5160-56-03.3 **Hospice services: reporting requirements.**

This rule sets forth the requirement for recording the hospice provider span for individuals receiving medicaid hospice care in accordance with Chapter 5160-56 of the Administrative Code, including individuals who may be covered by third-party insurance, such as medicare, for which the hospice seeks reimbursement.

(A) The designated hospice shall report the required enrollment information to the Ohio department of medicaid using the medicaid information technology system (MITS) for the following:

(1) Individuals in fee-for-service (FFS) medicaid hospice under the designated hospice's care on the effective date of this rule; and

(2) Individuals in which the hospice seeks to file an original or adjusted claim to ODM for medicaid hospice services rendered under codes T2042 and T2046, including:

(a) All individuals with FFS claims for routine home care, code T2042, for the dates of service on or after January 1, 2016 ,whether or not the claim has previously been submitted and paid.

(b) Individuals in the care of hospice prior to the effective date of this rule, if the provider is submitting an original FFS claim for hospice services other than the services specified in paragraph (A)(2)(a) of this rule.

(c) Individuals in the care of hospice prior to the effective date of this rule, if the provider is submitting an adjusted FFS claim or if ODM must adjust a FFS claim for hospice services other than the services specified in paragraph (A)(2)(a) of this rule.

(B) The designated hospice shall ensure the following information is entered into MITS prior to submitting a claim for reimbursement:

(1) The individual's recipient identification number (also referred to as the medicaid billing number) as shown on the individual's medicaid card;

(2) The date the individual elected hospice;

(3) The begin date and end date of every benefit period recognized under paragraph (D) of rule 5160-56-02 of the Administrative Code. For each benefit period, the designated hospice shall identify the benefit period as either the initial one time ninety-day period, the subsequent one time ninety-day period, or one of the subsequent unlimited sixty-day periods as applicable;

(4) The national provider identifier for the medical doctor who serves on the hospice interdisciplinary group (IDG) for each benefit period;

(5) The national provider identifier for the attending physician or the advanced practice registered nurse for each benefit period;

(6) The oral certification date(s), if applicable;

(7) The written physician certification date(s);

(8) The hospice terminal illness diagnosis code(s);

(a) At least one but not more than three terminal diagnosis codes for the individual;

(b) The effective dates (begin and ending date) that apply to the terminal diagnosis code(s) shall be entered in MITS by the designated hospice;

(9) The county (or counties if more than one) where hospice services were or will be provided during the benefit period;

(10) The national provider identifier of the long term care facility (LTFC) and the corresponding effective date and end date, if the individual resides in a LTCF and provider will be billing for hospice room and board services;

(11) Supporting documentation, as required to be attached to the claim, including:

(a) Copy of the current certification of the terminal illness;

(b) Copy of the individual's election statement;

(12) The date of death, when applicable; and

(13) Any updates or changes to be made to the benefit period as a result of a discharge pursuant to rule 5160-56-03 of the Administrative Code.

(C) The information specified in paragraph (B) of this rule shall be submitted to ODM only through the system in accordance with the requirements of the MITS system.

Replaces: 5160-56-03.3 Hospice services: reporting requirements.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

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