Hospice Services

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Overview

The hospice benefit is a comprehensive package of services offering palliative care support to terminally ill Minnesota Health Care Programs (MHCP) members and their families. Hospice care offers holistic support and relief from pain and other symptoms of the terminal illness.

The MHCP hospice benefit follows the same rules and regulations as the Medicare hospice benefit, which was designed to supplement the care that primary caregivers, such as family (as the member defines family), friends and neighbors provide. The hospice benefit is not intended to replace the supportive role of the member's informal support network of primary caregivers. As such, MA-covered services that replace the duties of primary caregivers do not duplicate the hospice team's services.

Examples of supportive functions that primary caregivers provide include the following:

- Coordinating the member's care
- Performing personal care
- Helping with activities of daily living
- Providing nutrition
- Helping with medications

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

- Adult foster care services
- Personal care assistant services
- Home delivered meals
- Lifeline
- Community Alternative Care (CAC), Community Access for Disability Inclusion (CADI), Brain Injury (BI), Elderly Waiver (EW), and Developmental Disabilities (DD) waiver services, and the Alternative Care program

Eligible Providers

A hospice organization may enroll as an MHCP hospice provider if it is licensed and certified for Medicare as a hospice organization by the Minnesota Department of Health.

A hospice may use contracted staff to supplement hospice employees during periods of peak recipient loads or other extraordinary circumstances. The hospice remains responsible for the quality of services provided by contracted staff.

Note: A nurse practitioner may not serve as the medical director or as the physician member of the hospice interdisciplinary group.

Eligible Members

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

- Is eligible for MA (Medicaid) or MinnesotaCare
- Is certified as terminally ill by the medical director of the hospice, or a physician member of the interdisciplinary group, and the member's attending physician, if he or she has one
- Has filed an election statement with the selected hospice, and if dual eligible, with both Medicare and Medicaid

Hospice eligibility

Help MHCP members with hospice eligibility by doing the following:

- Direct MinnesotaCare members to their local county human services agency for MA eligibility determination.
- Direct MA members who may be eligible for Medicare to the Social Security Administration for Medicare application
- Dually eligible members (members who are eligible for both Medicare and Medicaid) who elect the MA hospice benefit must also elect Medicare hospice. The elected hospice provider must submit the MHCP Hospice Transaction Form (DHS-2868) (PDF), which includes the Medicare election form, to DHS within two calendar days of beginning or changing services

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

- The member is no longer certified as terminally ill
- The member or his or her representative revokes the election of hospice care

Noncovered Services when in Hospice

Members aged 22 and older waive the following services that are not covered while the member is in hospice care:

- Other forms of health care for treatment of the terminal illness for which hospice care was elected
- Other forms of health care for a condition related to the terminal illness
- Other hospice services, or services equivalent to hospice care, except those provided by the designated hospice or its contractors
- Services provided under home and community-based services waivers that are related to the terminal illness

Election of Hospice

Hospice Transaction Form

The MHCP Hospice Transaction (DHS-2868) (PDF) is a multipurpose form for hospice providers to report hospice election, certification, revocation of hospice services, change of hospice provider, or a member's death

The elected hospice provider must follow the Hospice Transaction (DHS-2868) form's instructions and complete the form to begin hospice services and report changes. The elected Hospice Provider must submit the completed form within two calendar days of beginning or changing services so that hospice spans can be added to a member's profile and billing issues can be avoided.

People aged 22 and older who have elected hospice

The elected hospice provider must do the following:

- Explain the benefits the member will receive
- Explain the benefits the member is waiving

- Inform the member that hospice care is optional and the member may revoke election of hospices services at any time
- Give the member or legal representative a copy of the signed hospice transaction form
- Keep the signed hospice transaction form in their files

People aged 21 and under who have elected hospice

The elected hospice provider must do the following:

- Explain the benefits the member will receive
- Explain that the member (aged 21 and under) does not waive coverage for curative care for the diagnosed terminal illness
- Inform the member that hospice care is optional and he or she may revoke hospice election at any time
- Give the member or legal representative a copy of the signed hospice transaction form
- Retain the signed hospice transaction form in their files

The elected hospice provider must send a copy of the hospice transaction form to the attending physician or nurse practitioner (primary care provider) for them to verify that the member has a terminal illness with a life expectancy of six months or less. DHS must receive the form within two days of when the member signs it.

Pediatric Residential Hospice

MHCP covers hospice respite and end-of-life care for children who elect to receive care in a pediatric residential hospice facility. Members aged 21 or under who elect to receive hospice services do not waive coverage for services that are related to the treatment of the condition for which a diagnosis of terminal illness has been made. Hospice respite and end-of-life care under subdivision 22a are not hospice care services under this subdivision. Refer to information under the Overview heading in this manual section for more hospice coverage information.

Facilities being utilized as a pediatric residential hospice must be licensed as described under Minnesota Statutes sections 144A.75 to 144A.755 and that is a residential hospice facility under Minnesota Statutes, 144A.75, subdivision 13, paragraph a.

Establishing the Plan of Care

The elected hospice provider must designate a registered nurse to coordinate implementing the plan of care for each member.

The attending physician, the hospice medical director or physician designee, and the interdisciplinary group must establish a written plan of care for providing hospice services. The care the hospice provides must follow the established plan of care.

The plan of care must be in place and a designated registered nurse identified before providing hospice service.

Content of Plan of Care

The written plan of care must include the following:

- An assessment of the member's needs
- Services needed, including the management of discomfort and symptom relief
- Details of the scope and frequency of services needed to meet the member's and the member's family's needs

Review of Plan of Care

The attending physician, the hospice medical director or physician designee, and the interdisciplinary group must review and update the plan of care at intervals specified in the plan and document the reviews.

Covered Services

Hospice benefits include coverage for the following services when provided directly in response to the terminal illness:

- Physician services
- Nursing services
- Medical social services
- Counseling (Bereavement counseling does not qualify for additional payment)
- Medical supplies and equipment
- Outpatient drugs for symptom and pain control
- Dietary and other counseling
- Short-term inpatient care
- Respite care
- Home health aide and homemaker services
- Physical, occupational, and speech therapy
- Volunteers
- Other items and services included in the plan of care that are otherwise covered medical services

Hospice Services for Residents of Long-Term Care Facilities (LTCF)

MA-eligible residents of intermediate care facilities for the developmentally disabled (ICF/DDs) or nursing facilities (NFs) who become eligible for hospice services may elect to receive those services in the facility where they live. See Bed-hold information when a hospice patient resides in a nursing home and is absent from the nursing home for hospitalization, home visits, etc.

The elected hospice provider must notify the local county human services agency of the member's hospice election by sending (or faxing) a copy of the front page of the Hospice Transaction Form (DHS-2868) (PDF) to the county. The elected hospice provider will become the designated provider for the medical spenddown. The payment to the hospice for the room and board will exclude the amount of the member's medical spenddown.

The elected hospice and the LTCF must coordinate the care and service that each will provide to the member according the members plan of care, negotiate a rate and enter into a contract with the facility. The elected hospice provider may negotiate that the LTCF will continue to collect the recipient's spenddown.

The LTCF will bill the elected hospice the contracted amount and the elected hospice will be responsible to pay the LTCF the agreed upon amount as indicated in the contract.

Medicare and MHCP will make payments to the elected hospice provider. For dual eligible members, the elected hospice will bill Medicare as the primary payer for hospice services provided to dual eligible members and bill MHCP for the LTCF room and board regardless of whether the member is on MA or a managed care program: Minnesota Senior Health Option (MSHO) Minnesota Senior Care Plus (MSC+), Special Needs Basic Care (SNBC).

Current law requires a payment to the hospice provider of at least 95 percent of the rate that would have been paid for facility services for the member. Payments that MHCP will make are indicated in column (E) of the hospice payment rate table.

Hospice payment rates

Facility Type (A)	DHS Payment Rate (B)	Percentage of Rate (C)	Private Room (D)	Hospice Payment For Room & Board (E)
ICF/DD	ICF/DD	100%		95% * [(B)*(C)]
NF	NF Case Mix	100%		95% * [(B)*(C)]
NF	NF Case Mix	100%	111.5%	95% * {[(B)*(D)]*(C)}
NF First 30 Days[1]	NF Case Mix	120%		95% * [(B)*(C)]
NF First 30 Days[1]	NF Case Mix	120%	111.5%	95% * {[(B)*(D)]*(C)}
Out-of-state NF	NF Rate	100%		95% * [(B)*(C)]

[1] Begins with date of NF admission, not MA eligibility date.

Note: Residents of ICF/DDs and NFs may receive end-of-life care from their residential provider without making the hospice election. Facilities may be able to arrange for the specific care needs of people with terminal illness by making internal staffing adjustments, by adding staff, or by purchasing the specialized services. ICF/DD facilities may apply through their host counties for a variable rate adjustment to accommodate the increased needs of a person with terminal illness.

Bed-holds

When a hospice patient resides in a nursing home and is absent from the nursing home for hospitalization, home visits, etc., the hospice agency must verify that the nursing facility is eligible for the bed-hold day(s). Bed-hold days are available for up to 18 consecutive days per hospital admission and 36 days annually for therapeutic leave days when the facility occupancy rate is 96 percent or greater. Bed-hold day rates are 30 percent of the case-mix rate, of which the agency is entitled to 95 percent of the adjusted case-mix rate for that LTC facility.

Example: If the entire stay is May 1–10, with May 1–7 in the nursing home, submit revenue code 0658 with the case-mix for May 1–7. For the May 8–10 hospital stay days, submit revenue code 0185 with **only** the rate of charges billed.

Revenue code 0185 will pay only the submitted amount; use code 0185 only for hospital or therapeutic leave days when billing for hospice.

Hospice and other MA-covered services

Members facing death may have a complex set of health care needs that often stem from their terminal condition. These needs may also stem from other medical conditions that either pre-existed their terminal condition, or arise during the course of their terminal condition but are unrelated to their terminal condition. A member should never be asked to make an "either/or" choice between an otherwise MA-covered, medically necessary service that is not related to the terminal condition, and covered hospice services.

Home and Community-Based Services (HCBS) after Hospice Election

When a member is receiving concurrent HCBS and hospice services, the HCBS are usually in place before the hospice services began. In some situations, a member may seek case-managed HCBS or an increase in HCBS, after electing the hospice benefit.

Example: An adult with a disability is living with an aging mother who is the primary caregiver. The aging mother experiences a decline in health status and has to cut back on the amount of primary care she is able to provide for the member. The member applies for HCBS to access available services and supports that the primary caregiver can no longer provide. When HCBS is added or the member receives an increase in HCBS after the electing hospice benefits, county case management documentation must justify the addition or increase of the services.

Documentation requirements when a case manager is involved
When the MA-covered service is the type that includes HCBS case management, the hospice provider must notify the case manager in writing of the member's election of hospice and the anticipated start date. The hospice provider must give written notice by fax, mail, or hand delivery to the case manager within two business days using the Hospice Transaction Form (DHS-2868) (PDF).

Refer to these documentation requirements when working with a case manager:

- The hospice staff will assume lead responsibility for collaboration with the case manager and invite the case manager to participate in the hospice interdisciplinary care team meetings for a member receiving home and community-based services.
- The hospice staff must document the collaboration and forward the documentation within eight calendar days of the effective date of hospice services.
- Collaboration may be by telephone, fax, email, or a face-to-face visit. Include documentation in the member's hospice record.

When coordinating with the hospice provider the county case managers must add comments on the county service agreement documenting the coordination of services. The notes must indicate why continuing care services are necessary (that is, the services are pre-existing or they are new but treated as a condition not related to the terminal condition).

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

Note: When the member is receiving "traditional MA" home care and no case manager is involved, the hospice must coordinate care and communicate with the home care agency involved with the member, rather than through a county case manager.

County case manager approval of services that are concurrent with the hospice benefit
An MHCP internal edit will appear on the HCBS service agreement to alert counties that the member has elected the hospice benefit. To avoid duplication of service, the county case manager will be required to add a note to the service agreement and the member file to verify the services are not duplicate. Once a member elects hospice, HCBS claims will suspend for review.

Pre-existing health care needs

The member may already need and have in place some MA-covered services for pre-existing medical conditions or disability before seeking hospice. The hospice benefit is not intended to duplicate health services or supports that relate to a pre-existing condition. Examples of services that may already be in place include continuing care services such as home care related to a previous stroke, waiver services related to a disability, or adult foster care related to a disability such as elderly dementia. Examples of pre-existing medical care include services for conditions such as diabetes, ALS, arthritis, cardiac conditions, AIDS, or high blood pressure.

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

Medical needs that arise during the period of the hospice

Sometimes members need new health care services in addition to the services 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 or for a new condition or symptom unrelated to the terminal diagnosis.

Determining when an MA-covered service duplicates a hospice service
Generally, the hospice provider's responsibility to provide care coordination includes determining whether a service duplicates a hospice benefit service. The hospice care coordinator must assume the lead responsibility for collaborating with the county case manager, home care agency, physician, or other provider providing services that 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, which member need is the service addressing?

Refer to the following considerations to help determine the purpose of a service by asking whether it is to:

- Address a pre-existing condition or a pre-existing need?
- Address a health care problem that would have existed even without the terminal illness?
- Facilitate the member's ability to live in the community setting rather than an institution; and would that need have been present with or without the terminal illness?

Services provided outside the Hospice Benefit

The services identified in the next sections are not an all-inclusive list, but represent possible situations.

Concurrent Care for Children (birth through aged 21)

Concurrent care services means similar services provided by more than one physician on the same day for different specialty areas that may each establish medical necessity.

Children in hospice may receive treatment for the terminal illness in addition to other care and services required for the treatment of the terminal illness and remain in hospice and receive hospice care.

The hospice bills for hospice care related to the terminal illness. The clinic, outpatient and inpatient services providing the curative care bills for the treatment of the terminal illness.

Medical Supplies and Equipment

Hospice would provide medical supplies and equipment for the care and comfort of the member when related to the terminal illness as part of the hospice benefit.

For medical supplies or equipment not related to the terminal illness the provider who supplied the member with medical supplies or equipment would bill MHCP with a diagnosis code related to the need for the item, not the terminal illness. Review the coverage criteria and billing information in the MHCP Equipment and Supplies section of the MHCP Provider Manual. Each claim must include a signed statement from the hospice physician indicating why the equipment or supply was not related to the terminal condition. It is the responsibility of the elected hospice provider to coordinate and provide this statement to the medical supplier when requested.

Physician Services

The rendering provider may bill primary care and attending physician's services that are not related to the diagnosis of the terminal illness separately, as long as the primary care or attending physician is not an employee of or under contract with the hospice organization. Review the billing information in the Physicians and Professional Service section of the MHCP Provider Manual for additional information.

MHCP follows CPT guidelines for office, outpatient and inpatient services and consultations. Bill MHCP for services provided to an MA-only member. For dual eligible members, bill Part B Medicare; the claim will cross over for MA payment of copays and deductibles.

The following apply for physician services:

- Use the appropriate diagnosis code that identifies the reason for the treatment, service or item, not the diagnosis code for the terminal illness.
- Do not submit denied Medicare physician claims to MHCP that are related to the terminal illness.
- Denied Medicare claims for physician services that are not related to the terminal illness must have an attachment stating the services billed are not related to the terminal illness, and on the claim report the reason(s) Medicare denied the services.

Hospice Payments and Limits

MHCP will pay a hospice provider for each day a member is under the hospice's care. The payment methodology and amounts are the same as those used by the Medicare program.

Hospice providers are paid at one of the four fixed daily rates that apply to all services except certain physician services and room and board in a long-term care facility. See the current Minnesota Department of Human Services Hospice Rates (DHS-7275) (PDF) table for the established CBSA rates by location and level of service.

The limits and cap amounts are the same as those used in Medicare except that the inpatient day limit on both inpatient respite days and general inpatient days do not apply to members with AIDS.

The hospice provider may be paid for an amount that does not exceed the hospice cap payment. Room and board payments for a long-term care facility and certain payments to the member's attending physician are not considered when the cap amount is calculated.

Claims for Routine Home Care, (revenue code 0651)

A higher CBSA rate will be applied to claims for days 1–60 of hospice election, and a lower CBSA rate for days 61 and over.

Service Intensity Add-on (SIA): (revenue code 0551–registered nursing visit, or revenue code 0561–social service visit)

In addition to the established RHC payment for each day of hospice care, hospice providers may also bill for SIA payment for face-to-services they provide during the last seven days of life by a registered nurse or social worker. Social worker phone calls are not eligible for payment. SIA payments allow a combined total of 16 units per day (1 unit equals 15 minutes). Registered nurse and social worker services can be billed on the same claim using separate lines for each day of service. (Refer to the billing section below for additional details).

SIA payments will be paid at 25 percent of the hourly Continuous Home Care CBSA rate for each 15 minute unit, not to exceed 16 units per day.

Billing

Only the elected hospice provider identified on the Hospice Transaction Form and in the MHCP member's file may bill MHCP for hospice care. Refer to the current Uniform Billing Editor (UB) guide and the CMS Claims Processing manual for coding descriptions and requirements.

Coordination of Benefits

Hospice services are covered by Medicare, private insurance companies, MHCP and MCO programs. The elected hospice provider must bill all other possible payers before billing MHCP.

Depending on the members available coverage, the coordination of benefit would be as follows:

- **Dual eligible:** Bill Medicare as the primary payer followed by any private insurance and then MA if the member is responsible for any balance after other payments. (In most cases, Medicare will pay the full amount.)
- **MA and private insurance:** Bill the private insurance first and then MA
- **MA only:** Bill hospice care direct to MA
- Managed care organizations (MCO) and prepaid health plan (PPHP) members and providers: Contact your selected health plan for coordination of benefits information

Note: Regardless of other payers identified for a member living in an LTCF, bill MA only for the room and board. This includes MA members, dual eligible, or MCO members.

Hospice Care – Medical Services

Review the MN–ITS User Manual for Hospices Services for instructions for completing a hospice claim.

- Claim type: Use the 837I transaction set for hospice claims
- Bill type – use one of the following for type of bill:
  - 811 Non-hospital-based hospice (817 for non-hospital based hospice replacement claims)
  - 821 Hospital-based hospice (827 for hospital based hospice replacement claims)
- Revenue codes – When billing revenue codes 0651, 0652, 0655 and 0656, enter both of the following: value code for the service and the appropriate 5-digit Core Based Statistical Area (CBSA) code to identify the location where the hospice care was provided. The codes are the same for Medicare and MA.

HCPCS code (Q5001 – Q5010) for place of service, identifying the level of care can be used as separate service line; however, the service date on the separate service lines cannot overlap.

If the claim does not have a value code and the CBSA code for the location where the care was provided, DHS will deny the claim.

For home care, use one of the following revenue codes:

- 0651 Routine home care day (less than 8 hours):
  - Enter the appropriate HCPCS code (Code range Q5001 - Q5010)
  - Report units as days. (1 day = 1 unit; 30 days = 30 units)
  - For Service Intensity Add-on Payments (in the last seven days of life):
    - Use revenue code 0551 and HCPCS code G0299 Hospice RN services
    - Use revenue code 0561 and HCPCS code G0155 Hospice LSW
    - Report as units (1 unit = 15 minutes) with a max combined total of 16 units per day
    - Report each SIA RN or social worker service on separate lines for each day of service
    - Bill SIA claims on the same claim as the RHC claim, or bill separately if the last seven days of life cross over to the next month

- 0652 Continuous home care day, 8 or more hours of nursing care each day up to 24 hours per day:
  - Enter the appropriate HCPCS code (Code range Q5001–Q5010)
  - Report units in 15-minute increments. (8 hours = 32 units, 24 hours = 96 units)

For inpatient care use one of the following revenue codes:
- 0655 Inpatient respite day
- An inpatient respite care day is a day on which the individual who has elected hospice care receives care in an approved facility on a short-term basis for respite. For inpatient respite care day (0655) or general inpatient day the elected hospice and the facility would contract for the service. The facility would bill the elected hospice, the elected hospice would pay the facility and bill MHCP for the hospice care.
- 0656 General inpatient day
- A general inpatient care day is a day on which the hospice recipient receives general inpatient care in an inpatient facility for pain control or acute chronic symptom management which cannot be managed in other settings. The total number of general inpatient care days and inpatient respite care days must not exceed 20 percent of the total days provided to a hospice recipient.

For both inpatient respite and general inpatient days, billing may include date of admission but not date of discharge, unless discharge is due to member being deceased: Enter the appropriate HCPCS code (Code range Q5001–Q5010)

Fee-for-Service Room and Board

Use the following revenue code and billing criteria when billing for room and board payment for residents of a LTCF:
- Revenue code 0658 indicating hospice room and board for members who resided in a long-term care facility (nursing home or ICF/DD) before hospice election
- DHS does not pay for the discharge day, even upon death, when a member is residing in a LTC facility.

Revenue code 0658 does not require a value code or a CBSA code.

Pediatric Residential Hospice Facility Billing

Pediatric residential hospice facility providers must use the following billing codes and criteria.
- Use claim type: 837I transaction set for hospice claims
- Bill type: 89X
- Revenue code: 0679
- Value code: 61
- Value code amount: 33,460.00
- Bill each date of service on a separate line up to 24 maximum units (1 unit equals one hour).

Billing for pediatric residential hospice is 100% state funded.

Hospice Physician Services

Do not bill separately for physician services the physician or medical director of the hospice performs that are included in the hospice rate.

These core services include the following:
- Administrative requirements
- General supervisory tasks
- Participation in the establishment of the plans of care

- Supervision and care services, periodic review and updating plans of care
- Establishment of governing policies by the physician member of the hospice's interdisciplinary group

If the member did not identify an attending physician on the hospice transaction form or does not have an attending physician who provided primary care before the time of the terminal illness, he or she may choose to be served by either a physician or nurse practitioner who is employed by the hospice. You must give the member a choice of a physician or a nurse practitioner.

The hospice may bill for physician services that are nonadministrative when reasonable and necessary during a face-to-face visit with the hospice recipient and not related to the certification of the terminal illness.

Follow Medicare claims processing guidelines for billing physician's services for dual eligible hospice recipient.

Definitions

Cap Amount: The yearly limit on overall hospice payments.

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

Continuous Home Care Day: A day in which the member receives nursing services, including home health or homemaker services, on a continuous basis during a period of crisis, for at least eight hours and as many as 24 hours per day, as necessary to maintain the member at home. More than half the care during the crisis must be nursing care provided by a registered nurse or licensed practical nurse. The hospice uses the hourly rate for the actual hours of services provided, up to 24 hours.

Core Based Statistical Area (CBSA) Rate: Location code to determine hospice rate by state and county.

Employee: An employee of the hospice or, if the hospice is a subdivision of an agency or organization, an employee of the agency or organization assigned to the hospice unit, including a volunteer under the supervision of the hospice.

General Inpatient Day: A day in which the member receives general inpatient care in a hospital, skilled nursing facility, or inpatient hospice unit for control of pain or management of acute or chronic symptoms that cannot be managed in the home.

Home: The member's place of residence.

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

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

Inpatient Facility: A hospital, long-term care facility, or facility of a hospice that provides care 24 hours per day.

Interdisciplinary Group: A group of qualified individuals with expertise in meeting the special needs of hospice recipientss and their families, including, at a minimum, providers of core services. An interdisciplinary group must have at least one physician, one registered professional nurse, one social worker, and one pastoral or other counselor.

Legal Representative: A person who, under Minnesota law, may execute or revoke an election of hospice care on behalf of the member because the terminally ill member is mentally or physically incapacitated.

Palliative Care: Care affording relief, but not cure. Providing an alleviating medicine and managing the symptoms experienced by the hospice recipient. The intent is to enhance the quality of life for the hospice recipient and his or her family, but is not directed at curing the disease.

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

Social Worker: A person who has at least a bachelor's degree in social work from a program accredited or approved by the Council on Social Work Education and who complies with the Minnesota statues related to social work licensure.

Terminally Ill: A medical prognosis with a life expectancy of six months or less, given that the terminal illness runs its normal course.

Legal References

Minnesota Statues, 256B.0625, subdivision 22 – Covered Services – Hospice Care
Minnesota Rules, 9505.0297 - Hospice Care Services
Minnesota Rules, 9505.0446 - Hospice Care Payment Rates and Procedures
Balanced Budget Act of 1997
Minnesota Statutes, 144A.75, subdivision 13
Code of Federal Regulations, title 42, section 1396a