHO 180-Day Nursing Facility Benefits. Even when the health plan has responsibility for the NF room and board, the hospice days are outside of the managed care plan, and they do not count toward the 90 or 180 day benefit period.

INDIVIDUALS ADMITTED TO, OR RESIDING IN A NURSING FACILITY OR ICF-MR FACILITY

Additional information on hospice service in long-term care facilities is provided in Attachment A: Health Care Programs Provider Update # 105 Hospice Update.

Nursing Facility - A person residing in a certified nursing facility may receive hospice services in that setting. Some people with a terminal illness may enter a facility for the purpose of receiving hospice; others may enter a facility and elect hospice later. Persons admitted to a nursing facility for reasons other than short term respite are not eligible to receive home and community based services. Waiver service coordinators must “exit” the individual from the waiver program effective the date of admission. Home care authorizations also need to be “closed” when a recipient enters a nursing facility. Information on nursing facility payment in relationship to the hospice benefit is provided in Attachment A.

ICF-MR Facility - A person living in an ICF/MR facility may receive the hospice benefit in that setting. Once hospice is elected, the hospice provider receives the hospice benefit payment, as well as a payment equal to 95% of the per diem rate for the facility. In turn, the hospice provider
negotiates with the ICF/MR provider for room and board and certain other services and pays the ICF/MR.

**LEGAL AUTHORITY**

Code of Federal Regulations Title 42 Sections 418.24, 418.202, 418.402 and 409.45
OBRA 1990, Minnesota Statute 256B.0627

**ADDITIONAL RESOURCES**

Health Care Programs Provider Update #105 *Hospice Update* available at [http://www.dhs.state.mn.us/Provider/upd/](http://www.dhs.state.mn.us/Provider/upd/)

Minnesota Statutes and Rules: [http://www.leg.state.mn.us](http://www.leg.state.mn.us)

DHS bulletins: [http://www.dhs.state.mn.us](http://www.dhs.state.mn.us) Click on “Bulletins, Publications, and Manuals”

DHS forms can be obtained by calling the Forms Center at 651-296-9116.

Hospice Minnesota provides helpful information including a consumer guide, a guide to making difficult decision, a hospice locator and other tools and resources at [http://www.mnhospice.org/](http://www.mnhospice.org/) They can also be reached by calling 651-659-0423 or 1-866-290-4321.

The federal government has a printable brochure on Medicare Hospice Benefits, available in English, large print and Spanish. This brochure is available at [www.hcfa.gov/pubforms/](http://www.hcfa.gov/pubforms/) Click on publications, then Medicare Consumer Publications, enter hospice in the search box.

**ALTERNATIVE FORMATS**

This information is available in other forms to persons with disabilities by calling (651) 297-4112, or contact us through the Minnesota Relay Service at 1 (800) 627-3529 (TTY) or 1 (877) 627-3848 (speech-to-speech relay service).
The purpose of this provider update is to clarify policy and billing procedures regarding hospice services covered by Medical Assistance or MinnesotaCare (hereafter both are referred to as MA). Chapter 28 of the CY 2000 Minnesota Health Care Programs Provider Manual will be revised to reflect the content of this update.

Procedures described in this update apply only to MA recipients who receive their care through the Fee-For-Service delivery system. Procedures described in this update apply to all Fee-For-Service recipients, including those receiving other MA covered services such as Home and Community Based Services such as: Community Alternative Care (CAC) Waiver, Community Alternatives for Disabled Individuals (CADI) Waiver, Traumatic Brain Injury (TBIW) Waiver, Elderly Waiver (EW), the Mental Retardation or Related Conditions (MR/RC) Waiver, and the Alternative Care Program.

Hospice Benefit under Minnesota Medical Assistance and MinnesotaCare

The Hospice Benefit is a comprehensive package of services offering palliative care support to terminally ill individuals and their family. Hospice care is palliative, with a focus on holistic support and relieving pain and other symptoms of the terminal illness. Individuals electing the Hospice Benefit agree to receive only palliative care for their terminal illness or condition. When a recipient voluntarily elects the Hospice Benefit, they agree to forego curative care for their terminal diagnosis. In exchange, the recipient receives the hospice package of services.
The Hospice Benefit is available to recipients who have been certified by a physician as terminally ill. An individual is considered to be terminally ill if he or she has a medical prognosis with life expectancy of six months or less. Individuals who meet these requirements may elect the Hospice Benefit. Dually eligible recipients who elect the Medicare Hospice Benefit must also elect the MA Hospice Benefit. Recipients with a terminal illness must be informed of all MA service and support options including the Hospice Benefit. Hospice care is entirely optional and the recipient may revoke their election at any time.

In order for MA to cover hospice services, hospice providers must be Medicare-certified and have a current state hospice license, which requires certain standards of care. In order for hospice services to be covered, a plan of care must be established.

The MA Hospice Benefit is fashioned after the Medicare Hospice Benefit, which was designed to supplement the care provided by primary care givers such as family (as the patient defines family), friends and neighbors. The Hospice Benefit is not intended to replace the supportive role of the client’s informal support network of primary care givers. As such MA-covered services that replace the duties of primary care givers, do not duplicate the hospice team’s services. Examples of supportive functions that are provided by primary care givers include coordinating the patient’s cares, performing personal cares, assisting with activities of daily living, assisting with incidental activities of daily living, providing nutrition, and assisting with medications. Examples of services which may resemble the supportive role provided by primary care givers include Adult Foster Care services, Personal Care Assistant services, Home Delivered Meals, Lifeline, CAC, CADI, TBI, EW, and MR/RC Waiver services, and the Alternative Care Program.

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

- physician services
- nursing care
- medical social services
- counseling
- medical equipment and supplies
- outpatient drugs for symptom and pain control
- dietary and other counseling
- short-term inpatient care
- respite care
- home health aide and homemaker services
- speech, physical and occupational therapy
- volunteers
- other items and services included in the plan of care that are otherwise covered medical services
**Hospice Care Provided In Conjunction with Other MA-Covered Services**

The department understands that recipients facing death may have a complex set of health care needs. These needs often stem from their terminal condition. These needs may also stem from other medical conditions that either (a) pre-existed their terminal condition, or (b) arise during the course of their terminal condition but are unrelated to their terminal condition. A recipient should never be asked to make an “either/or” choice between an otherwise MA-covered, medically necessary service which is not related to the terminal condition, and covered, medically necessary Hospice Benefit service that is related to the terminal condition.

**Pre-existing health care needs**

Some MA-covered services may already be needed and/or in place before the client seeks hospice, due to the client’s pre-existing medical conditions or disability. The hospice benefit is not intended to duplicate health services or supports that relate to a pre-existing condition. Examples include continuing care services such as home care related to a previous stroke, waiver services related to a disability, or adult foster care related to a disability such as elderly dementia. Examples of preexisting medical care include services for conditions such as diabetes, ALS, arthritis, cardiac conditions, AIDS, or high blood pressure.

Preexisting continuing care services may need to be adjusted during the period that the client is receiving the Hospice Benefit. Clients with pre-existing needs, such as quadriplegia or stroke, may have more intensive physical needs due to the terminal illness than persons without such pre-existing conditions. The resulting higher needs are an interaction of the two conditions together, some of which may need to be addressed through increased continuing care services.

**Medical needs that arise during the period of the Hospice Benefit but which are unrelated to the terminal illness**

Sometimes recipients need new health care services in addition to the services that are offered as part of the Hospice Benefit. MA-covered services may be provided in response to conditions not related to the terminal condition. Examples of this include treatment for a hip fracture unrelated to the terminal diagnosis, or the development of a new condition or symptom unrelated to the terminal diagnosis.

**How to Determine When a MA-Covered Service Duplicates a Hospice Benefit Service**

Generally, the determination about whether a service duplicates a Hospice Benefit service will be made as part of the hospice provider’s general responsibility to provide care coordination. The hospice care coordinator must assume the lead responsibility for collaborating with the county case manager, home care agency, physician, or other provider providing the services which are outside of the Hospice Benefit.

Because some Hospice Benefit services and MA-covered services may be similar, this determination process should focus on the purpose, rather than the type of service -- that is, what recipient need is the service addressing?

The following considerations may be helpful in approaching the determination:

- Is the purpose of a service to address a pre-existing condition or a pre-existing need?
- Is the purpose of a service to address a health care problem that would have existed even without the terminal diagnosis?
- Is the purpose of a service to facilitate the client’s ability to live in the community setting rather than an institution, and would that need have been present with or without the terminal diagnosis?
Documentation Requirements When A Case Manager is Involved

When the MA-covered care is the type that includes county-based Home and Community Based Services (HCBS) case management, the hospice must notify the case manager in writing of the recipient’s election of hospice and the anticipated start date. Written notification via FAX, mail, or hand delivery must be given to the case manager within two business days. Submit the Hospice Transaction Form (DHS 2868) or a comparable statement of hospice election.

The hospice agency staff must assume lead responsibility for collaboration and documentation of that collaboration with the case manager. The hospice staff must forward the documentation within eight (8) calendar days of the effective date of hospice services. Collaboration may be completed via telephone, FAX, email, or face-to-face visit. Documentation such as this should be included in the recipient’s hospice record.

The case manager will be invited to participate in the hospice interdisciplinary care team meetings for a patient receiving home and community based services.

The case manager will keep a copy of the Cooperative Agreement in the recipient’s record.

When the client is receiving “regular MA” home care and no case manager is involved, the hospice must coordinate care and communicate with the Home Care Agency involved with the client, rather than through a county case manager.

Seeking HCBS After Hospice Election

When a recipient is receiving concurrent Home and Community Based Services (HCBS) and hospice services, the HCBS is usually in place before the hospice services began.

There may be situations where a recipient seeks case-managed HCBS, or an increase in HCBS, after electing the Hospice Benefit. Example: An adult with a disability is living with an aging mother, who is the primary care giver. The aging mother experiences a decline in health status, and has to cut back on the amount of primary care she is able to provide the recipient. The recipient therefore applies for HCBS to access available services and supports that the primary care giver no longer provide. In situations where the initial HCBS is added or increased after the Hospice Benefit is elected, county case management documentation must justify the addition/increase of the HCBS services.

County Case Manager Approval of Services that are Concurrent with the Hospice Benefit

An MMIS informational edit will appear on the Service Agreement to alert counties that the client has elected the hospice benefit. Following coordination with the hospice provider agency, county case managers must add comments on the county DHS Comment Screen of the MMIS Service Agreement documenting the coordination of services. The notes must indicate why continuing care services are necessary. (Either they are pre-existing, or they are new but treat a condition not related to the terminal condition.) The MMIS Service Agreement line items must be adjusted as needed to reflect the type and amount of services required. Changes to services continue to require a ten-day notice to clients to allow for continuity of care, client rights, and transitional needs.

When continuing care waiver or Alternative Care provider claims are received by the Department, a claim edit suspends the claim when the date of service overlaps with the hospice benefit period. Because the hospice provider becomes the primary payer of services, DHS will manually review HCBS provider claims to determine if payment is appropriate. Case management notes in MMIS will be reviewed at that time to ensure hospice provider
coordination with the county case manager has occurred. If it appears that the coordination by the hospice provider has not occurred, the claim will remain in suspense until the coordination process is completed. If it appears that the coordination process has occurred, then the claim will be paid. When payment appears appropriate, the claim will be paid as requested. The informational edit and manual review of claims will remain in place temporarily to encourage consistent coordination between the provider areas.

**Hospice Services for Residents of Long Term Care Facilities**

MA eligible residents of Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) and Nursing Facilities (NFs) who also meet hospice service eligibility may elect to receive hospice services where they live. The hospice provider becomes the primary provider of the service, and authorizes and funds the hospice benefits. Medicare and Medicaid payments are made to the hospice provider for both the hospice services it provides, and for the residential services provided by the facility. Current law requires a payment, to the hospice provider, of at least 95% of the rate that would have been paid for facility services for the individual. Effective July 1, 2001, payments to be made by DHS are indicated in column (E):

<table>
<thead>
<tr>
<th>Facility Type (A)</th>
<th>DHS Payment Rate (B)</th>
<th>Percentage of Rate (C)</th>
<th>Private Room (D)</th>
<th>Hospice Payment For Room &amp; Board (E)</th>
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<td>ICF/ MR</td>
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<td>95% * ((B)*(C))</td>
</tr>
<tr>
<td>NF</td>
<td>NF Case Mix</td>
<td>100%</td>
<td></td>
<td>95% * ((B)*(C))</td>
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<tr>
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<td>NF Case Mix</td>
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<td>115%</td>
<td>95% * (((B)<em>(D))</em>(C))</td>
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<tr>
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<td>NF Case Mix</td>
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<td></td>
<td>95% * ((B)*(C))</td>
</tr>
<tr>
<td>NF Days 31 - 90</td>
<td>NF Case Mix</td>
<td>110%</td>
<td></td>
<td>95% * ((B)*(C))</td>
</tr>
<tr>
<td>NF First 30 Days</td>
<td>NF Case Mix</td>
<td>120%</td>
<td>115%</td>
<td>95% * (((B)<em>(D))</em>(C))</td>
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<tr>
<td>NF Days 31 - 90</td>
<td>NF Case Mix</td>
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<td>115%</td>
<td>95% * (((B)<em>(D))</em>(C))</td>
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<tr>
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<td>NF Rate</td>
<td>100%</td>
<td></td>
<td>95% * ((B)*(C))</td>
</tr>
</tbody>
</table>

1 Begins with date of NF admission on or after July 1, 2001, (not MA eligibility date).

The hospice provider and residential provider negotiate the payment of the room and board per diem to the facility.

Residents of ICFs/MR and NFs may receive end-of-life care from their residential provider without making the hospice election. Facilities may be able to arrange for the specific care needs of persons with terminal illness by making internal staffing adjustments, or by also purchasing the specialized services, or making staff additions ICFs/MR facilities may apply through their host counties for a variable rate adjustment in order to accommodate the increased needs of a person with terminal illness. Bulletin 00-56-23 describes the variable rate process.

**Submitting the Hospice Transaction Form**

DHS must be notified of recipients who are enrolled in hospice (regardless of whether MA is the primary payer).

The Medicare approved transaction form is to be submitted to DHS immediately upon enrolling with Medicare Hospice. This election form must contain signatures with dates, MA number, election dates, terminal illness, date of death, recertification dates and revoked dates.
Dual eligible Medicare and Medicaid recipients may submit the Medicare approved hospice election form to DHS in place of the DHS hospice transaction form D HS-2868, 9/97.

The election form must also be sent to the financial worker when a spenddown is involved.

For recipients enrolled in a health plan, only submit their hospice election forms to DHS if they are residing in a nursing facility.

DHS must also be notified when the recipient is no longer receiving hospice care.

Mail or fax the Medicare Election Form and the Notification of Hospice termination to:

Minnesota Department of Human Services
Attention: Hospice Notification
444 Lafayette Road
St. Paul, MN 55155-3849
FAX (651) 282-674

Hospice overpayments for spenddowns may be sent back to the following address. A copy of the original RA must be included for correct claim credit.

Minnesota Department of Human Services
Attention: Benefit Recovery/Hospice
444 Lafayette Road
St. Paul, MN 55155-3850

Billing for Consulting Physician Services

When billing for the services of a Consulting Physician for a MA-only client (no Medicare or other third party payer involved), break out the technical portion and bill MHCP for the physician portion only. In this circumstance you must bill on a HCFA-1500.

Future Communications

- The MHCP Provider Manual (see dhs.state.mn.us/provider) will be updated to reflect the information in this update.
- Counties will receive a Bulletin which reflects the information in this update.
- DHS will convene quarterly hospice focus groups beginning in the spring of 2002, to maintain ongoing communication with the hospice provider community.
- DHS is working with the Minnesota Hospice Organization to present two future workshops, one on billing, and one on coordination between hospice and home and community based waivers.