SECTION 2

HOSPICE CARE PROVIDER MANUAL

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1 GENERAL POLICY

Hospice care comes from the recognition that a client's terminal condition warrants a change in focus from curative care to palliative care. Hospice care may be provided only by a hospice provider licensed by the Department, that is Medicare certified in accordance with 42CFR418, and that is a Medicaid provider.

Section 9505 of Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), permits states to provide hospice care under their Medicaid State Plans. COBRA requires the State to provide hospice services in the same amount, duration, and scope as Medicare services and at the same payment rate.

Effective March 1, 1989, the Utah Medicaid program added hospice care as a covered Medicaid service. All Medicaid hospice services (including room and board in a nursing facility for Medicare hospice clients) must be prior authorized in accordance with R414-14A.

Medicaid hospice providers shall adhere to the guidelines in this provider manual as well as the requirements contained in Administrative Rule R414-14A (Hospice Care). In the event that this provider manual is found to be in conflict with Rule R414-14A, the administrative rule will take precedence.

1 - 1 Definitions

Hospice provider means a public agency or private organization that is licensed under the provisions of R432-750, is primarily engaged in providing care to terminally ill individuals, meets the Medicare conditions of participation for hospice, and has a valid provider agreement with the Division of Medicaid and Health Financing (DMHF). This provider agreement must be separate and distinct from other provider agreements.

Pediatric Hospice Provider means a public agency or private organization that has met all the conditions to become a Medicaid hospice provider and that has also submitted the necessary additional documents to enroll as a pediatric hospice provider with Utah Medicaid. Additional documents include a signed copy of the Pediatric Hospice Provider Attachment and a copy of the provider's training curriculum to be utilized when training all paid and unpaid staff that will provide care to clients who are under 21 years of age.

Terminally ill means a medical prognosis that the client's life expectancy is six months or less if the terminal illness runs its normal course.

Attending physician means a doctor of medicine or osteopathy who is designated by the client at the time he or she elects to receive hospice care as having primary responsibility for the determination and delivery of the client's medical care.

Adult means a hospice client who is at least 21 years of age or older.

Cap period means the 12 month period ending October 31 used in the application of the cap on reimbursement for inpatient hospice care as described in R414-14A-23(5).

Employee means an employee of the hospice provider or, if the hospice provider is a subdivision of an agency or organization, an employee of the agency or organization who is appropriately trained and assigned to the hospice unit. "Employee" includes a volunteer under the direction of the hospice provider.

Legal Representative (or representative) means an individual who has been authorized under state law to make health care decisions, including initiating, continuing, refusing, or terminating medical treatments for a client who is unable to make health care decisions.

1 - 2 Eligible Recipients

1. Hospice care is available to categorically and medically needy individuals under Medicaid.

1 - 3 Access Requirements

Hospice services must meet the requirements relating to certification of terminal illness and the client's election of hospice care, as described in this chapter.

A. Certification of Terminal Illness

1. The hospice provider must obtain written certification by a physician that a client is terminally ill. The certification of a terminal condition must be based on a face-to-face assessment by a physician conducted no more than 90 days prior to the date of hospice enrollment. Hospice providers may not seek Medicaid reimbursement for hospice care until the date of a physician's certification.

2. Principal diagnoses of 'debility' and 'adult failure to thrive' will not be accepted as meeting the eligibility criteria for Medicaid hospice care if the patient does not have a least one additional, another, or coexisting principal terminal diagnosis that is more definitive.

1. If written certification is not obtained within two calendar days following the initiation of hospice care, a verbal certification may be made within two days following the initiation of hospice care, with a written certification not later than eight days after care is initiated. Payment begins with the day of certification. An appropriate entry in the client's medical record must be made and filed as soon as the oral certification is obtained.

B. Election of Hospice

1. In order to enroll in Medicaid hospice care, a client who meets the eligibility requirements must elect hospice care by filing a written election statement with a particular hospice provider. Election statements are designed and supplied to clients by hospice providers and must include the following elements:

   a) Identification of the particular hospice that will provide the hospice care,

   b) The client's (or legal representative's) acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care as it relates to the client's terminal illness,

c) For adult clients, acknowledgment that the client waives certain Medicaid services as set forth in R414-14A-9,

d) Acknowledgment that the client (or legal representative) may revoke the election of the hospice benefit at any time in the future. Adults must also acknowledge that revocation of hospice benefits will result in restoration of Medicaid benefits that were waived at the time of hospice election, and

e) Signature of the client or legal representative.

2. Pediatric hospice providers must have distinct election statements designed specifically for clients under 21 years of age. This election statement must inform pediatric clients and their legal representatives that by electing hospice care, they do not forfeit any other benefit that would otherwise be available to them through the Medicaid State Plan. This election statement must also inform them that upon turning 21 years of age, they will no longer have concurrent care benefits and will be subject to the rules governing adults who have elected Medicaid hospice care.

3. If the client is not physically or mentally capable or if the client is under 18 years of age, an election statement may also be filed by a representative authorized by state law to elect or revoke hospice care or terminate medical care on behalf of a terminally ill individual.

4. Medicaid payment for hospice care is not available prior to the day that the election was filed. The effective date of the election may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement.

5. An election to receive hospice care remains effective through the initial election period and through the subsequent election periods without a break in care as long as the patient:

   a. remains in the care of a hospice;

   b. does not revoke the election; and

   c. is not discharged from the hospice.

6. A client may elect to receive hospice care during one or more of the following election periods:

   a. an initial 90-day period;

   b. a subsequent 90-day period; or

   c. an unlimited number of subsequent 60-day periods

7. Since Medicaid hospice benefits are reserved for terminally ill patients who have a medical prognosis to live no more than six (6) months if the illness runs its normal course, when an adult patient (21 years of age or older) reaches 12 consecutive months in hospice care, an independent face to face physician review is required. Independent reviews are subsequently required every 12 months thereafter if the patient continues to receive extended hospice care. 12 consecutive months means 12 months in a row wherein Medicaid hospice care was provided during any portion of each of the 12 months.

C. Dual eligibility

If a client is dually enrolled in Medicare and Medicaid, he or she must enroll in both Medicare and Medicaid hospice care. The client must receive hospice coverage under Medicare. Medicaid is available to pay for Medicare coinsurance and/or room and board for clients who are residing in a Medicare-certified nursing facility, an intermediate care facility for people with intellectual disabilities (ICF/ID), or a freestanding hospice facility.

1. Rights Waived to Some Medicaid Services for Adult Clients

2. For the duration of an adult client's hospice enrollment, the client must waive all rights to Medicaid coverage for any services that are related to the treatment of the terminal condition for which hospice was elected, or a related condition, or for any services which are essentially duplicative of hospice care. Exceptions include such services that are

   a) provided by the designated hospice provider,

   b) provided by another hospice provider under arrangements made by the designated hospice, or

   c) provided by the client's attending physician if the services provided are not otherwise covered by the payment made for hospice care. (See chapter 3-3.)

3. If an adult client seeks medical treatment for illnesses or conditions that are not related to the client's terminal illness, this type of treatment is covered by Medicaid when provided by the appropriate provider. Hospice providers are not responsible to reimburse medical care providers for treatment that is unrelated to the client's terminal condition.

E. Concurrent Care for Clients Under 21 Years of Age

1. For the duration of hospice care, clients under the age of 21 years old may only receive hospice care which is provided by the designated hospice, or that has been provided under arrangements made by the designated hospice.

2. Clients under 21 years of age who elect to receive Medicaid hospice care may also receive concurrent Medicaid State Plan treatment for the terminal illness and other related conditions.

3. For life prolonging treatment rendered to clients under 21 years of age, Medicaid will reimburse the appropriate Medicaid enrolled medical care providers directly through the usual and customary Medicaid billing procedures. Hospice providers are not responsible to reimburse medical care providers for life prolonging treatment rendered to hospice clients who are under 21 years of age.

4. Each pediatric hospice provider will develop a training curriculum to ensure that the hospice's interdisciplinary team members, including volunteers, are adequately trained to provide hospice care to clients who are under 21 years of age. All staff members and volunteers providing pediatric hospice care must receive the training prior to provision of services, and at least annually thereafter. At a minimum, the training will include the following pediatric specific elements:

   (a) Growth and development
   (b) Pediatric pain and symptom management

(c) Loss, grief and bereavement for pediatric families and the child
(d) Communication with family, community and interdisciplinary team.
(e) Psycho-social/spiritual care of children
(f) Coordination of care with the child's community
(5) The Hospice Program will adopt the National Hospice and Palliative Care Organization's (NHPCO) Standards for Hospice Programs for their pediatric care.

F. Plans of Care

A plan of care must be established by the interdisciplinary group. At least one of the persons involved in development the initial plan must be a nurse or physician. The plan of care must be consistent with the hospice philosophy of care. This plan must be established on the same day as the face-to-face assessment and certification if the day of assessment and certification is to be a covered day of hospice care.

G. Revocation of Hospice Benefits

The client (or legal representative) may revoke the election of hospice care at any time. To revoke the election of hospice care, the client or representative must give the hospice a signed statement revoking the election of hospice care for the remainder of that election period with the date revocation is to be effective. The individual forfeits the remainder of the election period.

H. Provider Initiated Discharge from Hospice Care

1. Hospice providers may not initiate discharge of a patient from hospice care except in the following circumstances:

   a) The client moves out of the hospice provider's geographic service area or transfers to another hospice provider by choice.

   b) The hospice provider determines that the patient no longer meets the eligibility criteria for hospice.

   c) The hospice provider determines that the client's behavior (or the behavior of other persons in the patient's home) is disruptive, abusive, or uncooperative to the extent that delivery of care to the client or the ability of the hospice to operate effectively is seriously impaired. This type of discharge is called "for cause." When it becomes necessary to discharge for cause, the following steps must be taken prior to discharge:

      i. Advise the client that a discharge for cause is being considered,

      ii. Make a diligent effort to resolve the problem(s),

      iii. Ascertain that the discharge is not due to the client's use of necessary hospice services,

      iv. Document the problems and efforts to resolve the problem in the client's medical record,

v. Consult the attending physician, and

vi. Obtain a written discharge order from the hospice provider's medical director.

I. Notifications

The hospice provider is responsible to notify the Department of Health, Division of Medicaid and Health Financing (DMHF) whenever a client is enrolled in hospice care, whenever a client is discharged from hospice care, whenever a client moves into a nursing facility, intermediate care facility for people with intellectual disabilities (ICF/ID), or free standing inpatient hospice facility, or whenever there has been a change in hospice providers. When any of these events occurs, the hospice provider must submit the following applicable documents to DMHF within 10 (ten) calendar days:

1. A Prior Authorization Request Form, a copy of the signed election statement, and a copy of the physician's certification statement whenever a client is enrolled in hospice care and for each election period thereafter,

2. A Prior Authorization Request Form whenever a client's needs warrant a change to a different hospice service (such as continuous home care or GIP),

3. A Prior Authorization Request Form and a copy of the initial plan of care when a client becomes retroactively eligible for Medicaid and hospice care,

4. A copy of the Prior Authorization Request Form and revocation statement whenever a client chooses to revoke hospice benefits,

5. A copy of the client's written statement at the time of a change to a different hospice provider, and

6. A copy of the Prior Authorization Request Form indicating the effective date of the discharge. If the discharge is "for cause" as described in R414-14A-14, providers must attach a copy of the written discharge order signed by the hospice provider's medical director. Providers must also send to DMHF a written summary describing the "for cause" reason for discharge and any supporting documentation to show that the provider satisfied the required steps prior to discharging the client from hospice care.

The preferred method of receipt of these documents is by fax: (801) 323-1562

Providers also have the option to mail these documents to DMHF. The documents must be mailed early enough to be received by DMHF by the end of 10 calendar days.

Utah Department of Health
Division of Medicaid and Health Financing
Bureau of Authorization and Community-Based Services
Attn: Hospice Prior Authorization

PO Box 143112
Salt Lake City, UT 84114-3112

2 SERVICE COVERAGE

Services must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions.

All Medicaid hospice services (including room and board in a nursing facility for Medicare hospice clients) must be prior authorized. (Please refer to R414-14A and the prior authorization section of this manual for further details related to prior authorization requirements.)

2 - 1 Core Services

Hospice providers must provide the essential core services listed in this section. Frequency of services should be based upon an individualized assessment of need as determined by the attending physician and the interdisciplinary group and as specified in the plan of care. A hospice provider may use contracted staff to supplement hospice employees during periods of peak patient loads or other extraordinary circumstances. The hospice provider remains responsible for the quality of services provided by contracted staff.

A. Nursing care provided by or under the supervision of a registered nurse;

B. Medical social services provided by a qualified social worker under the direction of a physician;

C. Administrative and general supervisory activities performed by physicians who are employees of, or working under arrangements made with, the hospice provider;

D. Counseling services for the individual and family members or other persons caring for the person at home.

2 - 2 Other Covered Services

The following additional services must also be provided directly by, or made available by, the hospice provider whenever it is deemed appropriate and necessary by the treatment team and ordered by the attending physician.

A. Short-term general inpatient care (GIP) in a participating hospice inpatient unit, or a hospital, skilled nursing, intermediate care, or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be necessary for pain control or acute or chronic symptom management which cannot be provided in a home or other outpatient setting. A client's preference to die in a hospital or in another inpatient setting is not an allowable criterion for authorization of GIP care. GIP may not be authorized due to the breakdown of the primary care giving living arrangements or the collapse of other sources of support for the client.

B. Inpatient respite care is an option that may be furnished for up to 5 (five) consecutive days at a time to provide relief for the family members or others that are caring for the client at home. Inpatient respite care is not available to clients who are residents of nursing facilities, ICFs/ID, or freestanding

hospice inpatient units. Inpatient respite care is intended solely for the purpose of providing short term relief for family members or other caregivers who are experiencing stress or burnout as a result of caring for the patient's needs. Clinical log notes should reflect that this need clearly exists, and that inpatient respite care is not being used for any other purpose such as for work or schooling for the caregiver.

C. Medical appliances and supplies, including drugs and biologicals which are used primarily for the relief of pain and symptom control related to the terminal illness. Medical supplies must be included in the written plan of care. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the client's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care.

D. Home health aide and homemaker services furnished by qualified aides; home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the client, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the client. Aide services must be provided under the general supervision of a registered nurse.

E. Physical therapy, occupational therapy, and speech-language pathology services provided for purposes of symptom control or to enable the client to maintain activities of daily living and basic functional skills.

F. Special Modalities: Chemotherapy, radiation therapy, and other modalities may be used for palliative purposes if it is determined that these services are needed for palliation. This determination is based on the client's condition and the hospice provider's care giving philosophy. **No additional Medicaid payment may be made regardless of the cost of the services.**

G. Continuous home care is provided only during a period in which a client requires at least 8 (eight) aggregate hours of primarily nursing care in a 24-hour day in order to manage an acute medical crisis and to maintain the client at home. (A 24-hour day begins and ends at midnight.) The 8 (eight) aggregate hours of care must be predominately (more than half) comprised of nursing care provided by either a registered nurse or licensed practical nurse. Even though this service is entitled "continuous home care," the care provided is not necessarily required to be continuous. An example of an acceptable method of service delivery might be 4 (four) hours provided in the morning and another 4 (four) hours provided in the evening of the same 24-hour day. Homemaker and aide services may also be provided to supplement the nursing care. Extended stay residents of nursing facilities are not eligible for continuous home care services.

H. Bereavement counseling consists of counseling services provided to the individual's family after the client's death. Bereavement counseling is a required hospice service but it is not reimbursable.

3 REIMBURSEMENT

3 - 1 Hospice Care Rates

Hospice services are reimbursable to the hospice only. Medicaid payments for hospice services are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. However, Medicaid will not apply the aggregate caps used by Medicare. The rates will be based on the Medicare rates for Utah which are unique to each geographic region in the state. Providers should bill the rate that applies to the geographic region where the client resides, not the geographic region of the provider's address.

The five types of fixed daily rates are for routine home care, continuous home care, inpatient respite care, room and board, and general inpatient care, as described in this chapter.

A. Routine home care

The hospice will be paid the routine home care rate for each day the patient is at "home" and is not receiving continuous care during a period of crisis. The rate is paid (1) without regard to the volume or intensity of routine home care services, and (2) even when the patient is receiving hospital care for a condition that is unrelated to the terminal illness.

Extended stay residents of nursing facilities and ICFs/ID are considered to be "at home" for the purposes of this service and are eligible to receive routine home care.

B. Continuous home care

Continuous home care is to be provided only during a period of crisis. The hospice will be paid the continuous home care rate when continuous home care is provided as described in section 2-2 and in R414-14A-5 and R414-14A-17.

The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of 8 (eight) hours must be provided. For every hour or part of an hour of continuous home care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.

Continuous home care is a covered benefit only as necessary to maintain the terminally ill client at home. Extended stay residents of nursing facilities, ICFs/ID, or freestanding hospice inpatient units are not eligible for continuous home care.

C. Inpatient respite care

The hospice will be paid at the inpatient respite care rate for each day on which the client is in an approved inpatient facility and is receiving respite care. Payment for inpatient respite care will include the date of admission but not the date of discharge. Respite care will not be reimbursed for more than five consecutive days at a time.

Inpatient respite care is a covered benefit only as necessary to provide relief to family members or others who are providing care in the home setting, and is intended as a measure to preserve

the primary care giving living arrangement. Extended stay residents of nursing facilities, ICFs/ID, or freestanding hospice inpatient units are not eligible for inpatient respite care.

D. General inpatient care (GIP)

During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. The inpatient day limit on both inpatient respite care days and general inpatient care days does not apply to recipients afflicted with acquired immunodeficiency syndrome (AIDS).

A hospice may not arrange to provide inpatient services in a V.A. or military hospital because Medicaid cannot pay for services which have already been paid by another governmental entity.

General inpatient care may only be utilized on a short term basis for pain control or acute or chronic symptom management that cannot be managed in a home or other outpatient setting. A client's preference to die in a hospital setting is not an acceptable criterion for GIP services. GIP may not be authorized due to the breakdown of the primary care giving living arrangements or the collapse of other sources of support for the client.

E. **Room and Board**

For all clients residing in a nursing facility, ICF/ID, or a freestanding hospice inpatient unit who elect to receive hospice care (including clients under 21 years of age), Medicaid will pay the hospice provider an additional per diem for routine home care services to cover the cost of room and board in the facility. For nursing facilities and ICFs/ID, the room and board rate is 95 percent of the amount that the Department would have paid to the nursing facility or ICF/ID provider for that client if the client had not elected to receive hospice care. For freestanding hospice inpatient facilities, the room and board rate is 95 percent of the statewide average paid by Medicaid for nursing facility services.

For clients under 21 years of age, the hospice room and board rate is 100% of the amount that the Department would have paid to the nursing facility, ICF/ID, or freestanding hospice inpatient unit for that client if the client had not elected to receive hospice care.

3 - 2 Date of Discharge

Medicaid reimbursement for GIP or Inpatient Respite Care is available for the day of admission to the inpatient setting, but not for the day of discharge. The only exception is if the client dies while in the inpatient setting, the date of death is the date of discharge and is reimbursable at the GIP or Inpatient Respite Care rate. If the client is still living at the time of discharge from the inpatient setting, the appropriate home care rate will be paid to the hospice provider for the date of discharge.

For hospice care that is provided in a client's home, in a nursing facility, ICF/ID, or any other setting that is not an inpatient setting, Medicaid reimbursement is available at the appropriate home care rate for the date of admission but not for the day of discharge. The only exception is if the client dies, the date of death is the date of discharge and is paid at the appropriate home care rate.

3 - 3 Physician Services

Costs for administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. These activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies.

Direct patient care provided by the medical director, hospice-employed physician, or consulting physician should be billed in accordance with the usual Medicaid reimbursement policy for physician services. This reimbursement is in addition to the daily rates.

Reimbursement to an independent attending physician will be made in accordance with the usual Medicaid reimbursement methodology for physician services and is not based on whether the services are for the terminal illness or an unrelated condition.

Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.

The hospice should notify the Division of Medicaid and Health Financing of the election and the name of the physician who has been designated as the attending physician whenever the attending physician is not a hospice employee.

In-home physician visits by the attending physician are permitted only if the attending physician determines that direct management of the client in the home setting is necessary to achieve the goals associated with a hospice approach to care. Residents of nursing facilities, ICFs/ID, or free-standing inpatient hospice units are not eligible to receive in-home physician services.

3 - 4 Services Not Related to Terminal Illness

If a client seeks medical treatment for illnesses or conditions that are not related to the client's terminal illness, this type of treatment is covered by Medicaid in the usual and customary manner when rendered by an appropriate Medicaid provider (not the hospice provider).

Hospice providers should be involved in the decision making process whenever a client or a client's representative wishes to seek any medical treatment beyond that which is included in the hospice plan of care.

3 - 5 Medicaid Health Plans and Hospice

The hospice provider is responsible for determining whether an applicant for hospice care is covered by a Medicaid health plan prior to enrolling the client in hospice care, for coordinating services and reimbursement with the health plan, and for notifying the health plan when the client is discharged from hospice care. If a hospice recipient is enrolled in a health plan, the hospice provider selected by the recipient must have a contract with the health plan, and the health plan will be responsible to reimburse the hospice for hospice services.

If the hospice client is enrolled in Medicare, the Medicaid health plan is responsible for the health plan's rate less any amount paid by Medicare and other payors. The health plan is responsible for payment

even if the Medicare covered service is rendered by an out-of-plan provider or was not authorized by the health plan.

Providers should refer to R414-14A-28 for additional information and requirements related to Medicaid health plans and hospice care.

4 ADDITIONAL REQUIREMENTS FOR HOSPICE CLIENTS RESIDING IN NURSING FACILITIES (NFs) OR INTERMEDIATE CARE FACILITIES FOR PEOPLE WITH INTELLECTUAL DISABLITIES (ICFs/ID)

4 - 1 Medicaid Hospice

Medicaid hospice services are funded by Medicaid and provided by a Medicare-certified hospice which also has a provider agreement with the Division of Medicaid and Health Financing.

A. Agreement with NF or ICF/ID

When an individual residing in a nursing facility or ICF/ID elects hospice care, the hospice and the facility must enter into a written agreement which clearly defines the roles and responsibilities of each entity. The hospice provider is responsible for professional management of the client's hospice care and the facility agrees to provide room and board. **Room and board includes performance of personal care services, including assistance in the activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.**

The agreement includes at least the following:

1. identification of the services to be provided;
2. a stipulation that services may be provided only with the express authorization of the hospice;
3. the manner in which the contracted services are coordinated, supervised, and evaluated by the hospice;
4. the delineation of the role(s) of the hospice and the NF or ICF/ID in the admission process, recipient/family assessment, and the interdisciplinary group care conferences;
5. requirements for documenting that services are furnished in accordance with the agreement;
6. the qualifications of the personnel providing the services.

B. Notice of hospice revocation while in a NF or ICF/ID

In cases in which nursing facility residents revoke their hospice benefits, it is the responsibility of the hospice provider to notify the nursing facility of the revocation. The notice must be in writing and the hospice provider must provide it to the nursing facility on or before the revocation date.

C. Requirements for Admission to NF or ICF/ID

Even though a nursing facility or ICF/ID is the hospice client's residence for purposes of the hospice benefit, the facility must still comply with the requirements for participation in Medicare and/or Medicaid. This means that the client must be assessed, have a plan of care, and be provided with the services required under the plan of care. This result can be achieved through cooperation between the hospice and facility staff with the consent of the client. In this example, the hospice team may participate in completing the RAI (Resident Assessment Instrument).

D. Record keeping in NF or ICF/ID

The hospice must establish and maintain a clinical record for every individual receiving care and services. The record must be complete, promptly and accurately documented, readily accessible, and systematically organized to facilitate retrieval.

Entries are made for all services provided. Entries are made and signed by the person providing the services. The record includes all services whether furnished directly or under arrangements made by the hospice. Each individual's record contains:

1. the initial and subsequent assessments;
2. the plan of care;
3. identification data;
4. consent and authorization and election forms;
5. pertinent medical history; and
6. complete documentation of all services and events (including evaluations, treatments, progress notes, etc.)

The survey team will look for necessary documentation of services provided when they survey a nursing facility or ICF/ID.

E. Reimbursement

1. Reimbursement will be made to the hospice. The hospice will receive its routine daily rate plus an allowance for the facility's room and board. **(The room and board allowance is 95 percent of the facility's Medicaid per diem rate for each hospice enrollee in that facility. Medicaid's MMIS will automatically calculate 95 percent of the daily rate for that nursing facility upon receipt of the billing.)** The facility cannot bill Medicaid separately. The hospice receives Medicaid's payment and must, in turn, reimburse the facility for room and board.
2. Medicaid Health Plans

a. If a client is enrolled in a Medicaid health plan and has elected hospice care before being admitted to a nursing facility or ICF/ID, the health plan is responsible to reimburse the hospice provider for both the hospice care and the room and board.

b. If a client is a resident of a nursing facility or ICF/ID before electing hospice care, the hospice provider may bill Medicaid fee-for-service for the hospice care and the room and board.

3. Resident Cost-of-Care Contributions

a. When a hospice client in a nursing facility has a monetary obligation to contribute to his/her cost of care in the facility, the nursing facility will continue to collect and retain the contribution the same as for a non-hospice nursing facility resident.

b. The hospice will bill Medicaid for the room and board at the daily per diem rate of that nursing facility. Medicaid's MMIS will calculate 95 percent for the room and board, and will pay the hospice the 95 percent amount minus the client's cost-of-care obligation.

c. The hospice will reimburse the nursing facility the reduced amount received from Medicaid.

4. Billing Instructions

Hospice providers will bill the room and board for NFs or ICFs/ID in the same manner as for other hospice services–CMS 1500 or UB-92.

4 - 2 Medicare Hospice

Medicare hospice services are funded by Medicare and provided by a Medicare-certified hospice.

A. If a client is dually enrolled in Medicare and Medicaid, he/she must elect hospice care for both. The client must receive hospice coverage under the Medicare benefit.

B. When a client is receiving hospice services under Medicare, Medicaid will provide for payment of any coinsurance amounts, as well as room and board if the client resides in a nursing facility or ICF/ID. To obtain Medicaid reimbursement for room and board, the hospice provider must submit a Prior Authorization Request form to Medicaid in accordance with Medicaid guidelines. (Please refer to the prior authorization requirements chapter of this manual and R414-14A for full instructions related to requesting Medicaid prior authorization.)

C. Medicare hospice services will be billed to Medicare in the usual manner. Room and board will be billed to Medicaid by the hospice provider, and the hospice provider will reimburse the facility. Nursing facilities and ICFs/ID shall not bill Medicaid directly for room and board for hospice clients, including clients under 21 years of age.

D. If Medicare determines that a patient is no longer eligible for Medicare reimbursement for hospice services, the client will no longer be eligible for Medicaid reimbursement for hospice

services. Providers must immediately notify Medicaid upon learning of Medicare's determination. Medicaid reimbursement for hospice services will cease the day after Medicare notifies the hospice provider that the client is no longer eligible for hospice care.

HOSPICE PROCEDURE CODES

NOTE: All Medicaid hospice services (including room and board in a nursing facility for Medicare hospice clients) must be prior authorized in accordance with guidelines and requirements found in this manual and in R414-14A.

T2042 Routine home care - daily

T2043 Continuous home care – hourly (minimum of 8 hours)

T2044 Inpatient respite care - daily

T2045 General inpatient care - daily

T2046 Nursing facility room and board - daily

Hospice care for clients enrolled in a 1915(c) home and community-based waiver program

Clients who are enrolled in a 1915(c) waiver program are permitted to receive waiver services and hospice care concurrently when all eligibility criteria for both programs has been met. The hospice provider is responsible to provide medically necessary care that is directly related to the patient's terminal illness. The waiver program may continue to provide services that are unrelated to the client's terminal illness and that are assessed as being necessary to maintain safe residence in a home or community-based setting in accordance with waiver requirements.

The waiver case management agency and the hospice case management agency shall meet together upon commencement of hospice services to develop a coordinated plan of care that clearly defines the roles and responsibilities of each program.

Marketing limitations

Hospice providers are not permitted to engage in unsolicited direct marketing to prospective clients. Hospice providers are free and welcome to engage in marketing strategies such as mass outreach and advertisements, but are not permitted to approach a prospective client or legal representative unless the client or legal representative explicitly requests information from a particular hospice provider. Hospice providers shall refrain from offering incentives or other enticements to persuade a prospective client to choose that provider for hospice care.

Prior Authorization

All Medicaid hospice services (including room and board in a nursing facility for Medicare hospice clients) must be prior authorized. Prior authorization requests will only be considered when submitted by Medicaid providers who have a valid Utah Medicaid provider agreement for provision of hospice care.

Prior authorization can only be approved for the duration of defined election periods. Hospice providers are expected to submit prior authorization in alignment with election periods:

a. an initial 90-day period;
b. a subsequent 90-day period; or
c. an unlimited number of subsequent 60-day periods

To request prior authorization, the Medicaid hospice provider must complete and submit the Prior Authorization Request Form which can be found at the end of this chapter. Along with the Prior Authorization Request Form, providers must also submit a copy of the election statement which has been signed and dated by the client or the client's legal representative and a copy of the physician's certification statement. For general inpatient hospice care (GIP), additional clinical documents detailing the client's condition at the time of the request will also be required. Documents must be faxed to:

Division of Medicaid and Health Financing
Bureau of Authorization and Community-Based Services
Attn: Hospice Prior Authorization Specialist
(801) 323-1562

Since Medicaid hospice benefits are reserved for terminally ill patients who have a medical prognosis to live no more than six (6) months if the illness runs its normal course, when an adult patient (21 years of age or older) reaches 12 consecutive months in hospice care, an independent face to face physician review is required. Independent reviews are subsequently required every 12 months thereafter if the patient continues to receive extended hospice care. 12 consecutive months means 12 months in a row wherein Medicaid hospice care was provided during any portion of each of the 12 months.

Hospice agencies should advise patients of this requirement and provide the "Independent Physician Review for Extended Care" form to take with them to each independent review. Prior authorization requests for extended hospice care beyond 12 months will be denied if the "Independent Physician Review for Extended Care" form is not submitted along with the PA request or if this form indicates the patient does not continue to meet program eligibility requirements.

A. Prior authorization grace period

In order to allow for weekends, holidays, and after regular Department business hours, a hospice provider may begin service to a new Medicaid hospice client (including covering room and board) for a grace period up to 10 (ten) calendar days before submitting the Prior Authorization Request Form to the Department.

1) Before the end of the grace period, the hospice provider must complete and submit the prior authorization request form to the Department in order to receive reimbursement for hospice services rendered.

2) If the hospice provider does not submit the prior authorization request form timely, the Department will not reimburse the provider for the hospice care that is rendered before the date that the form is received.

B. Post-payment for hospice services while a client is in Medicaid pending status

If a provider admits a client to hospice care under a non-Medicaid funding source and the client becomes Medicaid eligible at a later date, the provider must submit the Prior Authorization Request Form to the Department along with a copy of the signed election statement and the initial plan of care immediately upon learning that the client is Medicaid eligible. (Providers should not send any information to the Department until the client's Medicaid eligibility has been established.) The Department will review the documents and reimburse a hospice provider retroactively to allow the hospice eligibility date to coincide with the client's Medicaid eligibility date when the following requirements are met:

1) The client met Medicaid eligibility requirements at the time the service was provided,

2) The hospice care met the prior authorization criteria at the time of delivery, and

3) The hospice provider reimburses the Department for care related to the client's terminal illness delivered by other Medicaid providers during the retroactive period.

C. Prior authorization for GIP

For general inpatient hospice care (GIP), additional requirements must be met for prior authorization beyond the initial 10 (ten) calendar days. Providers must submit the Prior Authorization Request Form along with copies of medical records that support the need for ongoing GIP care. Qualified Department staff will perform a clinical review of the medical records to verify that the client does indeed have exceptional care needs that cannot be managed in the client's home or another outpatient setting. Payment for any days beyond the initial 10 (ten) calendar day stay must be prior authorized before the hospice care is provided.

1) Because a clinical review takes time, hospice providers are strongly encouraged to submit the GIP prior authorization request and medical records at least 3 (three) State business days before the end of the initial 10 (ten) calendar day grace period if there is any reason to believe the client's GIP care will extend beyond 10 (ten) calendar days. Hospice providers must be proactive in submitting the necessary documents early enough to allow for the extra time needed to perform a clinical review.

2) If the Department determines that the medical records do not support the requirements for ongoing GIP care, the Department will not reimburse the hospice provider beyond the initial 10 (ten) calendar days.

Utah Medicaid Prior Authorization Request for Hospice Services

Hospice Provider Name:	
NPI Provider Number:	
Initial Hospice Admission Date: (No matter the funding source)	
Is the client Medicaid eligible upon initial admission?	☐ **Yes** (Submit this form and a copy of the signed election statement and physician certification statement to Medicaid within 10 calendar days. If this form is not received timely, Medicaid will not reimburse for hospice services rendered prior to the date the PA request is received.)
	☐ **No** (Complete this form & attach copies of the initial care plan, physician certification statement and signed election statement but DO NOT submit anything to Medicaid until after client becomes Medicaid eligible. Medicaid will then require all four documents when determining post payment authorization.)
Who Signed the Election Statement?	☐Client ☐Legal Representative as defined in R414-14A (Representative's name & relation to client: _____
Client's Name:	Last: _____ First: _____
Client's Medicaid ID Number:	
Client's Social Security Number:	
Client's Date of Birth:	
Diagnosis(es) Description: (Not codes)	
Date of physician certification statement:	
Physician:	Last: _____ First:_____
Hospice Contact Person:	
Contact Person Phone Number:	
Date of Client's Retro Medicaid Eligibility:	
Nursing Home or ICF/ID Name:	
Hospice Benefit Requested:	☐Routine ☐Room & Board ☐Other_____
Prior Auth Effective Dates:	_____ to _____ PA # _____ _____ to _____ PA # _____
Discharge date: _____/_____/_____ • **Fax to: 801-323-1562**	Date of death: _____/_____/_____ Date client revoked: _____/_____/_____ (Send a copy of the revocation form signed by the client or legal representative.)

Independent Physician Review for Extended Care

Medicaid hospice benefits are reserved for terminally ill patients who have a medical prognosis to live no more than six (6) months if the illness runs its normal course.

When an adult patient (21 years of age or older) reaches 12 months in hospice care, an independent face to face physician review is required. Independent reviews are subsequently required every 12 months thereafter if the patient continues to receive extended hospice care.

Hospice agencies should advise patients of this requirement and provide this form to take with them to each independent review. Prior authorization requests for extended hospice care will be denied if this form is not submitted along with the PA request or if this form indicates the patient does not continue to meet program eligibility requirements.

Section 1 - Patient Information: (This section can be filled in by the hospice provider.)

Patient's first name: _____ Patient's last name: _____

Medicaid ID number: _____ Patient's DOB: _____/_____/_____

Hospice provider name:_____

Section 2 - Independent physician evaluation results: (Completed by the independent physician.)

Does this patient have a terminal illness? ☐ Yes ☐ No ☐ Inconclusive

If yes, list the terminal diagnosis/es: _____

_____

_____

Please note: principal diagnoses of 'debility' or 'adult failure to thrive' will not be accepted as meeting the eligibility criteria for Medicaid hospice care.

Considering the normal course of the patient's diagnosis/es, does it appear the patient's life expectancy is six (6) months or less? ☐ Yes ☐ No ☐ Inconclusive

Section 3 – Independent physician's certification statement:

I certify that I am a physician licensed in the state of Utah and that I am not affiliated with hospice agency listed in Section 1 above. I further certify that I (or my staff) entered the evaluation results listed above and that they are based on a face to face evaluation performed on _____(date). The conclusions listed are unbiased and free from influence.

Physician's name: _____ License #: _____

Physician's signature: _____ Date: _____