wisconsin Medicaid update
department of health and family services
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POH 1659

To:
Hospices
HMOs and Other Managed Care Programs

Hospice handbook replacement pages

Wisconsin Medicaid has updated Part S, the hospice services handbook. Please follow the instructions below and substitute the appropriate pages in your Part S handbook.

Revised Physician Certification/ Recertification of Terminal Illness form

Appendix 5 is a revised Physician Certification of Terminal Illness form. A form that contains this information with the appropriate signature is required to be placed in the recipient's medical record. The form should not be sent to Wisconsin Medicaid. Appendix 5, dated July 1, 1999, completely replaces Appendix 5 dated June 1992.

Revised Notification of Medicaid Hospice Benefit Election Form

Effective for dates of service on and after July 1, 1999, the new Medicaid Hospice Benefit Election Form (Appendix 6) should be completed and mailed to the Medicaid fiscal agent when any of the following occur:

- A recipient elects the hospice benefit.
- A recipient moves to a nursing home and continues the hospice benefit.
- A recipient revokes the hospice benefit.

Appendix 6, dated July 1, 1999, completely replaces Appendix 6 dated August 1, 1990.

Revised Wisconsin Medicaid Recipient Election of Medicaid Hospice Benefit Form

Appendix 7 is a revised Recipient Election of Medicaid Hospice Benefit Form. A form that contains this information with the appropriate signature is required to be placed in the recipient's medical record. The form should not be sent to Wisconsin Medicaid. Appendix 7, dated July 1, 1999, completely replaces Appendix 7, dated August 1, 1990.

New Medicaid Hospice Benefit Revocation (Nonrecertification)/ Voluntary Discharge form

Appendix 7A is a new Hospice Benefit Revocation Discharge form. A form that contains this information with the appropriate signature is required to be placed in the recipient's medical record. The form should not be sent to Wisconsin Medicaid.

Revised list of Medicaid-covered services in addition to the hospice rate

Appendix 11 is a revised list of guidelines for services covered in addition to the hospice rate. Services not directly related to the terminal illness may be reimbursed separately by Wisconsin Medicaid. Appendix 11, dated July 1, 1999, completely replaces Appendix 11 dated June 1992.

Filing instructions for Part S replacement pages

The date in the upper-left corner of each appendix page is the date of this Part S transmittal.

Remove these pages...	Insert these pages...
Transmittal Log dated 10/1993	Transmittal Log dated 07/1999
Table of Contents: Pages S5-001 dated 10/1993	**Table of Contents:** Pages S5-001 dated 07/01/1999
Appendix 5: Pages S5-015 dated 06/1992	**Appendix 5:** Pages S5-015 dated 07/01/1999
Appendix 6: Pages S5-017 dated 08/01/1990	**Appendix 6:** Pages S5-017 through S5-018 dated 07/01/1999
Appendix 7: Pages S5-019 dated 08/01/1990	**Appendix 7:** Pages S5-019 dated 07/01/1999
	Appendix 7a: Pages S5-019a dated 07/01/1999
Appendix 11: Pages S5-027 through S5-029 dated 06/1992	**Appendix 11:** Pages S5-027 through S5-029 dated 007/01/1999

The Wisconsin Medicaid Update is the first source for provider information including Medicaid policy and billing information.

Wisconsin Medicaid is administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For provider questions, call the Medicaid fiscal agent at (800) 947-9627 or (608) 221-9883 or visit our web site at: www.dhfs.state.wi.us/medicaid.

Part S
Hospice Services
Transmittal Log

This log is a convenient record sheet for recording receipt of handbook replacement pages. Delete old pages and insert new pages as instructed. Use this log to help eliminate errors and ensure an up-to-date handbook.

Each set of Part S handbook replacement pages is numbered sequentially. This sequential numbering system alerts you to any missing sets of handbook replacement pages. For example, if the last transmittal number on your log is S-3 and you receive S-5, you are missing S-4. You may obtain copies of *complete* provider handbooks by completing the order form in Appendix 36 of Part A of the all-provider handbook.

Transmittal Number	Intitials	Issue Date
S-1		06/92
S-2		12/92
S-3		10/93
S-4		07/01/99

Transmittal Number	Intitials	Issue Date

HOSPICE
APPENDICES

APPENDIX 5
Wisconsin Medicaid
Physician Certification/Recertification of Terminal Illness

(Keep this information in the recipient's records. Do not send to Wisconsin Medicaid.)

A. Certification Statement

We (or I) certify that _____ is terminally ill with
(Name of Recipient)

_____.
(Description of Disease)

The life expectancy is six (6) months or less, if the disease runs its normal course.

_____
Recipient Medicaid Identification Number

_____ _____
Certification Date Hospice Medical Director or Designee

_____ _____ _____ _____
Certification Date Attending Physician Medicaid Provider Number Date

B. Recertification Statement

I recertify that the above patient is still considered terminally ill with the above-stated disease with a life expectancy of six (6) months or less, if the disease runs its normal course.

_____ _____ _____
Recertification Date Hospice Medical Director or Designee Date

APPENDIX 6
Wisconsin Medicaid
Notification of Medicaid Hospice Benefit Election Form

(Forward this form to the Medicaid fiscal agent at the address below.)

Part A. **(Complete for all recipients electing hospice.)**

_____ has elected to receive Medicaid hospice benefits.
(Recipient Name)

The recipient signed the Medicaid election form on _____ and has been certified by a physician as having six (6) months or less life expectancy if illness follows its usual course. Hospice has form on file. *Do not send to Wisconsin Medicaid*.
(Date)

Name of hospice: _____

Hospice Medicaid provider number: _____

Name of attending physician: _____

Attending physician's Medicaid provider number: _____

Is the attending physician employed by the hospice? Yes ____ No ____

Recipient Medicaid identification number: _____

****

Part B. **(Complete if recipient resides in a nursing home [skilled nursing facility (SNF) or intermediate care facility (ICF)] at time of election of hospice benefit.)**

_____ resides in _____
(Recipient Name) (Nursing Home Name)

at _____ level of care.

_____ and _____ are in agreement that
(Hospice Name) (Nursing Home Name)

the hospice shall provide services, and the nursing home shall provide room and board services as defined under COBRA, P.L. 99-272. "Room and board" includes the performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of the resident's room, and supervision and assistance in the use of durable medical equipment and prescribed therapies.

Wisconsin Medicaid will reimburse the hospice for room and board at 95% of the nursing home's current SNF and ICF 1 & 2 blended daily rate, for the appropriate number of days, for the hospice recipient in the nursing home. The hospice will in turn reimburse the nursing home.

The Medicaid provider number of the nursing home is _____.

****

Part C. **(Complete if the hospice recipient enters a nursing home after admission to the hospice.)**

_____ will reside at _____
(Recipient Name) (Nursing Home Name)

_____
(Address of Nursing Home)

as of _____.
(Date)

_____ and _____
(Hospice Name) (Nursing Home Name)

are in agreement that the hospice shall provide services, and the nursing home shall provide room and board as defined under COBRA, P.L. 99-272. "Room and board" includes the performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of the resident's room, and supervision and assistance in the use of durable medical equipment and prescribed therapies.

Wisconsin Medicaid will reimburse the hospice for room and board at 95% of the nursing home's current SNF and ICF 1 & 2 blended daily rate, for the appropriate number of days, for the hospice recipient in the nursing home. The hospice will in turn reimburse the nursing home.

The Medicaid provider number of the nursing home is _____.

****

Part D. **(Complete for revocation of Medicaid hospice benefits.)**

_____ has decided to discontinue the Medicaid hospice benefit.
(Recipient Name)

The recipient signed the Medicaid revocation form on _____.
(Date)

Name of hospice: _____

Hospice Medicaid provider number: _____

Name of attending physician: _____

Attending physician's Medicaid provider number: _____

Is the attending physician employed by the hospice? Yes _____ No _____

Recipient Medicaid identification number: _____

****

Mail to: Recipient Services
PO Box 6678
Madison, WI 53716

Appendix 7
Wisconsin Medicaid
Recipient Election of Medicaid Hospice Benefit Form

(Keep this information in the recipient's records. Do not send to Wisconsin Medicaid.)

Name of hospice: _____ Medicaid provider number: _____

I, _____, choose to receive hospice care from _____ hospice program. I acknowledge/understand the following:

1. I understand that the hospice program is palliative, not curative, in its goals. This means that the program does not attempt to cure disease, but emphasizes the relief of symptoms such as pain, physical discomfort, and emotional stress that may accompany a life-threatening illness.
2. By choosing Medicaid hospice benefits, I am giving up payment for other service benefits. Only the hospice program will be able to receive Medicaid reimbursement for most services. Medicaid will reimburse separately for covered physician services provided by my attending physician.
3. I can choose to discontinue hospice care at any time. To discontinue, I must complete a revocation statement. I can obtain this statement from the hospice coordinator.
4. If I choose to withdraw from my Medicaid hospice benefit in the middle of a benefit period, I understand that I may re-elect hospice at a later time.
5. I can choose to receive hospice care from another hospice program at any time during the hospice benefit period. To change programs, I must first confirm that the hospice I wish to be admitted to can admit me and on what date.
   I must inform _____ of my wishes so
   (Name of Hospice)
   arrangements for transfer can be made. I must document the date I wish to discontinue care from
   _____, the name of the hospice from which I wish to receive care,
   (Name of Hospice)
   and the date that care will start. No benefit days will be lost by changing to another hospice program.

ACKNOWLEDGING AND UNDERSTANDING THE ABOVE, I AUTHORIZE _____
(Name of Hospice)
HOSPICE TO BEGIN PROVIDING MEDICAID COVERED SERVICES ON _____.
(Month/Day/Year)
I DESIGNATE _____ AS MY ATTENDING PHYSICIAN.

_____ _____
Recipient Name Printed/Typed Witness Name Printed/Typed

_____ _____
Signature of Recipient or Legal Representative/Date Witness Signature/Date

APPENDIX 7A

Medicaid Hospice Benefit Revocation (Nonrecertification)/Voluntary Discharge

(Keep this information in the recipient's records. Do not send to Wisconsin Medicaid.)

I, _____, **(check one of the following)**
(Recipient Name)

☐ understand that my attending physician and the Hospice Interdisciplinary Team have determined that at this time I do not meet the Medicaid criteria for hospice benefit. The basis for this has been explained to me.

☐ choose to revoke election for Medicaid coverage for hospice care provided by

_____.
(Name of Agency)

Hospice services coverage will continue through _____. Medicaid
(Date)
hospice reimbursement will continue through _____.
(Date)

1. I understand I am revoking Medicaid hospice benefits for the remainder of the current period. I am in the _____ Medicaid hospice benefit period. I am forfeiting the remaining _____ days left in this period.
2. If it is determined that I once again meet the Medicaid criteria for the hospice benefit, I can elect Medicaid hospice coverage for the remaining benefit periods checked below:
   _____ Second Benefit Period — 90 days
   _____ Ongoing Benefit Period — 60 days
3. I have used the Medicaid benefit for a total of _____ days.
4. I understand that the Medicaid health care benefits I waived to receive Medicaid hospice coverage will resume _____ (the day following the last day of hospice coverage).
   (Date)
5. I do/do not **(circle one)** waive the fourteen (14) day waiting period required by the State of Wisconsin for voluntary discharge for _____.
   (Name of Agency)

_____
Signature of Recipient or Legal Representative Date

_____
Signature of Hospice Representative Date

APPENDIX 11
Additional Services for Hospice Recipients

This appendix presents guidelines for claims submitted for services other than hospice services and allowed attending physician services. The Wisconsin Medicaid consultant will only approve services unrelated to the terminal illness that are otherwise covered benefits of the Wisconsin Medicaid program and are medically necessary.

Provider Category	Claims Deny	Fail to Review	Claims Pay
Ambulatory surgical center			Yes
Attending physician	If type of service "H" is not indicated as the referring physician.	All services not listed in Appendix 9.	All services listed in Appendix 9.
Audiology			Yes
Case management	Yes		
Chiropractor			Yes
Community support program			Yes
Community care organization	Yes		
CRNA		Yes	
Dentist			Yes
ESRD			Yes
Family planning, PNCC	Yes		
HealthCheck	Yes		
Hearing instrument specialist			Yes
Home health	Yes		
ICF/MR	Yes		
IMD	Yes		
Inpatient hospital	Yes		
Lab			Yes
Medical vendor			Yes
Medical day treatment			Yes
Nursing facility	Yes		
Optometrist, optician			Yes
Other physicians	If primary attending physician is not indicated as the referring physician.	All services.	
Outpatient hospital		Yes	

Provider Category	Claims Deny	Fail to Review	Claims Pay
Outpatient mental health/substance abuse (alcohol and other drug abuse)			Yes
Pharmacy	Therapeutic class listed		Yes
Physician services		Yes	
Podiatrist			Yes
Portable X-ray			Yes
Rehabilitation agency/ therapies	Yes		
School-based services	Yes		
Transportation			Yes

Dept. of Health & Family Services
Division of Health Care Financing
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PO Box 309
Madison, WI 53701-0309