471-000-111 Form MS-44, "Hospice Prior Authorization Request" and Completion Instructions

Use: Form MS-44 is used to prior authorize hospice services for Medicaid eligible clients as required by Nebraska Medicaid NAC 471 Chapter 36

Completion: Providers of hospice services shall complete Form MS-44 as follows:

- Type of Prior Authorization Request: Enter the appropriate prior authorization type.
- Client's Medicaid Number and Name: Enter the client's 11-digit Medicaid number and full name.
- County of Client: Enter the location of the client.
- Provider's Information: Enter the 10-digit National Provider Identifier (NPI) and Taxonomy Code of the Billing Provider, as reported to Nebraska Medicaid. Enter the provider name, address, and nine-digit zip code.
- ICD Indicator and Primary Diagnosis Code: Check one of the ICD boxes. Enter the ICD-CM diagnosis code for the primary diagnosis. This code can be obtained from the physician. State the primary diagnosis and the date the diagnosis was made. For dates of services on or before September 30, 2015 only ICD-9 codes will be accepted on this form. For dates of service on or after October 1, 2015 only ICD-10 codes will be accepted.
- Authorization Period: Enter to and from dates which cover the period that service is to be provided.
- Services to be Authorized: Service description and procedure codes.
- Medicare Benefits: Check the box if client has Medicare A.
- Hospice Notifications: Complete the entire section.
- Required Attachments: Provide the required documentation listed in this section.

To view printable form click here: Hospice Prior Authorization Request

Department of Health & Human Services DHHS NEBRASKA

Division of Medicaid and Long-Term Care

Hospice Prior Authorization Request

This fax from agency listed below sent to DHHS and returned to said agency by DHHS Medicaid Prior Authorization Department after approval. Attached transmission may include protected health information, under the standards established per the Health Insurance Portability and Accountability Act of 1996, and Neb. Rev. Stat. § 68-31. If this information has been received in error, the recipient is directed to destroy the information and notify this office of the error immediately. Failure to do so may lead to civil or criminal penalties.

Type of Prior Authorization Request: ☐ Initial ☐ Recertification ☐ Additional service request to PA

Client Medicaid Number:	Client Name:
NPI:	Provider Name/Location:
Taxonomy:	Zip + 4:
County of Client:	Provider Phone/Fax Number:
ICD Indicator: ☐ ICD-9 ☐ ICD-10	Primary Diagnosis Code:
Authorization Period: to	

This authorization includes the following services at the indicated number of units:

Service	Code	# of Units
Routine Home Care	T2042	180 days/certification period
Continuous Home Care	T2043	72 hours
Inpatient Respite Care	T2044	5 days/month
General Inpatient Care	T2045	10 days/month

Does the Client have Medicare A? ☐ Yes ☐ No
If "Yes", list date and reason Medicare A Hospice Benefits exhausted_____

Have the following been notified of Hospice involvement?

Pharmacy? ☐ Yes ☐ No Comments_____
Equipment? ☐ Yes ☐ No Comments_____
Other suppliers ☐ Yes ☐ No Comments_____

Is Client on Managed Care? ☐ Yes ☐ No

Is Client on Medicaid Waiver? ☐ Yes ☐ No

If Client resides in or moves to a long term care facility (NF, AL, CDD, ICF/MR or IMD):

FacilityName/Location:_____

Hospice Provider Number for that Facility (if applicable):_____

Has Facility Billing Office been notified of Hospice involvement? ☐ Yes ☐ No

Is there a signed contract between Facility and Hospice Provider? ☐ Yes ☐ No

List Effective Date of Contract: _____

Other Medicaid Services provided to client: _____

Attachments to this request (Required):

- ☐ Signed Election Statement
- ☐ Physician Certification of Terminal Illness with Life Expectancy of 6 months or less
- ☐ Hospice Plan of Care
- ☐ Listing of all medications, biologicals, supplies, and equipment for which hospice is covering
- ☐ Clinical Criteria to support terminal status or supportive documentation for functional decline

*Prior Authorization: Void if client not Medicaid Enrolled
*Not valid if Share of Cost is met if client has excess income
*If client is on Medicaid Waiver, please contact Services Coordinator for Continued Coordination

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(Use previous version)