



HOSPICE

Chapter Twenty-Four of the Medicaid Services Manual

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**State of Louisiana
Bureau of Health Services Financing**

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OVERVIEW

Hospice care is an alternative treatment approach that is based on recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and support for the family. Palliative care focuses on comfort care and the alleviation of physical, emotional and spiritual suffering. Instead of hospitalization, its focus is on maintaining the terminally ill patient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible.

The hospice concept grew out of a belief that many of the physical, sociological, spiritual, educational and emotional needs of the terminally ill patient and family were not being met by the existing health care system. The dying person fears pain, loss of body and self-control, and loss of family and friends. For the spouse there are fears about what will happen to me; adult children must deal with role reversal, as the parent becomes more dependent.¹ Hospice care is an interdisciplinary approach to the delivery of care with attention to such needs.

Criteria for Hospice Care

A beneficiary must be terminally ill in order to receive Medicaid hospice care. An individual is considered terminally ill if they have a medical **prognosis** that their life expectancy is six months or less if the illness runs its normal course.

¹ Kilburn, L., Hospice Operations Manual: A Guide to Organizational Development, Management, Care Planning, Regulatory Compliance and Financial Services, National Hospice Organization, Arlington Virginia, 1988.

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BENEFICIARY REQUIREMENTS

To be eligible to elect hospice, a beneficiary must meet all Louisiana Medicaid eligibility criteria and be certified as terminally ill. “Terminally ill” is defined as a medical prognosis of limited expected survival, of approximately six months or less at the time of referral to a hospice, of an individual who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone are no longer appropriate.

Both the Bureau of Health Services Financing (BHSF) - Certification of Terminal Illness (CTI) Form and the BHSF - Notice of Election (NOE) Form must be completed, and a plan of care (POC) must be established. Prior authorization (PA) requirements stated in Section 24.6 – *Prior Authorization* of this chapter are applicable to all election periods. (See Appendix A for the NOE form and Appendix B for the CTI form).

Medicare and Medicaid (Dual Eligibles)

If the beneficiary is eligible for Medicare as well as Medicaid, the hospice care must be either elected or revoked simultaneously under both programs. Medicare is the primary payer.

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ELECTION OF HOSPICE CARE

An election statement for hospice care must be filed by the beneficiary or by a person authorized by law to consent to medical treatment for the beneficiary. (See Appendix A for details regarding the Notice of Election (NOE) form). For dual eligible beneficiaries, hospice care must be elected for both the Medicaid and Medicare programs simultaneously.

Reporting Election of Hospice Care

When a beneficiary elects Medicaid hospice, the provider must report initial hospice election to the hospice unit at Gainwell Technologies within 10 calendar days. Documentation to report beneficiary election of hospice must include the following completed forms:

1. Bureau of Health Services Financing (BHSF) Form Hospice - NOE with type bill 81A or 82A; and
2. BHSF Form Hospice-Certification of Terminal Illness (CTI). (See Appendix B).

A prior authorization (PA) packet, which includes the NOE, CTI, and medical documentation is required upon the initial election of hospice or if the beneficiary is re-electing hospice during any hospice benefit period.

It is the responsibility of the hospice provider to make sure the NOE, CTI, and any necessary attachments are properly completed prior to submitting to the hospice unit at Gainwell Technologies. The diagnosis code on the NOE and the diagnosis description on the CTI must match. The attending/referring physician's name on the NOE and CTI must match.

***All fields must be completed and submitted on the NOE and CTI within the 10 calendar day time frame. The top portion of the NOE form must be completed by the beneficiary or their legal representative only. The hospice provider cannot enter any information in the top section of the form.**

If these requirements are not met, reimbursement will not be available for the days prior to receipt. Reimbursement will be effective the date that BHSF receives the proper documentation.

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Providers are advised to contact the hospice unit at Gainwell Technologies to confirm receipt of NOE/CTI and any documentation submitted if a letter is not received within 30 calendar days of the hospice election date.

Pending Medicaid Eligibles

The electronic prior authorization (e-PA) system will not allow a provider to enter a request until the Medicaid eligibility information is placed on the Medicaid Eligibility Verification Systems (MEVS) and Recipient Eligibility Verifications Systems (REVS) file. The hospice provider will not be able to request PA until the beneficiary is deemed eligible for Medicaid. At the time a beneficiary is determined eligible for Medicaid, the request can be submitted for a retrospective review through the e-PA system. The begin date will be the hospice date of election or begin date of Medicaid eligibility whichever is the later date.

Attending Physician

The attending physician is the physician most involved with the beneficiary's care at the time of referral and prior to the election of hospice services. If the attending physician and the medical director of the hospice provider are one and the same, then a physician member of the interdisciplinary team (IDT) must also sign the BHSF Form Hospice - CTI. (See Section 24.5 – *Provider Requirements* for IDT requirements).

The attending physician is the physician identified within the Medicaid system as the provider to which claims have been paid for services prior to the time of the election of hospice.

If a beneficiary (or legal representative) wants to change their designated attending physician during an elected benefit period the beneficiary (or legal representative) must file a signed statement, with the hospice provider, that identifies the new attending physician in enough detail so that it is with enough detail to clearly indicate which physician or nurse practitioner (NP) was designated as the new attending physician. The statement needs to include the following:

1. The effective date of the change;
2. The date that the statement is signed; and
3. The beneficiary's (or legal representative's) signature, along with an acknowledgement that this change in the attending physician is the patient's (or legal representative's) choice.

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NOTE: There must be two different signatures on the BHSF Form Hospice - CTI for beneficiaries electing hospice services. (See Section 24.5 – *Provider Requirements* for detailed information on the CTI).

Election Statement Requirements

The election statement must include the following:

1. Identification of the hospice provider that will provide care;
2. The beneficiary's or their legal representative's signature acknowledging that they have been informed and fully understands the palliative rather than curative nature of hospice care, as it relates to the beneficiary's terminal illness and related conditions. The legal representative must indicate the relationship to the beneficiary, date the form and list a daytime phone number;
3. Acknowledgment that certain Medicaid services are waived by the election; and
4. The effective date of the election. This date must not be earlier than the date of the election statement and the beneficiary's or legal representative's signature. The beneficiary or legal representative must enter the date of admission on the top portion of the form. Hospice providers cannot complete this section. Forms submitted that do not meet this requirement will be considered incomplete.

The hospice election statement must include the patient's choice of attending physician after the election of hospice services. The beneficiary has the option to keep their current physician after hospice has been elected or designate a physician member of the hospice team to act as their attending physician once hospice services have been elected. The election form should include an acknowledgement by the beneficiary (or legal representative) that the designated attending physician or NP was the beneficiary's (or legal representative's) choice.

In cases where a beneficiary signs the NOE form with an "X"; there must be two witnesses to sign next to their mark. The witnesses must also indicate relationship to the beneficiary and list daytime phone numbers. Hospice provider representatives cannot sign as witnesses. Verbal elections are prohibited.

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Legal Representatives

When known relatives exist but persons other than relatives sign the BHSF Form Hospice – NOE, the non-relative must have legal rights (e.g. a medical power of attorney) to make medical decisions for beneficiaries who are physically or mentally incapacitated. Proof of these rights must be submitted at the time the election for hospice is made. Verbal elections are prohibited.

Definition of Relatives

For purposes of this section, a relative is defined as all persons related to the beneficiary by virtue of:

1. Blood;
2. Marriage;
3. Adoption; or
4. Court appointed legal guardians.

Election Periods

Hospice services are covered on the basis of periods and require PA. A beneficiary may elect to receive hospice care during one or more of the following election periods:

1. An initial 90-day period;
2. A subsequent 90-day period; and
3. Subsequent periods of 60 days each (requires PA).

The periods of care are available in the order listed and may be used consecutively or at different times during the beneficiary's life span. The hospice IDT must help manage the beneficiary's hospice election periods by continually assessing the appropriateness for hospice care, especially before the beneficiary enters a new election period.

Hospice services will end when a beneficiary's Medicaid eligibility (including Medically Needy Spend Down, etc.) ends. A new NOE form and CTI form is required with updated signatures whenever the beneficiary is recertified for Medicaid. A PA packet is also required for beneficiaries whose eligibility ended in a subsequent period. If the beneficiary's Medicaid eligibility ends during

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a benefit period (Spend Down, etc.) all required forms and documentation signed and dated within the day timeframe must be held by the provider in the beneficiary's records. Once eligibility is reestablished, a completed packet can then be submitted timely for retrospective authorization.

Providers are encouraged to communicate with family members regarding the beneficiary's Medicaid coverage.

NOTE: It is the responsibility of the provider to verify the beneficiary's Medicaid eligibility. A copy of the Medicaid eligibility approval letter should be included in request for PA.

Duration of Election

An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the beneficiary remains in the care of a hospice provider.

A beneficiary who revokes or is discharged alive during an existing election period will lose the remaining days in the election period. The beneficiary may at any future time elect to receive hospice coverage for any other hospice periods for which they are eligible.

Change of Designated Hospice Provider

A beneficiary or their legal representative is allowed to change the designation of the particular hospice provider from which hospice care will be received once in each election period. The change of the designated hospice provider is not a revocation of the election for the period in which it is made. To change the designation of hospice providers, the beneficiary or their legal representative must file with the hospice provider from which care has been received and the newly designated hospice provider, a signed statement that includes the following:

1. The name of the hospice provider from which the beneficiary has received care and the name of the hospice provider from which they plan to receive care; and
2. The effective date of the change.

Within five calendar days following receipt of the filed change form, the new hospice provider must submit a BHSF NOE/Revocation/Discharge/Transfer (81C/82C) to the Prior Authorization Unit (PAU) at Gainwell Technologies through e-PA. (See Appendix A for instructions).

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A BHSF NOE/Revocation/Discharge/Transfer (81C/82C) must be sent to the PAU through e-PA when a beneficiary is transferring from the original hospice provider within five calendar days.

NOTE: The BHSF Form Hospice - NOE is also used to update changes in the beneficiary's condition and status.

Medicaid Covered Services that are Waived

For the duration of an election of hospice care, a beneficiary who is 21 years of age or older waives all rights to the following Medicaid covered services:

1. Hospice care provided by a hospice agency other than the hospice agency designated by the beneficiary or a person authorized by law to consent to medical treatment for the beneficiary; and
2. If the beneficiary is 21 years or older, any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected services for a related condition, or services that are equivalent to hospice care, except for services provided by:
 - a. The designated hospice provider;
 - b. Another hospice provider under arrangements made by the designated hospice provider; and
 - c. The beneficiary's attending physician if that physician is not an employee of the designated hospice provider or receiving compensation from the hospice provider for those services.

Waiver Beneficiaries

Once a beneficiary elects hospice and a provider is chosen that hospice provider assumes all responsibility for the healthcare needs of the beneficiary related to the hospice illness. The hospice provider must coordinate all services to ensure there is no duplication of services. The Office of Aging and Adult Services (OAAS), Office for Citizens with Developmental Disabilities (OCDD), and hospice providers must ensure that all waiver beneficiaries considering hospice are counseled thoroughly enough to make an informed decision.

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Service Coordination

Medicaid expects the hospice provider to interface with other non-hospice providers depending on the need of the beneficiary to ensure that the beneficiary's overall care is met and that non-hospice providers do not compromise or duplicate the hospice plan of care (POC). This expectation applies to Medicaid hospice beneficiaries and Medicare/Medicaid (dual eligible) hospice beneficiaries. The hospice provider must ensure a thorough interview process is completed when enrolling a Medicaid or Medicare/Medicaid beneficiary to identify all other Medicaid or other state and/or federally funded program providers of care.

Adult Day Health Care Waiver

The Adult Day Health Care (ADHC) Waiver is a Medicaid Home and Community-Based Services (HCBS) Waiver program that expands the array of services available to individuals with functional impairments, and helps to bridge the gap between independence and institutional care by allowing them to remain in their own homes and communities.

ADHC Waiver beneficiaries who elect hospice services may choose to elect ADHC Waiver and hospice services concurrently. The hospice provider and the beneficiary's support coordination agency (SCA) must coordinate ADHC Waiver and hospice services when developing the beneficiary's POC. All core hospice services must be provided in conjunction with ADHC Waiver services. When electing both services, the hospice provider must develop the POC with the beneficiary, the beneficiary's caregiver and the SCA. The POC must clearly and specifically detail the ADHC Waiver and hospice services that are to be provided along with the frequency of services by each provider to ensure that services are non-duplicative, and the beneficiary's daily needs are being met. This will involve coordinating services where the beneficiary may receive services each day of the week.

The licensed hospice provider must provide all hospice services as defined in 42 Code of Federal Regulations (CFR) Part 418 which includes nurse, physician, hospice aide/homemaker services, medical social services, pastoral care, drugs and biologicals, therapies, medical appliances and supplies, and counseling in accordance with hospice licensing regulations.

Once the hospice program requirements are met, ADHC Waiver services and Long-Term – Personal Care Services (LT-PCS) (if applicable) can be utilized for those personal care tasks with which the beneficiary requires assistance. (See the *Medicaid Services Manual*, Chapter 9, Section 9.1 for a full description of ADHC Waiver covered services at <https://www.lamedicaid.com/provweb1/providermanuals/manuals/ADHC/ADHC.pdf>).

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Community Choices Waiver

The Community Choices Waiver (CCW) is a Medicaid HCBS Waiver providing an array of alternative services to individuals to assist them to live in their own home or community instead of in a nursing facility or institution.

CCW beneficiaries who elect to receive hospice services, may only receive personal assistance services (PAS) under this waiver program. PAS includes assistance and/or supervision with activities of daily living (ADL) and instrumental activities of daily living (IADL) that are necessary for the beneficiary with functional impairments to remain safely in the community.

CCW beneficiaries who elect hospice services may choose to elect CCW and hospice services concurrently. The hospice provider and the beneficiary's SCA must coordinate CCW and hospice services when developing the beneficiary's POC. All core hospice services must be provided in conjunction with CCW services. When electing both services, the hospice provider must develop the POC with the beneficiary, the beneficiary's care giver and the SCA. The POC must clearly and specifically detail the CCW and hospice services that are to be provided along with the frequency of services by each provider to ensure that services are non-duplicative, and the beneficiary's daily needs are being met. This will involve coordinating services where the beneficiary may receive services each day of the week.

The licensed hospice provider must provide all hospice services as defined in 42 CFR Part 418 which includes nurse, physician, hospice aide/homemaker services, medical social services, pastoral care, drugs and biologicals, therapies, medical appliances and supplies and counseling in accordance with hospice licensing regulations.

Once the hospice program requirements are met, then CCW PAS can be utilized for those personal care tasks with which the beneficiary requires assistance. (See the *Medicaid Services Manual*, Chapter 7, Section 7.1 for a full description of CCW covered services at <http://www.lamedicaid.com/provweb1/Providermanuals/manuals/CCW2/CCW.pdf>).

Program of All-Inclusive Care for the Elderly

Program of All-Inclusive Care for the Elderly (PACE) is an optional HCBS under the Medicaid State Plan. PACE is a capitated, managed care program for individuals age 55 or older and meet nursing facility level of care (NFLOC) and program requirements. The PACE IDT performs an assessment and develops an individualized POC. PACE programs bear financial risk for all medical support services required, including comprehensive care to beneficiaries who need end-of-life care, for PACE beneficiaries.

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Medicaid will not reimburse a hospice provider for services rendered to hospice beneficiaries participating in the PACE Program. PACE beneficiaries must voluntarily disenroll from the PACE program if they would like to receive hospice services from a licensed hospice provider. Hospice providers must contact the PACE provider before rendering hospice services to ensure that the PACE beneficiary is no longer enrolled in the PACE program.

Long Term-Personal Care Services

LT-PCS are provided under the Medicaid State Plan and are not included as a waiver service. LT-PCS are services that provide assistance with the distinct tasks associated with the performance of ADL and IADL.

Beneficiaries who elect hospice services may choose to elect LT-PCS and hospice services concurrently. The hospice provider and the long-term care access services contractor must coordinate LT-PCS and hospice services when developing the beneficiary's POC. All core hospice services must be provided in conjunction with LT-PCS.

When electing both services, the hospice provider must develop the POC with the beneficiary, the beneficiary's care giver and the LT-PCS provider. The POC must clearly and specifically detail the LT-PCS and hospice services that are to be provided along with the frequency of services by each provider to ensure that services are non-duplicative, and the beneficiary's daily needs are being met. This will involve coordinating services where the beneficiary may receive visits each day of the week.

The hospice provider must provide all hospice services as defined in 42 CFR Part 418 which includes nurse, physician, hospice aide/homemaker services, medical social services, pastoral care, drugs and biologicals, therapies, medical appliances and supplies and counseling. Once the hospice program requirements are met, then LT-PCS can be utilized for those personal care tasks covered in the LT-PCS program for which the beneficiary requires assistance. (See the *Medicaid Services Manual*, Chapter 30 *Personal Care Services (PCS)*, Section 30.2 for a full description of LT-PCS covered services at <http://www.lamedicaid.com/provweb1/Providermanuals/manuals/PCS/pcs.pdf>).

Additional Personal Care Services

Beneficiaries who are 21 years of age and older may be eligible for additional PCS as defined in the Medicaid State Plan. Services furnished under the PCS benefit may be used to the extent that

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the hospice provider would routinely use the services of the hospice beneficiary's family in implementing the beneficiary's POC.

The hospice provider must provide services to the beneficiary that are comparable to the services they received through Medicaid prior to their election of hospice. These services include, but are not limited to the following:

1. Pharmaceutical and biological services;
2. Durable medical equipment (DME); and
3. Any other services required by federal law.

NOTE: The above services are for illustrative purposes only. The hospice provider is not exempt from providing care if an item or category is not listed.

Beneficiaries under Age 21 Receiving Concurrent Care Hospice

Beneficiaries under 21 years of age who elect hospice shall be eligible for the concurrent care model of hospice. Concurrent care allows the beneficiary to elect to receive life-prolonging therapies. Life-prolonging therapies consist of any aspects of the beneficiary's medical POC that are focused on treating, modifying, or curing a medical condition so that the beneficiary may live as long as possible, even if that medical condition is also the hospice qualifying diagnosis. When the beneficiary turns 21 years of age, the concurrent care benefit is no longer available. Beneficiaries and families may change their election between standard and concurrent care anytime with the hospice during the hospice benefit period.

The hospice provider is responsible for making a daily visit available and optional to all beneficiaries under 21 years of age and for coordinating care to ensure there is no duplication of services. If a daily visit is declined by the beneficiary, or their family, then the hospice provider must maintain documentation of the date and reason for not making a visit. The daily visit is not required if the person is not in the home due to hospitalization or inpatient respite stays.

All questionable services and/or treatments will be sent for medical review. All treatments and therapies must be included in the POC. Documentation of therapies and treatment as well as progress notes are required upon each request for a continuation of hospice care and upon the initial request for hospice care if the beneficiary is already receiving curative treatment(s).

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Durable Medical Equipment

The hospice provider is responsible for providing DME or contracts for the provision of DME for hospice care. DME necessary for life-prolonging therapy shall be reimbursed separately to the appropriate provider.

Other Services

Beneficiaries who elect hospice services may also receive early and periodic screening, diagnostic, and treatment (EPSDT), pediatric day health care (PDHC), PCS, and intermittent or extended home health services concurrently.

Beneficiaries who elect hospice services may also receive from the following waiver services: OCDD, New Opportunities Waiver (NOW), Residential Options Waiver (ROW), Supports Waiver (SW), and Children's Choice Waiver (CC) concurrently as long as the developmental disabilities diagnosis is not related to the terminal hospice condition and are not duplicative of hospice care. The hospice provider must coordinate services with the waiver support coordinator and waiver services provider to ensure there is no duplication of services.

Coordination of Care

The hospice provider for a beneficiary receiving concurrent care is responsible for facilitating communication and coordinating services with the beneficiary, beneficiary's caregiver (if applicable) and beneficiary's non-hospice providers to ensure that the beneficiary's overall care is met and that services are non-duplicative.

A beneficiary with a serious illness may have multiple subspecialists, along with a pediatrician, and can continue to receive care from the subspecialist/pediatrician as necessitated by the beneficiary's goals of care. The subspecialist/pediatrician shall assist with care coordination for life-prolonging therapies. The hospice providers and subspecialist/pediatrician shall work together to ensure a collaborative approach when concurrent care model is being utilized.

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COVERED SERVICES

Hospice care includes services necessary to meet the needs of the beneficiary as related to the terminal illness and related conditions.

Core Services

Core services must routinely be provided directly by hospice employees, with the exception of physician's services and counseling services, which may be provided through contract. A hospice provider may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of the beneficiary under extraordinary or other non-routine circumstances. A hospice provider may also enter into a written arrangement with another Medicaid certified hospice provider for the provision of core services to supplement employee/staff to meet the needs of beneficiary. Circumstances under which a hospice provider may enter into a written arrangement for the provision of core services include the following:

1. Unanticipated period of an increase in the number of beneficiaries;
2. Staffing shortages due to illness; or
3. Other short-term temporary situations that interrupt beneficiary care. If contracting is used for any core services, professional, financial and administrative responsibility for the services must be maintained and regulatory qualification requirements of all staff must be assured.

An overview of core services is included below.

Physician Services

These are the services performed by a physician as defined in 42 Code of Federal Regulations (CFR) 410.20. In addition to palliation and management of the terminal illness and related conditions, physician employees of the hospice and those under contract, including the physician members of the interdisciplinary team (IDT), must also meet the general medical needs of the beneficiaries to the extent that these needs are not met by the attending physician.

Nursing Services

Nursing services are defined as nursing care provided by or under the supervision of a registered nurse (RN). Any nursing service provided by a licensed practical nurse (LPN) or licensed

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vocational nurse (LVN) must be under the supervision of the RN and must be reasonable and necessary to the treatment of the beneficiary's illness or injury.

This can also include services included under nursing care provided by a nurse practitioner (NP) who is not the beneficiary's attending physician. For example, in the absence of an NP, an RN would provide the services. Since the services are nursing in nature, payment is encompassed in the hospice per diem rate and may not be billed separately regardless of whether the services are provided by an NP or an RN.

Medical Social Services

Medical social services are provided by a social worker who has at a minimum a master's degree from a school of social work accredited by the Council on Social Work Education, and who is working under the direction of a physician.

Counseling Services

Counseling services must be available to the terminally ill individual, their family members, or other persons caring for the individual at home or in another nursing facility. Counseling includes bereavement counseling provided after the beneficiary's death as well as dietary, spiritual and any other counseling services (compliant with medication regimens) for the individual and family provided while the individual is enrolled in hospice.

Dietary Counseling

Dietary counseling may be provided for the purposes of training the beneficiary's family or other care-givers how to provide and prepare meals for the beneficiary. This can also be used in helping the individual and those caring for them to adjust to the beneficiary's approaching death. Dietary counseling, when required, must be provided by a qualified individual.

Bereavement Counseling

The hospice provider must have an organized program for the provision of bereavement services under the supervision of a qualified professional. The plan of care (POC) for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to one year following the death of the beneficiary). **Bereavement counseling is a required hospice service but it is not reimbursable.**

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Other Covered Services

The following additional services must also be provided directly by, or coordinated by, the hospice provider.

Pastoral Care

The hospice must make reasonable efforts to arrange for visits of clergy and other members of religious organizations in the community to beneficiaries who request such visits and must advise beneficiaries of this opportunity.

NOTE: Additional counseling may be provided by other members of the IDT as well as by other qualified professionals as determined by the hospice provider.

Short-Term Inpatient Care

Short-term inpatient care is provided in a participating hospice inpatient unit or a participating hospital that additionally meets the special hospice standards regarding staffing and beneficiary areas. Services provided in an inpatient setting must conform to the written POC. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home. Medicaid payments cannot be made for inpatient hospice care provided in a nursing or intermediate care facility for individuals with intellectual disabilities (ICF/IID) and a Veterans Administration (VA) medical facility to Medicaid only or Medicaid/Medicare beneficiaries who are eligible to receive veteran's health services.

Inpatient Respite Care

An inpatient respite care day is a day on which the individual receives care in an approved facility on a short-term basis to relieve the family members or other persons caring for the individual at home.

An approved facility is one that meets the standards as provided in 42 CFR 418.98(b). The inpatient respite care rate is paid for each day the beneficiary is in an approved inpatient facility and is receiving respite care. **Payment is made for respite care for a maximum of five continuous days at a time in any election period including the date of admission but not counting the date of discharge.** Payment for sixth day and any subsequent days is made at the routine home care rate. Respite care may not be provided when the hospice beneficiary is a resident in a nursing facility or ICF/IID facility.

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Medical Appliances and Supplies

Medical appliances and supplies, including drugs and biologicals as defined in Section 1861(t) of the Social Security Act, and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness is covered. Appliances may include covered durable medical equipment (DME) as well as other self-help and personal comfort items related to the palliation or management of the beneficiary's terminal illness and related conditions. Equipment is provided by the hospice for use in the beneficiary's home while they are under hospice care. Medical supplies include those that are part of the written POC.

The hospice must have a written policy for the disposal of controlled drugs maintained in the beneficiary's home when those drugs are no longer needed by the beneficiary.

Drugs and biologicals must be administered only by one of the following:

1. A licensed nurse or physician;
2. An employee who has completed a state-approved training program in medication administration;
3. The beneficiary if their attending physician has approved; or
4. Any other individual in accordance with applicable state and local laws.

Each drug and biological authorized for administration must be specified in the beneficiary's POC.

Hospice Aide and Homemaker Services

Home health and homemaker services must be provided by qualified aides. Home health services may only be provided by individuals who have successfully completed a home health aide training and competency evaluation program. These services may be provided by an employee of the hospice or may be contracted out.

Hospice aides/home health aides may provide personal care services (PCS) included in the POC. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the beneficiary, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the beneficiary.

Aide services must be provided under the general supervision of a RN. Written instructions for beneficiary care must be prepared by a RN. A RN must visit the home site when aide services are being provided, and the visit must include an assessment of the aide services.

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Therapy Services

Physical therapy, occupational therapy, and speech-language pathology services are provided for the purpose of symptom control or to enable the individual to maintain activities of daily living (ADL) and basic functional skills.

Other Items and Services

Any other item or service whether or not included in the POC, and is reimbursable under Medicaid, is a hospice covered service. The hospice provider is responsible for providing any and all services indicated in the POC as necessary for the palliation and management of the terminal illness and related conditions.

Example: A hospice provider determines that a beneficiary's condition has worsened and has become medically unstable. A hospital inpatient stay will be necessary for proper palliation and management of the condition. The hospice adds this inpatient stay to the POC and decides that due to the beneficiary's fragile condition the beneficiary will need to be transported to the hospital by ambulance. In this case, the ambulance service becomes a covered hospice service.

Hospice Provider Service Requirements

The hospice provider must make nursing services, physician services, drugs and biologicals routinely available on a 24-hour basis. The hospice is also required to make all other covered services available on a 24-hour basis to the extent necessary to meet the needs of the beneficiary. This care must be reasonable and necessary for the palliation and management of terminal illness and related conditions.

Waiver of Service Requirements

If located in a non-urbanized area (as defined by the Bureau of the Census), a hospice provider may apply for a waiver of the core nursing, physical therapy, occupational therapy, speech language pathology, and dietary counseling requirements if a good faith or diligent effort to hire these specialties can be demonstrated (as determined by Centers for Medicare and Medicaid Services (CMS)).

A waiver of the requirement that the hospice provider make physical therapy, occupational therapy, speech language pathology services and dietary counseling available (as needed) on a 24-hour basis may be obtained under certain conditions from CMS. These waivers are available only to a provider or organization that is located in an area which is not an urbanized area (as defined

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by the Bureau of Census) and that can demonstrate to CMS that it has been unable, despite diligent efforts, to recruit appropriate personnel. Hospice providers will be required to submit evidence to establish diligent efforts.

Waiver applications should be sent to the regional CMS office. Any waiver request is deemed to be granted unless it is denied within 60 calendar days after it is received by CMS. Waivers will remain effective for one year at a time. CMS may approve a maximum of two one-year extensions of each initial waiver. To receive a one-year extension, the hospice provider must request the extension prior to each additional year and certify that the employment market for appropriate personnel has not changed significantly since the initial waiver was granted if this is the case. No additional evidence is required with this certification.

Levels of Care

Payment rates are determined at one of four levels for each day of a beneficiary's hospice care. The four levels of care (LOC) are:

1. Routine home care;
2. Continuous home care;
3. Inpatient respite care; and
4. General inpatient care.

NOTE: Refer to Section 24.9 - *Reimbursement* for an explanation of the four LOC.

SERVICE LIMITATIONS**Services Unrelated to Terminal Illness**

Once a beneficiary elects to receive hospice services, the hospice provider is responsible for either providing or paying for all covered services related to the treatment of the beneficiary's terminal illness and related conditions. Although a beneficiary may present with multiple medical conditions, the attending physician certifies that at least one condition has created a terminal situation with a life expectancy of less than six months. It is incorrect to state a patient can elect hospice for one diagnosis and not another. A beneficiary must be enrolled in hospice for a terminal illness. If the beneficiary elects hospice, they have given up the option for therapeutic care for any and all of the related conditions. For example, if the beneficiary has cancer and chronic obstructive pulmonary disease (COPD) and wants active treatment for the COPD, they should not elect

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hospice. They should stay in regular Medicaid/Medicare. Beneficiaries (and more particularly providers) cannot pick and choose among their diagnoses for hospice election; it is the life expectancy related to the beneficiary's overall terminal condition that is the controlling factor.

Beneficiaries under 21 years of age who are approved for hospice may continue to receive life-prolonging therapies that are focused on treating, modifying, or curing a medical condition so that the beneficiary may live as long as possible, even if that medical condition is also the hospice qualifying diagnosis. (Refer to Section 24.2 – *Election of Hospice Care* of this manual chapter for beneficiaries under 21 years of age). The hospice agency is responsible for either providing or paying for all hospice services. The hospice provider is not responsible for reimbursement for life-prolonging therapies. Reimbursement for concurrent care shall be to the providers furnishing the care and made separately from the hospice per diem.

“Clinical condition” is defined as a diagnosis or a patient state (physical and/or mental) that may be associated with more than one diagnosis or that may be as yet undiagnosed. Therefore, any claim for services submitted by a provider other than the elected hospice provider will be denied if the claim does not have attached justification that the service was medically necessary and was not related to the terminal condition for which hospice care was elected. However, claims for prescription drugs and home and community-based services (HCBS) will not deny but will be subject to post-payment review. If documentation is attached to the claim, then the claim will be pending review.

NOTE: Service logs and progress notes will not suffice alone. They may be provided in addition; however, Gainwell Technologies will follow the written policy which states that the documentation must include the physician statement, documentation of procedure/diagnosis, admission and discharge information.

Determining Hospice Liability

Hospice providers are held liable for payments to non-hospice providers in the following situations:

1. The medical consultant with the fiscal intermediary (FI) determines which services rendered are actually hospice related;
2. Services rendered to a beneficiary on the same day an election for hospice is made; and
3. Charges incurred by beneficiaries who receive services while in an inpatient facility (hospital, long-term care (LTC), acute care facility, etc.) or other services (transportation) if the services are/were rendered on the same day a beneficiary

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elects/elected hospice. The time of day is not factored in when beneficiary information is processed and claims are submitted for payment. Hospice providers bill Medicaid for the whole day and not a partial day. **Providers are reimbursed for date(s) of service.**

Required Documentation

Any information necessary to justify that the service was medically necessary and was not related to the terminal condition, must be attached to the claim. Such documentation must include all of the following:

1. A statement/letter from the physician confirming that the services were not related to the beneficiary's terminal illness;
2. Documentation of the procedure and diagnosis which illustrates why the service was not related to the beneficiary's terminal illness; and
3. Hospital admission and discharge documentation information, where applicable.

Review of Documentation

The claim will deny if the information does not justify that the service was medically necessary and not related to the terminal condition for which hospice care was elected.

The provider must resubmit the claim with attached justification if a claim is denied and is for a covered service not related to the terminal condition for which hospice care was elected.

NOTE: This information must be submitted as a hard copy. **Do not submit electronically.**

If review of the claim and attachments justify that the claim is for a covered service not related to the terminal condition for which hospice care was elected, the claim will be released for payment. If prior authorization (PA) is required for any covered Medicaid services not related to the treatment of the terminal condition, the PA must be obtained just as in any other case.

Final determination of non-hospice related charges does not rest with the hospice provider. Hospice providers cannot deny payments to non-hospice providers based on not knowing the beneficiary received services from a non-hospice provider, services were not authorized or merely stating the services were not related to the hospice diagnosis.

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Claims submitted by the non-hospice provider will go through a physician review at the FI, and a final determination will be made at that time. The claim may still be denied as being hospice related. If denied, the non-hospice provider must then submit charges to the hospice provider. The hospice provider is responsible for payment of services rendered. Refusing to pay for these charges or any charges submitted from a non-hospice provider puts the hospice provider out of compliance with the provider agreement. Non-compliance with the provider agreement could place the provider in a position of sanctions being imposed, which include, but are not limited to, denial or revocation of enrollment, withholding of payments, exclusion from the program, recovery of overpayments and administrative fines. For additional information, please refer to Section 24.5 – *Provider Requirements*.

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PROVIDER REQUIREMENTS

A hospice provider must be Medicare certified in order to qualify for enrollment as a Louisiana Medicaid hospice provider. The hospice provider must be enrolled prior to billing for any services provided to Medicaid beneficiaries.

Licensure

Except to the extent required by the licensing standards for hospice as defined in the Louisiana Administrative Code (LAC) 48:I.Chapter 82, §8205.A.1, it shall be unlawful to operate or maintain a hospice program without first obtaining a license from the Louisiana Department of Health (LDH). LDH is the only licensing authority for hospice providers in the state of Louisiana.

Provider Responsibilities

The hospice provider must ensure employees providing hospice services have all licensure, certification or registration requirements in accordance to applicable federal and/or state laws.

Inpatient Care Cap

A cap is placed on the number of allowable inpatient hospice days that can be provided by a hospice facility to fee-for-service beneficiaries during the 12-month period beginning November 1st of each year to October 31st of the following year. This cap is calculated as 20 percent of the total number of hospice days provided by the facility.

A review of the total number of hospice days provided by a facility is performed annually. The rate for each day in excess of the allowable inpatient care cap is adjusted to pay the routine care amount. The difference between the two amounts shall be remitted to LDH.

Interdisciplinary Group

Additionally, the hospice provider must designate an interdisciplinary team (IDT) composed of qualified medical professionals and social support staff from all core services, with expertise in meeting the special needs of hospice beneficiaries and their families. The IDT must consist of the following individuals:

1. Physician;
2. Registered Nurse (RN);

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3. Social Worker; and
4. Pastoral or other counsel.

NOTE: Nurse practitioners (NPs) may not serve as medical director or as the physician member of the IDT.

Plan of Care

A written plan of care (POC) must be established before services are provided and must be maintained for each beneficiary admitted to a hospice program in accordance with the provisions set forth in the Licensing Standards for Hospices (LAC 48:I.Chapter 82). The initial POC must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice. The date of the POC should be the date it is first established. The care provided to a beneficiary must be consistent with the plan and be reasonable and necessary for the palliation or management of the terminal illness as well as all related conditions. In establishing the initial POC, the member of the basic IDT who assesses the patient's needs must meet or call at least one other group member (nurse, physician, or medical social worker or counselor) before writing the initial POC. At least one of the persons involved in developing the initial POC must be a nurse or physician. The POC is signed by the attending physician or an appropriate member of the IDT.

The POC must encompass plans on access to emergency care and address the condition of the beneficiary as a whole. All co-morbidities must be included even those not related to the terminal illness. In addition, the POC must meet general medical needs of beneficiaries to the extent that these needs are not being met by the attending physician. This information is being required to assess the beneficiary for complications and risk factors that would affect care planning (i.e., access to emergency care). Providers may not be responsible for providing care for the unrelated co-morbidities.

There is no official hospice POC form. Each hospice provider should develop a form which includes the required information and best meets its needs.

Physician Certification and Narrative

The hospice provider must obtain written certification of terminal illness (CTI) via the Bureau of Health Services Financing (BHSF) Form Hospice - CTI. The CTI must specify that the beneficiary's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. The CTI must be based on the physician's clinical judgment regarding the normal

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course of the individual's illness and must include the signatures of the physicians. A copy of this CTI must be on file in the beneficiary's clinical record.

Clinical information and other documentation that support the medical prognosis must accompany the CTI and must be filed in the medical record with a written certification. In addition, the attending physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of six months or less. This may be done as an addendum to the CTI and recertification forms if additional space is needed. The physician must also sign and date immediately following the narrative in the addendum. The physician must print and sign their name. The narrative must include a statement under the physician signature attesting that by signing, the physician confirms that they composed the narrative based on their review of the beneficiary's medical record or, if applicable, their examination of the patient. The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients. Submit this narrative along with the signed CTI form to the Hospice Prior Authorization Unit (PAU). A copy of this certification must also be on file in the beneficiary's clinical record.

The narrative associated with the third benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of six months or less.

Nurse Practitioners as Attending Physician

A NP is defined as a RN who is permitted to perform such services as legally authorized to perform (in the state in which the services are performed) in accordance with state law (or state regulatory mechanism provided by state law) and who meets training, education and experience requirements described in 42 Code of Federal Regulations (CFR) 410.75.

If a beneficiary does not have an attending physician or a NP who has provided primary care prior to or at the time of the terminal diagnosis, the beneficiary may choose to be served by either a physician or a NP who is employed by the hospice provider. The beneficiary must be provided with a choice of a physician or a NP. The attending physician or NP must be identified on the notice of election (NOE), or on an addendum to the NOE, during the election of hospice services. (See Section 24.2 – *Election of Hospice Care* of this manual chapter).

Services provided by a NP that are medical in nature must be reasonable and necessary, be included in the POC and must be services that, in the absence of a NP, would be performed by a physician. If the services performed by a NP are such that a RN could perform them in the absence of a

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physician, they are not considered attending physician services and are not separately billable. Services that are duplicative of what the hospice nurse would provide are not separately billable.

NPs cannot certify a terminal diagnosis or the prognosis of six months or less, if the illness or disease runs its normal course, or re-certify terminal diagnosis or prognosis. In the event that a beneficiary's attending physician is a NP, the hospice medical director and another physician designee must certify or re-certify the terminal illness. When a NP performs the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of six months or less, should the illness run its normal course. Regulations require the narrative to be composed by the certifying physician only.

Certification of Terminal Illness

The hospice provider must obtain written certification of terminal illness (BHSF Form Hospice - CTI) for each of the election periods, even if a single election continues in effect for two or more periods. Written certifications may be completed two weeks before the beginning of each election period. See Appendix B for detailed information on completing the BHSF Form Hospice - CTI.

Certification of Initial Period

The hospice provider must obtain BHSF Form Hospice - CTI no later than two calendar days after hospice care is initiated. If written certification is not obtained within two calendar days, verbal verification from the physician must be received by an IDT member and the verbal verification section on the form must be completed and submitted to BHSF within two calendar days following the initiation of hospice care. The clinical information may be provided verbally, and must be documented in the medical record and included as part of the hospice provider's eligibility assessment. Written certification must be obtained no later than eight calendar days after care is initiated. If the NOE (see Appendix A) physician's narrative and CTI Forms are not received within 10 calendar days of the initiation of hospice care, the date of admission (election) will be the date that BHSF receives the proper documentation.

NOTE: The 10 calendar day requirement is the same for Medicaid only beneficiaries as well as dual eligible (Medicaid/Medicare) beneficiaries.

Verbal Certification

If verbal certification is made, the referral from the physician must be received by a member of the hospice IDT. The entry of the verbal certification in the beneficiary's clinical record must

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include at a minimum the beneficiary's name, attending physician's name, terminal diagnosis, prognosis, and the name, date and signature of the IDT member taking the referral. The diagnosis code on the NOE and the diagnosis description on the CTI must match. The diagnosis description must be notated on the CTI.

Hospice staff must make an appropriate entry in the beneficiary's clinical record as soon as a verbal certification is received and file written certifications in the clinical record.

Sources of Certification

For the initial 90 calendar day period, the hospice provider must obtain a completed certification form from the following:

1. The beneficiary's attending physician. The attending physician must be a doctor of medicine or osteopathy and must be identified by the beneficiary, at the time of election for hospice care, as having the most significant role in the determination and delivery of the individual's medical care; and
2. The hospice's medical director or a physician member of the hospice IDT.

The beneficiary shall not be required to relinquish their attending physician in order to receive hospice benefits. If the attending physician wishes to relinquish care of the beneficiary to the hospice's medical director, the attending physician must:

1. Sign the BHSF Form Hospice - CTI; and
2. Submit a narrative statement indicating relinquishment of the care of the patient to the hospice physician.

For all subsequent periods, the hospice provider must submit the completed CTI form to the PAU within 10 calendar days prior to the last day of the current benefit period. The form must be signed and dated by either the medical director or a physician member of the IDT.

Face-to-Face Encounters

Section 3131(b) of the Affordable Care Act of 2010 requires a hospice physician or NP to have a face-to-face encounter with every hospice beneficiary to determine the continued eligibility of that beneficiary prior to the beneficiary's 180th day recertification and each subsequent recertification. These required encounters are due no more than 30 calendar days prior to the recertification date.

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LDH will align with the Centers for Medicare and Medicaid Services (CMS) regarding the face-to-face requirement.

The regulation requires that the hospice physician or NP attest that the encounter occurred, and the recertifying physician must include a narrative which describes how the clinical findings of the encounter support the beneficiary's terminal prognosis of six months or less. The attestation language must be located directly above the physician or NP attestation signature and date line. The physician or NP must sign and date the form. The statement must include the date of visit, the requested period, signature of the physician or NP who made the visit along with his date of signature. The physician must print and then sign their name. Visit notes are not a substitute for a physician narrative, which is a brief explanation of the clinical findings that supports continuing eligibility for the hospice benefit. Outside attending physicians are not allowed to perform the face-to-face encounter. The hospice provider is responsible for either providing the encounter itself or for arranging for the encounter. Please note volunteer physicians are considered hospice employees. Hospice providers are supposed to provide physician services to their beneficiaries when needed during a time of crisis.

If a beneficiary improves or stabilizes sufficiently over time while in hospice, such that they no longer have a prognosis of six months or less from the most recent recertification evaluation or definitive interim evaluation, that beneficiary should be considered for discharge from Medicaid hospice services.

NOTE: In the event that a beneficiary is in the hospital or emergency room (ER), and a referral is made to hospice, the physician attending to the beneficiary in the hospital or ER or the physician referring the beneficiary to hospice services must sign the BHSF Form Hospice - CTI, if the beneficiary does not have an attending physician.

BHSF Written Notice of Hospice Decision

The Hospice PAU notifies the hospice provider and the hospice beneficiary (or legal representative) of the beneficiary's approval or denial of hospice services in writing. **It is the Hospice provider's responsibility to notify the nursing facility.** The approval letter contains the election date and the prior authorization (PA) requirements (if applicable). The denial letter gives the reason(s) for the denial.

Disaster Operations

The provisions set forth in the Licensing Standards for Hospices (LAC 48:I. Chapter 82) state, "The hospice provider shall have policy and procedures and a written plan for emergency

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operations in case of disaster.” To ensure compliance, all providers should adhere to the following procedure in the event a state emergency occurs where evacuations are required:

1. Transportation during an emergency evacuation of a nursing facility beneficiary receiving hospice services is the responsibility of the nursing facility;
2. Hospice beneficiaries who receive hospice services in their home and are without accessible transportation during an emergency evacuation will be directed to a parish pick-up point; and
3. Transportation during an emergency evacuation of an in-patient hospice facility beneficiary is the responsibility of the inpatient hospice facility.

It is the responsibility of the hospice provider to know the location of beneficiaries under their care at all times.

PROGRAM INTEGRITY

To maintain the programmatic and fiscal integrity of the Medicaid program, the federal and state governments have enacted laws, promulgated rules and regulations and policies concerning fraud and abuse, and LDH has established policies concerning those laws, rules, regulations and procedures. It is the responsibility of the provider to become familiar with these laws and regulations.

Non-compliance with the provider agreement may place the provider in a position of sanctions being imposed which include, but are not limited to, denial or revocation of enrollment, withholding of payments, exclusion from the program, recovery of overpayments and administrative fines.

Providers, beneficiaries and others may also be subject to criminal prosecution, civil action and/or administrative actions if they violate laws, rules, regulations or policies applicable to the Medicaid program.

Providers should refer to the *Medicaid Services Manual*, Chapter 1 *General Information and Administration* for a full description of administrative sanctions.

NOTE: The provider should also refer to the laws and regulations related to sanctions for each program of enrollment and should review LAC 50:I. Chapters 41 and Subpart E.

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PRIOR AUTHORIZATION PROCESS

Prior authorization (PA) is required upon the initial request for hospice coverage. Requests for PA must be submitted within 10 calendar days of the hospice election date. If the PA is approved, it covers 90 days. If another 90-day election period is required, the PA request must be submitted at least 10 days prior to the end of the current election period. This will ensure that requests are received and approved/denied before the preceding period ends. If this requirement is not met and the period ends, reimbursement will not be available for the days prior to receipt of the new request. If approved, reimbursement will be effective the date the Prior Authorization Unit (PAU) receives the proper documentation.

The completed PA (see *Required Documentation* in this section,) which includes the updated and signed “Hospice Certification of Terminal Illness (CTI)” (Bureau of Health Services Financing (BHSF) Form Hospice - CTI) and all related documents, must be received before the period ends. Any PA request received after the period has ended will become effective on the date the request is received by the PAU if the request is approved. This policy also applies to PA packets received after Medicaid eligibility has ended. It is the responsibility of the provider to verify eligibility on a monthly basis. The PA only approves the existence of medical necessity, not beneficiary eligibility. (See Appendix B for detailed information regarding BHSF Form Hospice - CTI).

All requests for hospice PA must be submitted to Gainwell Technologies through their electronic prior authorization (e-PA) system. No other form or substitute will be accepted.

Electronic Prior Authorization

The e-PA system is a web application that provides a secure web-based tool for providers to submit PA requests and to view the status of previously submitted requests. For more information regarding e-PA, visit the Louisiana Medicaid web site or call the PAU.

NOTE: PA is not required for dual eligible beneficiaries (Medicare primary) during the two 90-day election periods and the subsequent 60-day election periods. However, they must submit a copy of the Medicare Common Working File screen showing the hospice segment through the e-PA system and the signed CTI and Notice of Election (NOE) forms.

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Required Documentation

Documentation should paint a picture of the beneficiary's condition by illustrating the beneficiary's decline in detail (e.g. documentation should show last month's status compared to this month's status and should not merely summarize the beneficiary's condition for a month). In addition, documentation should show daily and weekly notes and illustrate why the beneficiary is considered to be terminal and not "chronic". Explanation should include the reason the beneficiary's diagnosis has created a terminal prognosis and show how the systems of the body are in a terminal condition. Telephone courtesy calls are not considered face-to-face encounters and will not be reviewed for PA.

The following information will be required upon the initial request for hospice services.

First Benefit Period (90 days)

1. Hospice Election Form (primary diagnosis code(s) using the International Classification of Disease (ICD), Tenth Revision (ICD-10) or its successor; other codes);
2. Hospice - CTI Illness form (BHSF Form Hospice – CTI);
3. Clinical/medical information;
4. Hospice provider plan of care (POC) includes the following:
 - a. Progress notes (hospital, home health, physician's office, etc.);
 - b. Physician orders for POC; and
 - c. Include Minimum Data Set (MDS) or jRaven form (original and current) if beneficiary is in a facility; weight chart; laboratory tests; physician and nursing progress notes. **The MDS/jRaven form (original and current) is not required if the beneficiary has been in a long-term care facility less than 30 days. The MDS/jRaven form must be provided upon the subsequent request for continuation of hospice services.**

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5. Documentation to support beneficiary's hospice appropriateness must include the following:
 - a. Paint picture of beneficiary's condition;
 - b. Illustrate why beneficiary is considered terminal and not chronic;
 - c. Explain why their diagnosis has created a terminal prognosis; and
 - d. Show how the body systems are in a terminal condition.

Second and Subsequent Periods

Providers requesting PA for the second period, and each subsequent period, must send the request packet to the PAU at (see Appendix D for Contact/Referral Information) that includes the following:

1. MDS/jRaven forms (original and current) are required; weight chart; laboratory tests; physician and nursing progress notes if the beneficiary resides in a nursing facility;
2. An **updated** Hospice - CTI form (BHSF Form Hospice - CTI) and a face-to-face encounter signed and dated by the hospice provider's medical director or physician member of the interdisciplinary team (IDT) for the third and subsequent requested PA periods;
3. An updated POC;
4. Updated physician's orders;
5. List of current medications (within last 60 days);
6. Current laboratory/test results (within last 60 days if available);
7. Description of hospice diagnosis;

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8. Description of changes in diagnoses;
9. Progress notes for all services rendered (daily/weekly physician, nursing, social worker, aide, volunteer and chaplain);
10. A social evaluation;
11. An updated scale such as: Karnofsky Performance Status Scale, Palliative Performance Scale or the Functional Assessment Tool (FAST);
12. The beneficiary's current weight, vital sign ranges, lab tests and any other documentation supporting the continuation of hospice services. Documentation must illustrate the beneficiary's decline in detail. Compare last month's status to this month's status; and
13. Original MDS/jRaven; current MDS/jRaven form if beneficiary is a resident in a facility.

This information must be submitted for all subsequent benefit periods and must show a decline in the beneficiary's condition for the authorization to be approved.

For PA, the prognosis of terminal illness will be reviewed. **A beneficiary must have a terminal prognosis in addition to a completed Hospice - CTI form and proof of the face-to-face encounter.** Authorization will be made on the basis that a beneficiary is terminally ill as defined in federal regulations. These regulations require certification of the **prognosis**, rather than diagnosis. Authorization will be based on objective clinical evidence in the **clinical record** about the beneficiary's condition and not simply on the beneficiary's diagnosis.

A cover letter attached to the required information will not suffice for supporting documentation.

The supporting information must be documented within the clinical record with appropriate dates and signatures.

Example: A beneficiary receives hospice care during an initial 90-day period and is discharged or revokes their election of hospice care during a subsequent 90-day period, thus losing any remaining days in that election period. If this beneficiary chooses to elect a subsequent period of hospice

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care, even after an extended period without hospice care, prior authorization will be required. The NOE, Hospice CTI form, and all PA documentation are due within the 10 day time frame. Reimbursement will be effective the date the required information is received by the PAU if receipt is past 10 days.

A provider, who anticipates the possibility of providing hospice care for a beneficiary beyond the initial 90-day election period, must submit a PA packet to the PAU. The required information and any supporting documentation must be sent.

Written Notice of Prior Authorization Decision

PA requests will be reviewed using the Medicare criteria found in local coverage determination hospice determining terminal status (L34538) and approved or denied within five working days. Once the review process has been completed and a decision has been made, the hospice provider will receive a written notification of the decision. A denial does not represent a determination that further hospice care would not be appropriate, but that based on the documentation provided, the beneficiary does not appear to be in the terminal stage of illness. Providers are encouraged to submit PA packets for the next subsequent period within the set time frame when there is evidence of a decline in health if a prior period had been denied.

NOTE: It is the hospice provider's responsibility to inform the nursing facility of approval or denial.

Reconsideration

If a beneficiary does not agree with the denial of a period or subsequent period, reconsideration may be requested. Documentation must be recent and not for dates that were previously omitted or previously submitted. All reconsideration requests will be reviewed within five working days from the receipt of the written request.

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HOSPICE REVOCATION AND DISCHARGE

When a beneficiary revokes or is discharged alive during an election period, the beneficiary loses any remaining days in the election period. The beneficiary may at any future time elect to receive hospice coverage for any other hospice periods for which they are eligible.

This requirement will affect both Medicaid-only and dual eligibles. The Centers for Medicare and Medicaid Services (CMS) requires the election and revocation/discharge to be simultaneous for both payer sources. If a beneficiary is eligible for Medicare as well as Medicaid (dual eligible) and revokes hospice care, the revocation forms must be submitted to the appropriate agency in compliance with the agency's requirements simultaneously.

The date of discharge (except discharge due to death) is not reimbursed by Medicaid.

Revocations

A beneficiary or their legal representative may revoke the election of hospice care at any time during an election period. This is a right that belongs solely and exclusively to the beneficiary or legal representative.

At no time is the hospice provider to demand a revocation. In addition, the hospice beneficiary or legal representative must not be asked to sign a blank form to be completed by the hospice provider prior to submission to the Prior Authorization Unit (PAU) through an electronic prior authorization (e-PA). In the event it is discovered during the verification process that a hospice provider encouraged revocation for the purpose of potentially avoiding hospice related charges, and the beneficiary or legal representative is in agreement, the revocation will not be honored.

Required Statement of Revocation

When a beneficiary revokes or is discharged alive during an election period, the beneficiary or legal representative must sign and date a statement acknowledging that they are aware of the revocation and state reason the revocation is chosen. This written statement must be completed by the beneficiary or legal representative and include the beneficiary's contact information.

The statement must be submitted to the hospice PAU for verification and follow up.

A signed statement must include the date the revocation is to be effective. A beneficiary or their legal representative cannot designate an effective date earlier than the date that the revocation is

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made. The date of signature and proper written statement must also be included. This revocation shall be received by the hospice PAU within five calendar days of revocation.

At no time will the effective date be earlier than the date the request is signed. Revocations that are back dated will be forwarded to the Medicaid Program Integrity Section for investigation for possible fraudulent activity. A verbal revocation of benefits is NOT acceptable.

The requirements for revocation and time limits also apply to beneficiaries who have both Medicare and Medicaid eligibility (dual eligible).

Discharges

A hospice provider must discharge a beneficiary from hospice care upon receipt of a revocation statement or upon discovery the beneficiary is not terminally ill.

Reasons for Discharge

Beneficiaries must be discharged **only** in the following circumstances:

1. There is a change in terminal status;
2. The beneficiary relocates from the hospice's geographically defined service area;
3. The safety of the beneficiary or of the hospice staff is compromised. The hospice provider must make every effort to resolve these problems satisfactorily before discharge, and efforts must be documented in detail in the beneficiary's clinical record;
4. Medicaid-only beneficiaries who enter a non-contracted nursing home or hospital and all options have been exhausted (a contract is not attainable, the beneficiary chooses not to transfer to a facility with which the hospice provider has a contract, or to a hospice provider with which the skilled nursing facility (SNF) has a contract). The hospice provider must notify the payer source to document that all options have been pursued and that the hospice provider is not discharging the beneficiary without due cause; and
5. The hospice provider determines that the beneficiary's (or other persons in the beneficiary's home) behavior is disruptive, abusive or uncooperative to the extent that delivery of care to the beneficiary, or the ability of the hospice staff to operate effectively, is seriously impaired.

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The hospice provider must do the following before it seeks to discharge a beneficiary for cause:

1. Advise the beneficiary that a discharge for cause is being considered;
2. Make a serious effort to resolve the problem(s) presented by the beneficiary's behavior or situation;
3. Ascertain that the beneficiary's proposed discharge is not due to the beneficiary's use of necessary hospice services;
4. Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into the beneficiary's clinical record; and
5. Obtain a written physician's discharge order from the hospice medical director prior to discharging a beneficiary for any reason.

NOTE: If a beneficiary has an attending physician involved in their care, the physician should be consulted before discharge with their review and decision included in the discharge note. This order shall be submitted to the hospice PAU with the required Medicaid discharge forms within five calendar days.

Documentation of Discharge

The hospice provider must clearly document why it was necessary to discharge the beneficiary.

Within five calendar days after discharge, the provider must submit the Notice of Termination with type bill 81B or 82B via the Bureau of Health Services Financing (BHSF) Form Hospice – Notice of Election (NOE) through e-PA so the files may be updated in a timely manner.

Discharge/Revocation Due to Hospital Admit

It is against Medicaid hospice policy to encourage beneficiaries to revoke hospice services when they have an inpatient admission, emergency room (ER) visit, ambulance transport or other outpatient services and re-elect hospice after services are delivered. These cases will be verified and closely monitored by the hospice PAU for referral to Program Integrity.

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Service Availability upon Revocation or Discharge

A beneficiary is no longer covered for hospice care under Medicaid upon discharge or revocation. All previously waived benefits will resume.

NOTE: This does not apply to waiver services received prior to hospice election.

Notice of Transfer

A Notice of Transfer is sent when the beneficiary is in the middle of an election period and wants to change hospice providers. A beneficiary may change hospice providers once each election period. The date of discharge from the current hospice provider must be only one day before the date of admission to the newly designated hospice provider.

Within five calendar days after discharge, the transferring hospice provider must submit the signed a type bill 81C via BHSF Form-Hospice through e-PA so the files may be updated in a timely manner. The new hospice provider receiving the beneficiary must also submit a completed notice of transfer (81C) to the hospice PAU within five days of receipt of transfer. Refer to Appendix A of this chapter.

Late Notifications

Failure to submit Notices of Revocation, Discharge or Transfer in a timely manner can result the inability for other providers to bill for services. Late submissions will be monitored by the department and PAU, and may be subject to monetary penalties.

Revocations received through e-PA that are more than five days old can be submitted with any proof of prior attempts to submit timely. For example, a fax confirmation sheet reflecting the appropriate discharge/revocation form with explanation (81B) is acceptable as proof as long as there is a successful fax transmission with a date on the confirmation sheet. A blank or failed fax confirmation sheet is not acceptable.

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RECORD KEEPING

The hospice provider must have sufficient space, facilities and supplies to ensure effective record keeping.

A hospice provider must maintain and retain the business and professional records sufficient to document fully and accurately the nature, scope and details of the health care provided. The hospice provider must provide reports and keep records as the Louisiana Department of Health (LDH) determines necessary to administer the program. Failure to comply may result in one or more of the following:

1. Recoupment;
2. Sanction;
3. Loss of enrollment; or
4. Referral to Surveillance and Utilization Review Systems (SURS).

Contract Services

If services are provided on a contractual basis, the hospice provider must have a legally binding written agreement for the provision of arranged services that includes requirements as detailed in the Louisiana Administrative Code (LAC) 48:I.Chapter 82-*Licensing Standards for Hospices*, Section 8237.

Review by State and Federal Agencies

When requested, a provider must furnish access to all administrative, personnel and beneficiary records to authorized state and federal personnel, at all reasonable times. Providers' records are subject to audit by LDH, the State Attorney General's Office, the Office of Inspector General (OIG), and the Centers for Medicare and Medicaid Services (CMS) or other appropriate state or federal agencies.

Administrative Files

The hospice provider must disclose all financial, beneficial ownership, equity, surety or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint

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ventures, agencies, institutions or other legal entities providing any form of health care services to beneficiaries of medical assistance.

The provider's administrative files must include, at a minimum:

1. Documentation identifying the governing body;
2. A list of members and officers of the governing body, their addresses and terms of membership;
3. An organizational chart which delineates lines of authority and responsibility for all hospice personnel;
4. Documentation of the provider's administrative policies and procedures as detailed in LAC 48:I.Chapter 82-*Licensing Standards for Hospices*, Section 8235; and
5. Documentation of quality assurance as detailed in LAC 48:I.Chapter 82-*Licensing Standards for Hospices*, Section 8239.

Personnel Records

The provider must have written employment and personnel policies that detail the following:

1. Job descriptions for all positions, including volunteers and students, that include the duties, qualifications and competencies;
2. A description of hiring practices that includes a policy against discrimination based on race, color, religion, sex, age, national origin, disability, political beliefs, disabled veteran, veteran status or any other non-merit factor;
3. A description of procedures for employee evaluation, promotion, disciplinary action, termination and hearing of employee grievances; and
4. A written record on each employee that includes the following:
 - a. An application for employment and/or resume;
 - b. References;

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- c. Verification of professional credentials;
- d. Performance evaluations;
- e. Employee's starting and termination date; and
- f. Time sheets for all times on duty.

Beneficiary Clinical Records

In accordance with LAC 48:I.Chapter 82-*Licensing Standards for Hospices*, Section 8233, the hospice provider must establish and maintain a clinical record for every beneficiary receiving care and services. The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval. The clinical records must substantiate the services billed to Medicaid by the hospice provider. Services not specifically documented in the beneficiary's clinical record as having been rendered will be deemed not to have been rendered and no reimbursement will be provided. Entries are to be made for all services provided. Entries are to be signed and dated by the person providing the services. The record includes all services whether furnished directly or under arrangements made by the hospice provider. Each beneficiary's record must contain the following:

- 1. The initial and subsequent assessments;
- 2. The plan of care (POC) (updated and original);
- 3. Identification data;
- 4. Authorization forms;
- 5. Pertinent medical history, beneficiary's primary hospice diagnosis, other diagnoses and prognosis;
- 6. Physician's orders, including, if respite, continuous care or general inpatient care, orders for these services, including number of days and justification;
- 7. Complete documentation of all services and events (including evaluations, treatments, progress notes for all services rendered, etc.);

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8. Certification statements and physician narratives of the terminal illness for each benefit period;
9. Election statements; and
10. Discharge/revocation/transfer forms and notes, if applicable.

Confidentiality and Protection of Records

The hospice provider must safeguard the clinical record against loss, destruction and unauthorized use in accordance with Medicaid policies, federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA). All medical assistance information regarding beneficiaries must be held confidential and used for authorized Medicaid purposes only. A provider shall disclose information in their possession only when the information is to be used in conjunction with a claim for health benefits or when the data is necessary for the functioning of the Medicaid program.

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REIMBURSEMENT

With the exception of payment for physician services, Medicaid reimbursement for hospice care is made at one of four predetermined per diem rates for each day a Medicaid beneficiary is under the care of the hospice regardless of the amount of services furnished on any given day. The four rates are prospective rates; there are no retroactive adjustments other than the limitation on payments for inpatient care. The rates are calculated on a yearly basis and based on information provided by the Centers for Medicare and Medicaid Services (CMS) and in line with the provider requirements as set forth in 42 Code of Federal Regulations (CFR) Part 418.

The payment rates for each level of care (LOC) are those used under Part A of Title XVIII (Medicare) of the Social Security Act, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. These rates are adjusted for regional wage differences. The hospice shall submit claims, for payment for hospice care only, on the basis of the geographic location (Metropolitan Statistical Area) where the services are furnished.

The rates are effective from October 1 through September 30 of each federal fiscal year (FY). The provider should split bills if they span the effective date of the annual updates to the payment rates.

Claim Form

Bills are submitted on a Form UB-04. Claims-related information can be found in Section 24.10 of this Chapter.

Levels of Care

Payment rates are determined for the following four categories of hospice care into which each day of care is classified:

1. Routine Home Care;
2. Continuous Home Care;
3. Inpatient Respite Care; and
4. General Inpatient Care.

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Routine Home Care (Revenue Code 651)

A routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous home care. The routine home care rate is paid for each day the beneficiary is under the care of the hospice and not receiving one of the other categories of care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

Routine home care is also paid when the beneficiary is receiving hospital care for a condition **unrelated** to the terminal condition. This rate is also paid in the following situations:

1. If the beneficiary is in a hospital that is not contracted with the hospice;
2. If the beneficiary is receiving outpatient services in the hospital; or
3. For the day of discharge from general inpatient care or respite LOC.

Reimbursement is based upon a two-tier payment system. Reimbursement begins at a higher rate and then decreases to a lower rate. The higher rate is payable for the first 60 days of an initial election of hospice services. If the member remains in hospice, on day 61, payment drops to the lower rate.

Examples include the following:

1. A member that is discharged or voluntarily revokes hospice elections and readmits to hospice in less than 60 days will have no disruption for the purpose of counting days;
2. A member that is discharged or voluntarily revokes hospice elections and readmits to hospice in 61 or more days constitutes a new hospice election and the higher rate of pay starts again; and
3. A member who transfers to another hospice, in either a managed care organization (MCO) or fee-for-service (FFS) Medicaid, continues the count of days from the original hospice provider.

An additional add-on rate may apply. (See Service Intensity Add-on in this section).

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Service Intensity Add-On Rate (Revenue Code 659)

A service intensity add-on (SIA) payment will be reimbursable for a visit by a registered nurse (RN) or a social worker, when provided during routine home care (HR651) in the last seven days of a patient's life. The SIA payment is in addition to the routine home care rate.

Claims for SIA services must be billed in units. Each unit is equal to 15 minutes. The maximum number of reimbursable units per day is 16 units. The seven-day maximum number of reimbursable units is 112 units. All claims must be submitted with documentation demonstrating the necessity of the services provided. Documentation submitted should reflect the arrival and departure time of the professional providing the services. Visits for the pronouncement of death only will not be reimbursed as an eligible visit.

Continuous Home Care (Revenue Code 652)

The individual receiving hospice care is not in an inpatient facility and receives care consisting predominantly of nursing care on a continuous basis at home. Continuous home care is only furnished during brief periods of medical crisis and only as necessary to maintain the terminally ill beneficiary at home. Routine home care code must be billed if less skilled care is needed on a continuous basis to enable the beneficiary to remain at home. Services should reflect direct beneficiary care during a period of crisis and should not reflect time related to staff working hours, time taken for meal breaks, time used for educating staff or time use for reporting. Continuous home care is not paid during a hospital, skilled nursing facility (SNF) or inpatient hospice facility stay.

Criteria for continuous home care include the following:

1. A period of medical crisis is when a beneficiary requires continuous care, which is primarily nursing care, to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either an RN or a licensed practical nurse (LPN), and a nurse must be providing care for more than half of the period of care. Nursing care can include skilled observation and monitoring when necessary, and skilled care needed to control pain and other symptoms; or
2. A minimum of eight hours of care must be provided during a 24-hour day which begins and ends at midnight. If fewer than eight hours of continuous care are provided, the services are covered as routine care rather than continuous home care. This care need not be continuous (i.e. four hours could be provided in the morning and another four hours provided in the evening of that day). The care must be

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predominantly nursing care provided by either an RN or LPN. Homemaker and aide services may also be provided to supplement the nursing care. Care by a hospice aide and/or homemaker cannot be discounted or provided “at no charge” in order to qualify for continuous home care.

NOTE: The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate.

Inpatient Respite Care (Revenue Code 655)

An inpatient respite care day is a day on which the individual receives care in an approved facility on a short-term basis to relieve the family members or other persons caring for the individual at home.

NOTE: An approved facility is one that meets the standards provided in 42 CFR, Section 418.98(b). The inpatient respite care rate is paid for each day the beneficiary is in an approved inpatient facility and is receiving respite care. Payment is made for respite care for a maximum of **five** continuous days at a time in any election period, including the date of admission, but not counting the date of discharge. Payment for the sixth day, and any subsequent days, is made at the routine home care rate. Respite care may not be provided when the hospice beneficiary is a resident in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

Criteria for Inpatient Respite Care:

1. If the beneficiary, who resides in the home, goes into a nursing facility for respite care and returns home after the respite care, the beneficiary need not be in a nursing facility Medicaid bed;
2. Medicaid will pay the inpatient respite care rate for the day of death;
3. Services provided in the facility must conform to the hospice’s plan of care (POC); and
4. The hospice is the professional manager of the beneficiary’s care despite the physical setting of the care or the LOC.

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General Inpatient Care (Revenue Code 656)

A general inpatient care day is a day on which an individual receives general inpatient care in an inpatient facility that meets the standards as provided in 42 CFR 418.98(a) and for the purpose of pain control or acute or chronic symptom management which cannot be managed in other settings. General inpatient care is a short-term LOC and is not intended to be a permanent solution to a negligent or absent caregiver or considered to be a beneficiary's permanent or temporary residence. Once symptoms are under control, a lower LOC must be billed.

Criteria for general inpatient care include the following:

1. General inpatient care and room and board in a nursing facility or ICF/IID cannot be reimbursed for the same beneficiary on the same covered days of service;
2. The hospice must have a contract with the inpatient facility, delineating the roles of each provider in the beneficiary's POC; and
3. Services provided in the facility must conform to the hospice's POC.

The hospice is the professional manager of the beneficiary's care despite the physical setting of the care or the LOC.

Payment for Physician Services

In addition to the four basic payment rates for hospice care, hospices can also bill Medicaid for certain physician services. For purposes of Medicaid hospice, these physicians' services can be divided into the following three categories:

1. Professional services, or those actual procedures performed by the physician, are designated by the appropriate Current Procedural Terminology (CPT)-4 code. (Direct care services furnished to individual beneficiaries by hospice employees and for physician services furnished under arrangements made by the hospice unless furnished on a volunteer basis);
2. Administrative services include administrative and general supervisory activities generally performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary team (IDT). Group activities include participation in the establishment of POC, supervision of care and services, periodic review and updating of POC and establishment of governing policies;

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3. The four basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the beneficiary's terminal illness and related conditions. This includes the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice; and
4. Technical services include laboratory, x-ray and other non-professional services performed by the physician or other health care professionals.

NOTE: It should be noted that administrative and technical services are included in the four basic payment rates for hospice when the services are related to the terminal illness and related conditions.

Provision of Physician services

For purposes of Medicaid hospice, physicians providing these services are divided into two categories:

1. Attending Physician; and
2. Consulting Physician.

Only professional services are reimbursable outside of the four payment rates for hospice care.

The medical director of the hospice is to assume overall responsibility for the medical component of the hospice's beneficiary care program.

Attending Physician

During the election process, the patient designates the physician primarily responsible for their care while receiving hospice. This physician is the attending physician. The attending physician is not required to be an employee of the hospice.

Non-Employee

If the attending physician is not an employee of the hospice, the attending physician's professional services will be billed to Medicaid by the physician.

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An independent attending physician is reimbursed in accordance with the usual Medicaid reimbursement methodology for physician services. Any other technical or administrative services are covered under the daily reimbursement rates paid to the hospice and are reimbursed by the hospice to the physician according to their agreement.

The attending physician can choose to bill Medicaid for physician care plan oversight if the coverage and documentation requirements are met.

Employee

If the attending physician is an employee of the hospice or a volunteer (such as medical director or physician member of the IDT), the physician's professional services are billed to Medicaid by the hospice. The hospice is responsible for reimbursing the physician.

The hospice must ensure that the services were professional and not technical or administrative.

The hospice is reimbursed in accordance with the usual payment rules for Medicaid physician services. The hospice must reimburse the physician for the technical component of the service out of the per diem rate as agreed upon in the physician's arrangement with the hospice.

Physicians who are designated by beneficiaries as the attending physician and who also volunteer services to the hospice are, as a result of their volunteer status, considered employees of the hospice. **Physician services furnished on a volunteer basis are excluded from Medicaid reimbursement.** The hospice may be reimbursed on behalf of a volunteer physician for specific services rendered which are not furnished on a volunteer basis (a physician may seek reimbursement for some services while furnishing other services on a volunteer basis). Liability rests with the provider to reimburse the physician for those physician services rendered.

In determining which services are furnished on a volunteer basis and which services are not, a physician must treat beneficiaries on the same basis as other beneficiaries in the hospice. For instance, **a physician may not designate all physician services rendered to non-Medicaid beneficiaries as volunteered and at the same time seek payment from the hospice for all physician services rendered to Medicaid beneficiaries.**

Example: Dr. Jones has an agreement with a hospice to serve as its medical director on a volunteer basis. Mrs. Smith, a Medicaid beneficiary, enters this hospice and designates Dr. Jones as her attending physician. Dr. Jones, who does not furnish direct beneficiary care services on a volunteer basis, renders a direct beneficiary

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care service to Mrs. Smith. Dr. Jones seeks reimbursement from the hospice for this service. The hospice is then paid by Medicaid in accordance with the usual payment rules for Medicaid physician services for the service that Dr. Jones rendered to Mrs. Smith. The hospice then reimburses Dr. Jones for that service.

Consulting Physician

Any physician services other than those rendered by the attending physician are classified as consulting physician services. The procedure for billing for consultant physicians is the same as for employee attending physicians. The hospice must have a contractual agreement with the physician.

The hospice is responsible for billing Medicaid for the physician's professional services and is to reimburse the physician for the services as indicated in their contractual agreement. The hospice can contract with a group of physicians as long as all the physicians in the group are listed in the contract.

Payment for Long-Term Care Facility Residents

The hospice provider will be paid an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility for a beneficiary who meets the following criteria:

1. Resides in a nursing facility or ICF/IID;
2. Is eligible under the Medicaid State Plan for nursing facility services or services in an ICF/IID if they had not elected to receive hospice care;
3. Elects to receive hospice care; and
4. For whom the hospice provider and the nursing facility or ICF/IID have entered into a written agreement in accordance with the provisions set forth in the Licensing Standards for Hospices (Louisiana Administrative Code (LAC) 48:I.Chapter 82), under which the hospice provider takes full responsibility for the professional management of the individual's hospice care, and the facility agrees to provide room and board to the individual.

Payment to the facility is to be discontinued and effective as of the date of the resident's hospice election. Payment will be made to the hospice to take into account the room and board furnished

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by the facility for a Medicaid beneficiary. The hospice must then reimburse the facility for room and board. Dual eligible beneficiaries in a skilled nursing facility (bed) are ineligible for reimbursement for room and board by Medicaid. Hospice must submit claims to Medicare.

The amount to be paid is determined in accordance with the rates established under the Social Security Act, Section 1902(a) (13) (B). The rate of reimbursement is 95 percent of the per diem rate that would have been paid to the facility for that beneficiary in that facility under the Medicaid State Plan, except that any patient liability income (PLI) determined by the Medicaid Program will be deducted from the payment amount. It is the responsibility of the nursing facility or ICF/IID to collect the beneficiary's PLI.

This rate is designed to cover "room and board" which includes performance of personal care services (PCS), including assistance in the activities of daily living (ADL), administration of medication, maintaining the cleanliness of the beneficiary's environment, and supervision and assistance in the use of durable medical equipment (DME) and prescribed therapies. Certain DME is included in the "room and board" rate. A list of DME supplies can be found at the Louisiana Medicaid website at www.lamedicaid.com, under the fee schedules link (see Appendix D).

Nursing facilities are currently reimbursed on a case-mix methodology in which the rates can be adjusted from time to time. Hospice providers are subject to the same per diem rate adjustments as the nursing facilities, as deemed necessary. This may result in an overpayment or underpayment, and the claims will be reprocessed accordingly.

NOTE: See Section 24.10 - *Claims Related Information* of this manual chapter for additional claims related information regarding payment for nursing and ICF/IID residents.

Provider of First Choice

The nursing facility retains the right to decide if it wishes to offer the option of hospice. If the nursing facility chooses not to offer hospice care and a resident requests this service, the resident is to be informed that hospice is not available in the facility. The nursing facility is to assist with arrangements for transfer to another facility that offers the service, if the resident so chooses.

Non-Emergency Transportation for Non-Hospice Related Medical Appointments

It is the responsibility of the nursing facility to arrange for or provide transportation to all non-hospice related medical appointments. This includes wheelchair bound residents and those residents going to therapies. Transportation shall be provided to the nearest available qualified

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provider of routine or specialty care within reasonable proximity to the facility. Residents can utilize medical providers of their choice in the community in which the facility is located when they are in need of transportation services.

In cases where residents are bed bound and cannot be transported other than by stretcher, and the nursing facility is unable to provide transportation, an ambulance may be used. The nursing facility will reimburse the provider at the non-emergency transportation rate.

Emergency Transportation for Non-Hospice/Hospice Related Medical Conditions

It is the responsibility of the nursing facility to contact the hospice provider for any and all emergencies. **The hospice agency has full responsibility for the professional management of the individual's care.**

Medicare Coinsurance

For dual eligible beneficiaries (Medicare and Medicaid coverage) for whom Medicare is the primary payer for hospice services, Medicaid will also provide for payment of any coinsurance amounts imposed under §1813(a)(4) of the Social Security Act.

Additionally, hospice services should not be billed to Medicaid for dual eligible beneficiaries. These services are covered in the hospice Medicare reimbursement. Room and board for skilled nursing is billed to Medicare.

After providing a service to a dual eligible beneficiary, the provider sends a claim to its Medicare carrier or the intermediary. After Medicare processes the claim, it sends the provider an explanation of Medicare benefits. If Medicare has approved the claim, Medicaid will pay the deductible and/or coinsurance through its established Medicare crossover process.

Drugs and Biologicals Coinsurance (Dual Eligibles)

The amount of coinsurance for each prescription approximates five percent of the cost of the drug or biological to the hospice, determined in accordance with the drug co-payment schedule established by the hospice, except that the amount of coinsurance for each prescription may not exceed five dollars. The cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances.

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To ensure the correct billing of drug services, it is imperative that the hospice provider communicate with the pharmacist to verify which drugs are related to the terminal illness (billed to the hospice) and which drugs are not related to the terminal illness (billed to Medicaid).

NOTE: Refer to the pharmacy provider manual, Chapter 37 for more information on prescription services and associated co-payments. The manual can be accessed on the Louisiana Medicaid website at www.lamedicaid.com.

Respite Care Coinsurance (Dual Eligibles)

The amount of coinsurance for each respite care day is equal to five percent of the payment made under Medicare for a respite care day. The amount of the individual's coinsurance liability for respite care during a hospice coinsurance period may not exceed the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began.

NOTE: Federal law mandates that Medicaid is the payer of last resort. Refer to Chapter 1 of the Louisiana Medicaid provider manual, *General Information and Administration*. The manual can be accessed on the internet at www.lamedicaid.com.

Telephone Calls and Consultations

Hospices may report some social worker calls as a visit. Hospices may not report any other types of phone calls.

Non-covered Days

Hospice providers are reimbursed for date of death only. Providers are not reimbursed for dates of discharge nor revocation.

Hospice Services to Medicaid/Medicare/Veteran's Eligible Beneficiaries

Medicaid beneficiaries that are dual eligible veterans and reside at home in their community may elect hospice services and have the services paid under the Medicare hospice benefits.

If a dual eligible veteran who had been receiving Medicare hospice services in their home is admitted to a Veterans Administration (VA) owned and operated inpatient facility, the beneficiary must revoke the Medicare hospice benefits. The same applies for a Medicaid-only beneficiary. Medicare and Medicaid are not allowed to pay for those services for which another federal entity is primary payer.

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CLAIMS RELATED INFORMATION

Reimbursement requires compliance with all Medicaid requirements. Hospice providers bill for room and board using the standard 837 Institutional (837I) electronic claim transaction or the hardcopy UB-04 Form, regardless of the date of service. All supplemental billing must also be submitted electronically using the 837I format or on the UB-04 hard copy claim form. The 837I is the preferred method of claim submission.

Medicaid Requirements for Enrolling Ordering, Prescribing and Referring Providers

The Affordable Care Act (ACA) requires physicians or other practitioners who order, prescribe, or refer items or services to Medicaid beneficiaries to enroll in the Medicaid Program, even when they do not submit claims to Medicaid. ACA requirements are designed to ensure that items or services for Medicaid beneficiaries originate from appropriately licensed providers who have not been excluded from Medicare or Medicaid.

Individuals who order, prescribe, or refer items or services for Medicaid beneficiaries, but choose not to submit claims to Medicaid, are referred to throughout this notice as “Ordering, Prescribing, and Referring (OPR) providers.”

Professional and Institutional Billing Providers should begin notifying any individuals who you report on fee-for-service (FFS) claims as an ordering, prescribing or referring provider that they must enroll with Louisiana Medicaid.

OPR providers must understand the implications of failing to enroll in Medicaid. If you are an OPR provider, then the individuals and facilities who bill services for Medicaid beneficiaries based on your order, prescription, or referral will not be paid for those items or services unless you enroll in Medicaid. Timely filing claim requirements may be impacted while waiting for providers to be enrolled; therefore, applications should be submitted as quickly as possible.

Effective with claims using dates of service on or after September 1, 2016, the Louisiana Medicaid Program will deny FFS claims that use referring providers who are not enrolled as of the date of service. Providers should monitor the Louisiana Medicaid website for future information specific to ordering providers.

Louisiana Medicaid has established edits for issues with prescribing providers.

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Enrollment

Practitioners currently enrolled as participating providers in FFS Medicaid Program are not required to enroll separately as an OPR provider.

Diagnosis Codes

All billers should use the correct diagnosis codes (International Classification of Diseases (ICD)-10-CM or its successor) that supports medical necessity and are appropriate for use with hospice related conditions.

Revenue Codes

Bill for hospice services provided according to the level of care (LOC) and location of the beneficiary for each day of the hospice election period.

Frequency of Billing

The UB-04 form should be submitted each month after the month for which services were provided. Providers do not have to split a claim for a month's dates of service around the beneficiary's election period dates. However, a claim cannot span more than two election periods. The provider should split bills if they span the effective date of the annual increase in the payment rates for hospice care services.

Claims Submission for Beneficiaries Residing In the Home

Hospice providers only bill for direct hospice services when a beneficiary resides in the home. If the beneficiary is dual eligible with Medicare Part A, a bill should not be submitted to Medicaid because Medicare Part A reimburses hospice services at 100 percent.

Claims Submissions for Beneficiaries Residing In a Long Term Care Facility

Hospice providers' bill for both direct hospice services and room and board when a beneficiary resides in a nursing facility unless the beneficiary is dual eligible with Medicare Part A. If the beneficiary is dual eligible with Medicare Part A, then Hospice providers bill only for room and board. Because Medicare Part A reimburses hospice services at 100 percent, no bill for direct hospice services or room and board in a skilled nursing facility (SNF) should be submitted to Medicaid.

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The room and board rate of reimbursement is 95 percent of the per diem rate that would have been paid to the facility for that beneficiary in that facility under the Medicaid State Plan, except that any patient liability income (PLI) determined by the Bureau of Health Services Financing (BHSF) will be deducted from the payment amount. It is the responsibility of the nursing facility or intermediate care facilities for individuals with intellectual disabilities (ICF/IID) to collect the beneficiary's PLI.

Hospice providers may only bill Medicaid once per calendar month for nursing facility or ICF/IID room and board.

Medicaid Only

Providers should bill for routine or continuous home care and bill the rate to cover room and board as appropriate. The Medicaid parish office will advise the resident and nursing facility or ICF/IID of the resident's PLI. Medicaid will deduct the resident's PLI from the amount to be reimbursed to the hospice. The hospice provider is to pay the facility according to the contract agreement subject to adjusted claims the nursing facility may encounter as a result of case mix methodology.

Medicaid and Medicare (Dual Eligible)

Providers should bill for the room and board rate for each day the resident is in the facility. Providers should bill Medicare for routine or continuous home care, as appropriate. The hospice provider is to pay the facility according to the contract agreement subject to adjusted claims the nursing facility may encounter as a result of the case mix methodology.

NOTE: General inpatient care and room and board cannot be reimbursed for the same beneficiary for the same covered day of service.

Claims Submissions for Schedule (Room and Board ONLY)

Claims for room and board are processed according to a predetermined schedule set by the Louisiana Department of Health (LDH) and is updated every calendar year. This schedule includes deadlines for initial monthly claim submissions as well as deadlines for monthly supplemental claim submissions.

NOTE: Providers who bill hardcopy claims should continue to submit the initial monthly UB-04 forms in one package.

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Payment rates are determined at one of the four levels for each day of a beneficiary's hospice care.

Providers should use the following chart to determine the appropriate level for billing:

Revenue Code	Units of Service	Level of Care	Required Documentation
651	24-Hours (1 day)	Routine Home Care The routine home care rate is paid for each day the beneficiary is under the care of the hospice and not receiving one of the other categories of care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day. It is also paid when the beneficiary is receiving hospital care for a condition unrelated to the terminal condition. This rate is also paid in the following situations if the beneficiary is: <ol style="list-style-type: none"> 1. In a hospital that is not contracted with the hospice; 2. In a hospital for care unrelated to the terminal condition; 3. Is receiving outpatient services in the hospital; or 4. For the day of discharge from general inpatient care or respite LOC. 	The hospice must develop and maintain a plan of care (POC) for the beneficiary. The beneficiary's clinical record should include any updates to the POC and changes to the beneficiary's condition between the updates. The beneficiary's clinical record should include all disciplines' progress notes (daily/weekly/monthly) that record the type and frequency of the services provided to the beneficiary.
659	1 unit=15 minutes	Service Intensity Add-On Rate The service intensity add-on (SIA) rate will be reimbursed only when billed in conjunction with the Routine Home Care code. Services must be rendered by a registered nurse (RN) or a social worker only. Bill codes G0299 (RN) or G0155 (social worker) for each day a visit is made within the last seven days of a person's life. Claims must be submitted in hardcopy with documentation and progress notes justifying the intensity and number of visits. Payment will be reimbursed in 15 minute increments (one unit). The maximum total billed per day cannot exceed four hours.	The date of service must have been previously submitted to Medicaid and/or the appropriate health plan and is already on file before payment can be made on the SIA rate.

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Revenue Code	Units of Service	Level of Care	Required Documentation
652	1 Hour	Continuous Home Care A minimum of eight hours of care must be provided during a 24-hour day, which begins and ends at midnight. This care need not be continuous, i.e., four hours could be provided in the morning and another four hours provided in the evening of that day. Homemaker and aide services may also be provided to supplement the nursing care. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate.	Documentation must: Clearly document reason for continuous care. List the dates of service that the beneficiary was under continuous home care. Record hour by hour and day by day what services were provided, the beneficiary's condition, and the type of personnel providing the continuous care.
655	1 Day	Inpatient Respite Care The payment for respite care may be made for a maximum of five consecutive days in an election period at a time including the date of admission, but not counting the date of discharge alive. Payment for the sixth and any subsequent day is to be made at the routine home care rate.	Documentation must: Clearly indicate the facility in which the beneficiary is receiving the respite LOC, the dates that the beneficiary was at respite LOC, and why the respite care was necessary. NOTE: The total number of days allowed is subject to the inpatient care cap. See provider responsibilities for more information.

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Revenue Code	Units of Service	Level of Care	Required Documentation
656	1 Day	<p>General Inpatient Care</p> <p>For the date of admission to the contracted inpatient facility, the general inpatient rate is to be paid.</p> <p>For the day of discharge from the contracted inpatient unit, the appropriate routine home care rate is to be paid unless the beneficiary dies as an inpatient.</p> <p>Upon death, the general inpatient rate is to be paid for the discharge date for the beneficiary admitted to the contracted facility.</p> <p>The provider should bill revenue code 656 for beneficiaries admitted to a contracted facility.</p> <p>The hospice may not bill the general inpatient rate for days that the beneficiary is in a non-contracted facility or in a facility for a reason unrelated to the terminal condition or in an inpatient facility where the facility is considered the beneficiary's temporary or permanent residence/home. The hospice bills routine home care rate for these days.</p>	<p>Documentation must include:</p> <p>The name of the facility in which the beneficiary is receiving the general inpatient LOC;</p> <p>The dates the beneficiary was at the general inpatient LOC;</p> <p>A clear explanation of the reason why the admission was necessary;</p> <p>The beneficiary's condition during the inpatient stay; and</p> <p>The physician's discharge summary and any hospice interdisciplinary notes during the beneficiary's inpatient stay.</p> <p>NOTE: General inpatient care days are subject to limitations. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings. Once the symptoms are under control, routine home care must be billed. The total number of days allowed is subject to the inpatient care cap. See provider responsibilities for more information.</p>
657	1 day	<p>Physician Services</p> <p>For use when physician professional services are being provided to hospice beneficiaries; and the hospice is responsible for reimbursing the physician.</p> <p>The physician can be an employee of the hospice, a volunteer, or a consultant.</p>	<p>Document all beneficiary encounters.</p>

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Third Party Liability

Medicaid, by law, is intended to be the payer of last resort. Therefore, other available third-party resources, including private insurance, must be used before Medicaid pays for the care of a Medicaid beneficiary.

If probable third-party liability (TPL) is established at the time the claim is filed, Medicaid will deny the claim and return it to the provider for determination of TPL for most Medicaid services. In these cases, the Bureau then pays the balance of the claim to the extent that payment is allowed under Medicaid's fee schedule after the third party's payment. Early and periodic screening, diagnostic, and treatment (EPSDT) diagnostic and screening services are exempt from this requirement. For these services, Medicaid will pay the claim up to the maximum allowable amount. However, these exceptions do not include treatment or therapy that must be billed to the beneficiary's third-party carrier (if applicable) prior to billing Medicaid. When Medicaid is billed, hard copy of the claim must be filed with the third-party carrier's Explanation of Benefits (EOB) attached to the claim form.

For beneficiaries with private insurance, hospice providers should still submit requests for hospice services timely to the hospice Prior Authorization Unit (PAU) in order for the appropriate reviews and future accurate reimbursement to take place.

Exception: The only time Medicaid is considered as primary is when the beneficiary has health coverage through Indian Health Services. In these cases, claims should be billed to Medicaid first, then to Indian Health Services.

Timely Filing Guidelines

To be reimbursed for services rendered, all providers must comply with the filing limits set by the Medicaid Program. Refer to Chapter 1 of the Louisiana Medicaid provider manual, *General Information and Administration*. The manual can be accessed on the internet at www.lamedicaid.com.

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PROGRAM MONITORING

Federal regulations require continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services of providers and by beneficiaries.

The Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF), which administers the Medicaid Program, routinely conducts program monitoring to ensure that Medicaid payments being made for services are for eligible beneficiaries, that the services provided are medically necessary and appropriate, and that they are provided by the appropriate provider. Participating hospices are responsible for ensuring that requirements, such as record documentation for services rendered, are met in order to receive payment. Hospices agree to give access to records and facilities to BHSF, its authorized representatives, representatives of LDH or the State Attorney General's Medicaid Fraud Control Unit, and authorized federal personnel upon reasonable request.

Data on hospice, certifications and claims may be analyzed for the appropriateness or necessity of review. Providers and beneficiaries, including new hospice certifications, are identified for review either from systems generated reporting using various sampling methodologies or by referrals and complaints. Computerized exception reports may be used to look at utilization patterns for providers and beneficiaries. Appropriateness of review may also be indicated for claims which involve vague or unreliable diagnoses, and/or of individual hospice providers that have a high percentage of beneficiaries enrolled with diagnoses that do not normally represent a terminal illness. Data regarding average length of stay and use of the continuous home care and the general inpatient care category of care may also be helpful in identifying providers and claims that may be appropriate for review.

Review of Medical Eligibility

A review may be conducted of hospice certifications to focus on hospice medical eligibility. A beneficiary must have a terminal prognosis and not just certification of terminal illness. Claims may be denied on the basis that a beneficiary is not terminally ill as defined in federal regulation. These regulations require certification of the beneficiary's prognosis, rather than diagnosis, i.e. denial is to be based on objective clinical evidence contained in the clinical record regarding the beneficiary's condition and not on the beneficiary's diagnosis.

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Utilization Review Visits

Desk reviews may be made periodically of each Medicaid participating hospice provider.

On-site visits may be made and can be unannounced. The utilization review will include an interdisciplinary team (IDT) review of the services provided by the hospice with respect to the following:

1. Care being provided to the beneficiaries;
2. Adequacy of the services available to meet current health needs and to provide the maximum physical and emotional well-being of each beneficiary;
3. Necessity and desirability of the continued participation in hospice services by the beneficiary;
4. Feasibility of meeting the beneficiary's health needs in alternate care arrangements; and
5. Verification of the existence of all documentation required by Medicaid.

Services not documented in the beneficiary record will be determined not to have been performed and reimbursement will either be retracted or will not be made.

Other subsequent visits may be made for the purpose of the follow-up of deficiencies or problems, complaint investigation or technical assistance.

Requests for Clinical Records

When a new certification or claim is selected for review, a request will be made for the provider to submit the clinical records for a specific beneficiary's dates of service. The following documentation is required:

1. Physician's certification;
2. Plan of care (POC);
3. Laboratory results;

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4. Medication lists;
5. Progress notes for all services rendered;
6. Physician's orders/updated physician orders to the POC; and
7. Minimum Data Set (MDS) form or jRaven form.

A screening of the material received will be conducted before the claim is reviewed to ensure that the required documentation is included.

NOTE: The screening does not verify that the POC is valid, i.e., signed and dated; only that it has been received. It is the hospice's responsibility to ensure that all services rendered are appropriately documented and submitted to substantiate coverage.

In addition to the required documentation, any information that will support the beneficiary's hospice appropriateness should be included. Such documentation must include the following:

1. Detailed description of the beneficiary's condition;
2. Detailed description of the beneficiary's decline in detail. As an example, documentation should show last month's status compared to this month's status and should not merely summarize the beneficiary's condition for a month, but also show daily and weekly notes;
3. Explanation of why the beneficiary is considered to be terminal and not chronic;
4. Explanation of why their diagnosis has created a terminal prognosis;
5. Demonstration of how the systems of the body are in a terminal condition;
6. Demonstration of how the proposed services, specific to that individual, are reasonable and medically necessary; and
7. Demonstration of how the cause of death was related to the hospice diagnosis, when the beneficiary has expired, if applicable.

The hospice has 35 calendar days to submit the clinical records.

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If the required documents are not submitted, an additional request will be sent to the hospice. Only one additional request will be made for this additional documentation.

If the physician's orders/updated physician orders to the POC are missing, an additional request will only be sent to the hospice for continuous care or general inpatient care categories.

Claims will be reviewed within 60 days from the date of receipt of the clinical records. To ensure a thorough and fair review, trained professionals will review all claims utilizing available resources, including appropriate consultants, and make on-site reviews as necessary. The prognosis of terminal illness will be reviewed and the reasonableness and medical necessity of the proposed services, specific to the beneficiary, for the palliation or management of the terminal illness, will be considered.

APPEALS

Service Denial

A hospice client who disagrees with the denial of hospice services has the right to request an appeal with the Division of Administrative Law (DAL). This request must be post marked no later than 30 days from the date of the denial notice. The request for appeal, stating the reason for the request and the denial letter, should be sent directly to the DAL. Information about the appeal process can be found by contacting the DAL (see Appendix D of this manual chapter) or refer to Chapter 1 - *General Information and Administration of the Medicaid Services Manual*. The manual can be accessed on the internet at www.lamedicaid.com.

Claims Payment Denial

If a denial is upheld upon reconsideration and the hospice provider disagrees with a claims payment decision, the hospice provider has the right to request an appeal with the DAL within 30 days of the reconsideration decision date. The request for reconsideration and the denial letter should be submitted directly to the DAL. Information about the appeal process can be found by contacting the DAL (see Appendix D of this manual chapter) or refer to Chapter 1 - *General Information and Administration of the Medicaid Services Manual*. The manual can be accessed on the internet at www.lamedicaid.com.

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ACRONYMS/DEFINITIONS/TERMS

Activities of Daily Living (ADLs) – The functions or basic self-care tasks which an individual performs in a typical day, either independently or with supervision/assistance. ADLs include bathing, dressing, eating, grooming, walking, transferring and/or toileting.

Adult Day Health Care (ADHC) Waiver – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to individuals who: are age 65 or older, or aged 22-64 and have a physical disability, and meet nursing facility level of care (NFLOC) requirements.

Attending/Primary Physician - A doctor of medicine or osteopathy, fully licensed to practice medicine in the State of Louisiana, who is designated by the beneficiary as the physician responsible for their medical care. The attending physician is the physician identified within the Medicaid system as the provider to which claims have been paid for services prior to the time of the election of hospice.

Bereavement Counseling - Organized counseling provided under the supervision of a qualified professional to help the family cope with death related grief and loss issues. This is to be provided for at least one year following the death of the beneficiary.

BHSF Form Hospice - (Notice of Election (NOE)/Revocation/Discharge/Transfer) - This is the required form used to notify the hospice Prior Authorization Unit (PAU) of a beneficiary's election or cancellation of the hospice program as provided by Louisiana Medicaid. This form is also used to update changes in the Medicaid hospice beneficiary's condition and status.

BHSF Form Hospice - Certification of Terminal Illness (CTI) - This is the required form to be used by the hospice agency for documentation of written and verbal certification of terminal illness for Medicaid beneficiaries. **This form is not to be altered by the Hospice provider. In addition, this form may be utilized for dually eligible (Medicare/Medicaid) beneficiaries.**

Clinical Condition – A diagnosis or beneficiary state that may be associated with more than one diagnosis, or may be as yet undiagnosed.

Concurrent Care – Beneficiaries who are under 21 years of age and elect hospice are entitled to receive a hospice benefit while continuing to receive all necessary disease-directed and life-prolonging therapies with the goal of providing access to comprehensive care, in order to live as long and as well as possible.

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Community Choices Waiver (CCW) – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to individuals who: are age 65 or older, or aged 21- 64 and have a physical disability, and meet the NFLOC requirements.

Core Services - Nursing services, physician services, medical social services and counseling services, including bereavement counseling, dietary counseling, spiritual counseling and any other counseling services provided to meet the needs of the individual and family.

Curative Treatments – Medical treatment and therapies provided to a beneficiary with the intent to improve symptoms and cure the patient’s medical problem.

Department/LDH - Louisiana Department of Health.

Discharge - The point at which the beneficiary’s active involvement with the hospice services is ended and the hospice provider no longer has active responsibility for the care of the beneficiary.

Geographic Area - Area around location of licensed agency which is within a 50-mile radius of the agency premises.

Hospice Employee - An individual whom the hospice provider pays directly for services performed on an hourly or per visit basis and the hospice provider is required to issue a form W-2 on their behalf. If a contracting service or another agency pays the individual, and is required to issue a form W-2 on the individual's behalf, or if the individual is self-employed, the individual is not considered a hospice employee. An individual is also considered a hospice employee if the individual is a volunteer under the jurisdiction of the hospice.

Instrumental Activities of Daily Living (IADLs) – Those routine household tasks that are considered essential for sustaining the individual’s health and safety, but may not require performance on a daily basis. IADLs may include laundry, meal preparation and storage for the beneficiary, shopping, light housekeeping, assistance with scheduling and/or accompanying the beneficiary to medical appointments, etc.

Interdisciplinary Team (IDT) - An IDT designated by the hospice provider, composed of representatives from all the core services. The IDT must include at least a doctor of medicine or osteopathy, a registered nurse (RN), a social worker and a pastoral or other counselor. The IDT is responsible for: participation in the establishment of the plan of care (POC); provision or supervision of hospice care and services; periodic review and updating of the POC for each individual receiving hospice care; and establishment of policies governing the day-to-day provision of hospice care and services.

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Level of Care (LOC) - Hospice care is divided into four categories of care rendered to the hospice beneficiary: (1) routine home care; (2) continuous home care; (3) inpatient respite care; and (4) general inpatient care.

Life-Prolonging Therapies - Any aspects of the beneficiary's medical POC that are focused on treating, modifying, or curing a medical condition so that the beneficiary may live as long as possible, even if that medical condition is also the hospice qualifying diagnosis. Beneficiaries under age 21 are entitled to receive life-prolonging therapies in the concurrent care model of hospice.

Long Term-Personal Care Services (LT-PCS) – A Medicaid state plan service which provides assistance with ADLs and IADLs as an alternative to institutional care to qualified Medicaid beneficiaries who are age 21 or older and meet specific program requirements.

Non-Core Services - Services provided directly by hospice employees or under arrangement. These services include, but are not limited to home health aide and homemaker, physical therapy services, occupational therapy services, speech-language pathology services, inpatient care for pain control and symptom management and respite purposes, and medical supplies and appliances, including drugs and biologicals.

Office of Aging and Adult Services (OAAS) – The office within LDH that is responsible for the management and oversight of certain Medicaid home and community-based services (HCBS) waiver programs (CCW and ADHC Waiver), state plan programs, adult protective services for adults ages 18 through 59, and other programs that offer services and supports to the elderly and adults with disabilities.

Office for Citizens with Developmental Disabilities (OCDD) – The office within LDH that is responsible for management and oversight of 1915 (c) Medicaid HCBS waiver programs (New Opportunities Waiver (NOW), Residential Options Waiver (ROW), Supports Waiver (SW), and Children's Choice Waiver (CC)) that services individuals of all ages with intellectual and/or developmental disabilities.

Plan of Care (POC) - A written document established and maintained for each individual admitted to a hospice program. Care provided to an individual must be in accordance with the POC. The POC includes an assessment of the individual's needs and identification of the services, including the management of discomfort and symptom relief.

Program of All-Inclusive Care for the Elderly (PACE) – Program which coordinates and provides all needed preventive, primary health, acute and long-term care (LTC) services to qualified beneficiaries age 55 and older in order to enhance their quality of life and allow them to continue to live in the community.

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Relative - For the purpose of legal representation, a relative is all persons related to the beneficiary by virtue of blood, marriage, adoption or legal guardianship as court appointed.

Service Intensity Add-On (SIA) Rate – A rate for RN and social worker visits provided to a patient within the last seven days of life.

Support Coordination Agency – For OAAS, this is an entity which delivers Medicaid support coordination services under an agreement with LDH/OAAS.

Terminal Illness - A medical prognosis of limited expected survival, of approximately six months or less at the time of referral to a hospice program, of an individual who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone are no longer appropriate.

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**APPENDIX A: BENEFICIARY NOTICE OF
ELECTION/REVOCATION/DISCHARGE/TRANSFER**

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BENEFICIARY NOTICE OF ELECTION/REVOCATION/DISCHARGE/TRANSFER**Purpose of Form**

The Bureau of Health Services Financing (BHSF) Form Hospice – Notice of Election (NOE) is used to notify the Hospice Prior Authorization Unit (PAU) of a hospice beneficiary’s voluntary election or cancellation of the Hospice Program.

This form is also used to update changes in the beneficiary’s condition and status.

Upon completion, the form along with the Certification of Terminal Illness (CTI), physician narrative, and all related documentation must be sent to:

**Gainwell Technologies via the e-PA system
@Lamedicaid.com**

NOTE: Electronic submissions are required due to the time-frames.

Notifications and Type of Bill

The alpha character for the third digit of the BHSF Form Hospice – NOE’s field titled “Type of Bill” is used to indicate the type of notification that is being provided.

CHAPTER 24: HOSPICE**APPENDIX A: BENEFICIARY NOTICE OF****ELECTION/REVOCATION/DISCHARGE/TRANSFER****PAGE(S) 11**

Notification	Type Bill	Description
NOE	81A/82A	When a beneficiary elects Medicaid hospice care, the beneficiary must sign and date the BHSF Form Hospice - NOE. The hospice provider is required to submit this form as a NOE immediately after obtaining the receipt and receipt of the physician's completed BHSF Form Hospice – CTI, including verbal certification where applicable. Both the forms, properly completed must be received by the Hospice Program within 10 calendar days following the initiation of hospice care. If this requirement is not met, reimbursement is not available for the days prior to receipt of the forms. Reimbursement will become effective the date the hospice PAU receives the proper documentation.
Notice of Termination	81B/82B	This notice is used for a beneficiary who has revoked/discharged from a hospice election period. This must be sent to the Hospice PAU within five calendar of discharge or revocation. For revocation, a signed written statement by the beneficiary or legal representative must accompany the form with 81/B noted. In addition, the beneficiary's or legal representative's contact information must be provided.
Notice of Change (Transfer)	81C/82C	A Notice of transfer is sent when the beneficiary is in the middle of an election period and wants to change hospice providers. A beneficiary may change hospices once each election period. The date of discharge from the current hospice must ideally be only one day before the date of admission to the newly designated hospice. These providers must communicate with each other to decide how the coordination of the beneficiary's hospice care will be handled. The first hospice should send the beneficiary's history and plan of care (POC) to the new hospice. The first hospice must submit the notice of transfer to the hospice PAU within five calendar days after receipt of the filed notice of change statement. The new hospice provider must submit the Notification of Transfer (81C/82C) to the

CHAPTER 24: HOSPICE**APPENDIX A: BENEFICIARY NOTICE OF
ELECTION/REVOCATION/DISCHARGE/TRANSFER****PAGE(S) 11**

Notification	Type Bill	Description
		Hospice PAU within five calendar days of transfer. The date of admission on the Notification of Transfer should be the date the beneficiary was admitted into the new hospice. NOTE: An 81C/82C must also be sent to the Hospice PAU when a beneficiary is transferring to or from a nursing facility.
Notice of Void (of a NOE)	81D/82D	This notice is used to void an 81A/82A that was established in error, such as if the beneficiary changes their mind, or if the wrong Date of Admission was previously submitted. Please note: A notice of void will not be honored if submitted to avoid payments to non-hospice providers. Notice of Voids must be submitted within five calendar days. NOTE: If claims have processed during the voided election period, claims must be voided before 81D/82D is submitted and a recoupment made to the intermediary.

Instructions for Completing the BHSF Form Hospice-Notice of Election**Completing the BHSF Form Hospice****PART I**

The first section of the form (PART I) is to be completed by the beneficiary or legal representative only. The signature of the beneficiary or legal representative is required. The beneficiary or legal representative may sign prior to the admission date or on the admission date, but not after the admission date. **The legal representative must show relationship to the beneficiary and provide contact information.**

1. Election/Admission Date - REQUIRED

The date of admission cannot precede the physician's certification by more than two calendar days, and is the same as the certification date if the certification is not completed on time. The date must be entered by the beneficiary or legal representative. Hospice providers are prohibited from entering information in this field.

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APPENDIX A: BENEFICIARY NOTICE OF**ELECTION/REVOCATION/DISCHARGE/TRANSFER****PAGE(S) 11**

NOTE: If the BHSF Form Hospice - NOE form and the CTI are not received within 10 calendar days of the initiation of hospice care, the date of admission (election) will be the date the Hospice PAU receives the proper documentation. This rule applies to beneficiaries receiving Medicaid only, as well as Medicaid/Medicare (dual eligible) beneficiaries.

EXAMPLE: The hospice election date (admission) is January 1, 2019. The physician's certification is dated January 3, 2019. The hospice date for coverage and billing is January 1, 2019. The first hospice benefit period ends 90 days from January 1, 2019. However, if the required forms and completed packet is not received within the 10 calendar day timeframe, the benefit begin date will be the date the completed packet is received by the hospice PAU. For example, if the required forms and completed packet are received on January 11, 2019, the begin date would be January 11, 2019.

The admission date will change when the beneficiary re-elects hospice any time after a revocation or discharge.

2. Signature of Patient/Legal Representative – REQUIRED

The signature of the beneficiary or legal representative is required. The beneficiary or legal representative may sign prior to the admission date or on the admission date, but not after the admission date. The date of signature will become the LDH approval date if signed after the admission date.

In cases where a beneficiary signs the NOE form with an “X”, there must be two witnesses to sign next to the beneficiary’s mark. The witnesses must also indicate relationship to the beneficiary and daytime phone number. One witness must be a relative or legal representative. Hospice representatives cannot sign as a witness.

Definition of Relative

A relative is defined as all persons related to the beneficiary by virtue of blood, marriage, adoption or legal guardians as court appointed.

Non-Relatives

Persons other than relatives signing the BHSF Form Hospice - NOE must have legal rights, (a medical power of attorney) to make medical decisions for beneficiaries who are physically or mentally incapacitated. Proof of these rights must be notarized or court issued documents and submitted at the time the election for hospice is made. Verbal elections are prohibited.

CHAPTER 24: HOSPICE

**APPENDIX A: BENEFICIARY NOTICE OF
ELECTION/REVOCATION/DISCHARGE/TRANSFER****PAGE(S) 11**

3. Date of Signed - REQUIRED

The beneficiary or legal representative must enter date at time of signature.

4. Representative's Daytime Phone Number - REQUIRED

The legal representative must provide their contact information including the area code.

5. Printed Name of Above Signee – REQUIRED

The person who signed acknowledgement of Patient's Declaration must also print name. This could be the beneficiary or the authorized representative, whichever has signed.

6. Legal Representative's Relationship to Patient - REQUIRED

The legal representative must show relationship to the beneficiary. If the legal representative is not related to the beneficiary, follow the instructions as outlined in number two above.

PART II

The second section of the form (**PART II**) is to be completed by the hospice provider.

NOTE: When revoking hospice services, the beneficiary or legal representative must complete the reason for revocation.

Patient Information**7. Patient Name - REQUIRED**

Enter the beneficiary's first name, middle initial and last name in this order as it is printed on the beneficiary's Medicaid card.

8. Patient Address - REQUIRED

Enter the beneficiary's complete mailing address, including zip code.

9. Patient Medicaid ID Number - REQUIRED

Enter the beneficiary's 13-digit Medicaid identification (ID) number exactly as it appears in the beneficiary's current Medicaid information using the plastic Medicaid "swipe" card, electronic

CHAPTER 24: HOSPICE

APPENDIX A: BENEFICIARY NOTICE OF**ELECTION/REVOCATION/DISCHARGE/TRANSFER****PAGE(S) 11**

Medicaid Eligibility Verification System (e-MEVS), or Recipient Eligibility Verification System (REVS). Make certain that the last two digits are the correct individual suffix for your beneficiary. The number must match the beneficiary's name. If the patient is not eligible for Medicaid, reimbursement is not made by Medicaid.

NOTE: Providers enrolling patients with "Pending" ID numbers are assuming responsibility for those patients. **It is the provider's responsibility to notify the hospice PAU when beneficiaries have been approved for Medicaid.**

10. Patient Medicare ID Number – REQUIRED, IF APPLICABLE

This field should only be used if the beneficiary has Medicare. Enter the beneficiary's Medicare health insurance number.

11. Patient Date of Birth (DOB) - REQUIRED

Enter the month, day and year of birth (MM-DD-YYYY) of beneficiary. Example: 06-12-1903.

12. Type Bill - REQUIRED

Enter the three-digit numeric type of bill code, as appropriate. The first digit identifies the type of facility. The second classifies the type of care. The third is referred to as a "frequency" code and it indicates the sequence of this bill in this particular episode of care.

Code Structure:

1st Digit - Type of Facility

8 - Special facility (hospice)

2nd Digit - Classification

1 - Hospice (Non-hospital based)

2 - Hospice (Hospital based)

3rd Digit - Frequency

A - Hospice Admission Notice

Definition

Use when the hospice is submitting form as an admission notice.

B - Hospice Termination/ Revocation Notice

Use when the hospice is submitting form as a notice of termination/revocation for a previously posted hospice election.

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APPENDIX A: BENEFICIARY NOTICE OF**ELECTION/REVOCATION/DISCHARGE/TRANSFER****PAGE(S) 11**

C - Hospice Change of Provider Notice	Use when form is used as a notice of change in the hospice provider or nursing facility.
D - Hospice Election Void/Cancel	Use when form is used as a notice of a void/cancel of hospice election.
E - Hospice Change of Ownership	Use when form is used as a notice of change in ownership for the hospice.

13. Statement Covers Period – REQUIRED, IF APPLICABLE

This field is to be used when filing an 81B/82B document and upon the initial election of hospice only. The “From” date is the start date of the period from which the beneficiary is revoking. The “Through” date is the date of revocation. Dates must be entered numerically as MM-DD-YYYY. “From” date must match the date the beneficiary/legal representative elects the hospice service.

14. Primary Diagnosis Code(s) - REQUIRED

Use the most specific and accurate numeric International Classification of Diseases (ICD)-10-CM diagnosis code(s) for the terminal illness that is current. The principal diagnosis is defined as the condition established after study to be chiefly responsible for the beneficiary’s admission. The Centers for Medicare and Medicaid Services (CMS) only accepts ICD-10-CM diagnostic and procedural codes using definitions contained in the Department of Health and Human Services (DHHS) Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. CMS approves only changes issued by the Federal ICD-10-CM Coordination and Maintenance Committee. Use full ICD-10-CM or its successors’ diagnoses codes including all five digits where applicable.

15. List All Other Diagnosis Codes - REQUIRED

Enter the full ICD-10 or its successors’ codes, including all five digits where applicable, for any other terminal diagnosis and **or related condition. List ALL co-morbidities.**

16. Discharge/Revocation Reason(s) - REQUIRED

Enter the reason(s) for the discharge or revocation. Beneficiary or legal representative must sign and date NOE form if the beneficiary is revoking hospice services.

The beneficiary or legal representative must also provide a statement for the reason of revoking services.

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APPENDIX A: BENEFICIARY NOTICE OF**ELECTION/REVOCATION/DISCHARGE/TRANSFER****PAGE(S) 11**

The hospice provider must sign and date if the beneficiary is discharging. The hospice provider must also provide the reason the beneficiary is being discharged.

Forms received after the specified time limits will become effective upon date of receipt.

Provider Information**17. Hospice Provider Name - REQUIRED**

Enter the hospice provider name.

18. Hospice Address - REQUIRED

Enter the hospice provider address (street number and name, city, state, and zip code).

19. Hospice Provider Number - REQUIRED

Enter the seven-digit Medicaid provider identification number.

20. Hospice Provider Telephone Number – REQUIRED

Enter the hospice provider telephone number including area code. Fax number is optional.

21. Name of Nursing Facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – REQUIRED, IF APPLICABLE

Enter the name of the facility in which the beneficiary resides or intends to reside. Medicaid field office staff determines long-term care (LTC) eligibility.

22. Attending Physician Printed Name - REQUIRED

Print the name of the attending physician currently responsible for referring, certifying, and signing the individual's POC for medical care and treatment.

NOTE: The attending physician's name must be the same on the NOE and CTI.

23. Attending Physician Provider Number - REQUIRED

Enter the attending physician's seven digit Medicaid provider ID number.

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APPENDIX A: BENEFICIARY NOTICE OF**ELECTION/REVOCATION/DISCHARGE/TRANSFER****PAGE(S) 11**

24. Hospice Relationship Status - REQUIRED

Enter the word "employee" or "non-employee" here to describe the relationship the beneficiary's attending physician has with the hospice. "Employee" also refers to a volunteer under your jurisdiction.

25. Hospice Provider's Representative's Signature – REQUIRED

Signature required.

26. Hospice Provider's Representative's Printed Name – REQUIRED

Printed name required.

27. Date – REQUIRED

Hospice representative must enter date at time of signature.

CHAPTER 24: HOSPICE

APPENDIX A: BENEFICIARY NOTICE OF
ELECTION/REVOCATION/DISCHARGE/TRANSFER

PAGE(S) 11

Department of Health and Hospitals
Louisiana Medicaid Hospice Program

RECIPIENT NOTICE OF ELECTION/REVOCATION/DISCHARGE/TRANSFER

PART I: TO BE COMPLETED BY PATIENT OR LEGAL REPRESENTATIVE ONLY

- 1** Hospice is a program that gives help and support to patients during the final months of life. The program also helps loved ones cope. I choose to receive services from the Hospice provider named below starting

1

Election/Admission Date (MM-DD-YYYY)

NOTE: To get hospice services, I must have Medicaid and my doctor must write that I am in my final months of life.

PATIENT'S STATEMENT

I understand and accept:

- I can get hospice for 3 months if approved for the service. If I need more days the hospice provider will ask for these days for me.
- If my illness is better, I will no longer get hospice services under the Medicaid Program. If I no longer receive hospice services, I can keep on using my Medicaid card for other services.
- By choosing hospice I understand that I will not be treated for my terminal sickness and any related condition.
- If I have Medicaid and Medicare, I must choose hospice with Medicaid and Medicare at the same time.
- I am signing this paper because I understand hospice services. The hospice provider explained the services to me/my legal representative and also explained to me that I can choose to not receive hospice care at any time.

SIGNATURES

Signature of Patient/Legal Representative

2

Date of Signed (MM-DD-YYYY)

3

Representative's Daytime Phone # (incl. area code)

4

Printed Name of Above Signee

5

Legal Representative's Relationship to Patient

6

PART II: TO BE COMPLETED BY HOSPICE PROVIDER

PATIENT INFORMATION

Patient Name (First, Middle Initial, Last)

7

Patient's Address

8

City

State

Zip

Patient Medicaid ID #

9

Patient Medicare ID #

10

Date of Birth (MM-DD-YYYY)

11

Type Bill

12

Statement Covers Period

From

(MM-DD-YY)

Through

(MM-DD-YY)

13

Primary Diagnosis Code (s)

14

List All Other Diagnosis Codes

15

Discharge/Revocation Reason(s):

16

PROVIDER INFORMATION

Hospice Provider Name

17

Hospice Address

18

City

State

Zip

Hospice Provider #

19

Hospice Provider Phone # (incl. area code & Fax)

20

Name of Nursing Facility or Intermediate Care Facility (ICF-DD)

21

Attending Physician Printed Name

22

Attending Physician Provider #s

23

Hospice Relationship Status

24

SIGNATURES

Hospice Provider Representative's Signature

25

Hospice Representative's Printed Name

26

Date (MM-DD-YYYY)

27

Department of Health and Hospitals

Louisiana Medicaid Hospice Program

RECIPIENT NOTICE OF ELECTION/REVOCATION/DISCHARGE/TRANSFER

PART I: TO BE COMPLETED BY PATIENT OR LEGAL REPRESENTATIVE ONLY

1 Hospice is a program that gives help and support to patients during the final months of life. The program also helps loved ones cope. I choose to receive services from the Hospice provider named below starting

Election/Admission Date (MM-DD-YYYY)

NOTE: To get hospice services, I must have Medicaid and my doctor must write that I am in my final months of life.

PATIENT'S STATEMENT

I understand and accept:

- I can get hospice for 3 months if approved for the service. If I need more days the hospice provider will ask for these days for me.
- If my illness is better, I will no longer get hospice services under the Medicaid Program. If I no longer receive hospice services, I can keep on using my Medicaid card for other services.
- By choosing hospice I understand that I will not be treated for my terminal sickness and any related condition.
- If I have Medicaid and Medicare, I must choose hospice with Medicaid and Medicare at the same time.
- I am signing this paper because I understand hospice services. The hospice provider explained the services to me/my legal representative and also explained to me that I can choose to not receive hospice care at any time.

SIGNATURES

Signature of Patient/Legal Representative	Date of Signed (MM-DD-YYYY)	Representative's Daytime Phone # (incl. area code)
Printed Name of Above Signee	Legal Representative's Relationship to Patient	

PART II: TO BE COMPLETED BY HOSPICE PROVIDER**PATIENT INFORMATION**

Patient Name (First, Middle Initial, Last)		Patient's Address		City	State	Zip
Patient Medicaid ID #		Patient Medicare ID #		Date of Birth (MM-DD-YYYY)		
Type Bill	Statement Covers Period From (MM-DD-YYYY) Through (MM-DD-YYYY)		Primary Diagnosis Code (s)	List All Other Diagnosis Codes		
Discharge/Revocation Reason(s):						

PROVIDER INFORMATION

Hospice Provider Name		Hospice Address		City	State	Zip
Hospice Provider #	Hospice Provider Phone # (incl. area code & Fax)		Name of Nursing Facility or Intermediate Care Facility (ICF-DD)			
Attending Physician Printed Name			Attending Physician Provider #s		Hospice Relationship Status	

SIGNATURES

Hospice Provider Representative's Signature	Hospice Representative's Printed Name	Date (MM-DD-YYYY)
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CHAPTER 24: HOSPICE

APPENDIX B: CERTIFICATE OF TERMINAL ILLNESS PAGE(S) 5

CERTIFICATION OF TERMINAL ILLNESS**Instructions for Completing the Bureau of Health Services Financing
Form Hospice - Certification of Terminal Illness****Purpose of the Bureau of Health Services Financing Form Hospice -
Certification of Terminal Illness**

The purpose of the Bureau of Health Services Financing (BHSF) Form Hospice - Certification of Terminal Illness (CTI) is to document written and verbal CTI for Medicaid beneficiaries. Additionally, this form may be utilized for dual eligible (Medicare/Medicaid) beneficiaries.

NOTE: This form is not to be altered by the Hospice provider.

The CTI, BHSF Form Hospice - Notice of Election (NOE) and all related documents must be electronically submitted via electronic prior authorization (e-PA) system. (See Appendix D for contact information).

Completing the BHSF Form Hospice-CTI

For Medicaid-only beneficiaries, there must be two different signatures on the CTI. For dual eligible (Medicare Part A) beneficiaries, only one physician's signature is necessary.

Submission of the physician's CTI is required all election periods. However, additional copies of certification forms for all election periods must be made available to the Bureau upon request.

NOTE: A stamped physician's signature is not acceptable on the certification. The physician must date this form at time of his signature. No stamped dates are acceptable. Submitting forms incorrectly may delay the hospice segment being added to the system. If the physician forgets to date the certification; another signed and dated CTI can be obtained to verify when the certification was obtained. The hospice approval date will be the date the signed and dated CTI is received in the hospice program office if submitted beyond the 10-day time limit.

Patient Information**1. Patient Name - REQUIRED**

Enter the beneficiary's first name, middle initial and last name in this order.

CHAPTER 24: HOSPICE

APPENDIX B: CERTIFICATE OF TERMINAL ILLNESS **PAGE(S) 5****2. Patient Medicaid Identification (ID) Number - REQUIRED**

Enter the beneficiary's 13-digit Medicaid ID number exactly as it appears in the beneficiary's current Medicaid information using the plastic Medicaid "swipe" card, electronic Medicaid eligibility verification system (e-MEVS), or the recipient eligibility verification system (REVS). Make certain that the last two digits are the correct individual suffix for your beneficiary. The number must match the beneficiary's name. If the patient is not eligible for Medicaid, reimbursement is not made by Medicaid.

3. Patient's Date of Birth (DOB) - REQUIRED

Enter the month, day and year of birth (MM-DD-YYYY) of patient.
Example: 06-12-1903.

Certification of Terminal Illness

For the first benefit period (90 days) both attending physician and the hospice medical director or the physician member of the interdisciplinary team (IDT) must certify terminal illness.

Subsequent benefit periods (2nd, 3rd, 4th, etc.) require only the signature of the hospice medical director or the physician member of the IDT must certify terminal illness.

First Benefit Period (90 days)**4. Signature of Attending Physician - REQUIRED**

This is the signature of the attending physician prior to electing hospice and currently responsible for referring, certifying and signing the individual's plan of care (POC) for medical care and treatment.

5. Date Signed (MM-DD-YYYY) - REQUIRED

The attending physician must enter the date at the time of signature.

6. Printed Name of Above Attending Physician - REQUIRED

Print the name of the attending physician currently responsible for certifying and signing the individual's POC for medical care and treatment.

7. Signature of Hospice Medical Director or Physician Member of IDG - REQUIRED

This is the signature of the hospice medical director or physician member of IDT.

8. Date Signed (MM-DD-YYYY) - REQUIRED

The hospice medical director or physician member of the IDT must enter date at time of signature.

CHAPTER 24: HOSPICE

APPENDIX B: CERTIFICATE OF TERMINAL ILLNESS **PAGE(S) 5****9. Printed Name of Hospice Medical Director or Physician Member of IDT Signee - REQUIRED**

Print the name of the hospice medical director or physician member of the IDT who signed in as per number seven.

Second Benefit Period (90 Days)**10. Signature of Hospice Medical Director or Physician Member of IDG - REQUIRED**

This is the signature of the hospice medical director or physician member of the IDT.

11. Date Signed (MM-DD-YYYY) - REQUIRED

The hospice medical director or physician member of the IDT must enter the date at the time of signature.

12. Printed Name of Hospice Medical Director or Physician Member of IDT Signee - REQUIRED

Print the name of the hospice medical director or physician member of the IDT who signed in as per number 10.

Third Benefit Period (60 Days)**13. Signature of Hospice Medical Director or Physician Member of IDT - REQUIRED**

This is the signature of the hospice medical director or physician member of the IDT.

14. Date Signed (MM-DD-YYYY) - REQUIRED

The hospice medical director or physician member of the IDT must enter the date at the time of signature.

15. Printed Name of Hospice Medical Director or Physician Member of IDT Signee - REQUIRED

Print the name of the hospice medical director or physician member of the IDT who signed in as per number 13.

Referring Physician Narrative Statement**16. Narrative Statement - REQUIRED**

The attending/referring physician must complete a narrative providing the diagnosis, prognosis and the justification for hospice care. The narrative must be completed prior to the election of hospice care. The physician's signature is required.

CHAPTER 24: HOSPICE

APPENDIX B: CERTIFICATE OF TERMINAL ILLNESS **PAGE(S) 5**

The narrative must include a statement under the physician signature attesting that by signing, the physician confirms that they composed the narrative based on their review of the beneficiary's medical record or, if applicable, their examination of the patient.

17. Signature of the Referring Physician - REQUIRED

This is the signature of the referring physician.

18. Date Signed (MM-DD-YYYY) - REQUIRED

The referring physician must enter the date at the time of signature.

19. Printed Name of the Referring Physician - REQUIRED

Print the name of the referring physician who signed in as per number 17.

NOTE: If additional periods are to be certified, use an additional form.

Verbal Verification (within two days of election date)

This section must be used to document that verbal verification was obtained from the physician as named in this section confirming the beneficiary's prognosis of life expectancy of six months or less if the terminal illness runs its course. Either the verbal or written certification must be obtained within two days of the election date so hospice care can begin.

20. Printed Name of Physician Who Gave Verbal Verification - REQUIRED

Print the name of the physician who gave verbal verification of the beneficiary's terminal illness.

21. Signature of the IDT Member Taking Referral - REQUIRED

This is the signature of the member of the IDT who obtained the physician's verbal CTI.

22. Printed Name of IDT Member Signee Taking Referral - REQUIRED

Print the name of the IDT who signed in as per number 21.

23. Date Signed (MM-DD-YYYY) - REQUIRED

The IDT member must enter date at time of signature.

CHAPTER 24: HOSPICE

APPENDIX B: CERTIFICATE OF TERMINAL ILLNESS

PAGE(S) 5

**Department of Health and Hospitals
Louisiana Medicaid Program
HOSPICE CERTIFICATION OF TERMINAL ILLNESS**

PATIENT INFORMATION		
Patient's Name (First, Middle Initial, Last) 1	Patient's Medicaid ID # (13-digits) 2	Patient's Date of Birth (MM-DD-YYYY) 3
FIRST BENEFIT PERIOD (90 Days)		
Having reviewed this patient's medical record and/or examination of the patient, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.		
SIGNATURES (Physicians must date at time of signature)		
Signature of Attending Physician 4	Date Signed (MM-DD-YYYY) 5	
Printed Name of Above Attending Physician 6		
Signature of Hospice Medical Director or Physician Member of Interdisciplinary Group (IDG) 7	Date Signed (MM-DD-YYYY) 8	
Printed Name of Above Hospice Medical Director or Physician Member of IDG 9		
SECOND BENEFIT PERIOD (90 Days)		
Having reviewed this patient's medical record and/or examination of the patient, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.		
SIGNATURES (Physicians must date at time of signature)		
Signature of Hospice Medical Director or Physician Member of Interdisciplinary Group (IDG) 10	Date Signed (MM-DD-YYYY) 11	
Printed Name of Above Hospice Medical Director or Physician Member of IDG 12		
THIRD BENEFIT PERIOD (60 Days)		
Having reviewed this patient's Medical record and/or Examination of the patient, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.		
SIGNATURES (Physicians must date at time of signature)		
Signature of Hospice Medical Director or Physician Member of Interdisciplinary Group (IDG) 13	Date Signed (MM-DD-YYYY) 14	
Printed Name of Above Hospice Medical Director or Physician Member of IDG 15		
REFERRING PHYSICIAN NARRATIVE STATEMENT:		
Review of the individual's clinical circumstances and medical information to provide clinical justification for admission to hospice services. Narrative must be written legible by the physician.		
16		
SIGNATURES (Physicians must date at time of signature)		
Signature Referring Physician 17	Date Signed (MM-DD-YYYY) 18	
Printed Name of Above Physician 19		

NOTE: If additional periods are to be certified, use an additional form

VERBAL VERIFICATION (within two days of election date)		
I certify that on the date signed below a verbal verification was obtained from the physician named below; confirming that the recipient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.		
SIGNATURES		
Physician's Name (printed) 20		
Signature of IDG Member Taking Referral 21	Printed Name of IDG Member Taking Referral 22	Date Signed (MM-DD-YYYY) 23

CHAPTER 24: HOSPICE

APPENDIX C: HOSPICE DIAGNOSIS CODES**PAGE(S) 1**

HOSPICE DIAGNOSIS CODES

Diagnosis code(s) are required when submitting a request for hospice services. Certain codes require criteria that must be met before the associated request can be approved and appropriate documentation is required on submission. This list is not all inclusive and additional codes may be added upon request with documentation and justification as to why the patient has a prognosis of six months or less with this diagnosis. Each code submitted will be considered on a case-by-case basis.

All claims/authorizations must use the applicable diagnosis codes that reflect the policy intent.

CHAPTER 24: HOSPICE SERVICES**APPENDIX D: CONTACT/REFERRAL INFORMATION****PAGE(S) 4****CONTACT/REFERRAL INFORMATION****Gainwell Technologies**

The Medicaid Program's fiscal intermediary (FI), Gainwell Technologies, can be contacted for assistance with the following:

TYPE OF ASSISTANCE	CONTACT INFORMATION
e-CDI technical support	Gainwell Technologies (877) 598-8753 (Toll Free) (225) 216-6303
Electronic Media Interchange (EDI) Electronic Claims testing and assistance	P.O. Box 91025 Baton Rouge, LA 70898 Phone: (225) 216-6000 Fax: (225) 216-6335
Hospice Prior Authorization Unit (PAU)	Phone: (800) 877-0666 Fax: (225) 216-6481
Pharmacy Point of Sale (POS)	P.O. Box 91019 Baton Rouge, LA 70821 Phone: (800) 648-0790 (Toll Free) Phone: (225) 216-6381 (Local) <i>*After hours, please call REVS</i>
PAU	Gainwell Technologies – PAU P.O. Box 14919 Baton Rouge, LA 70898-4919 (800) 488-6334
Provider Enrollment Unit (PEU)	Gainwell Technologies - PEU P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370 (225) 216-6392 Fax
Provider Relations Unit	Gainwell Technologies – Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 Phone: (225) 924-5040 or (800) 473-2783 Fax: (225) 216-6334
Recipient Eligibility Verification (REVS)	Phone: (800) 766-6323 (Toll Free) Phone: (225) 216-7387 (Local)

CHAPTER 24: HOSPICE SERVICES**APPENDIX D: CONTACT/REFERRAL INFORMATION****PAGE(S) 4****Louisiana Department of Health (LDH)**

TYPE OF ASSISTANCE	CONTACT INFORMATION
General Medicaid Information	General Hotline (888) 342-6207 (Toll Free) http://ldh.la.gov/index.cfm/subhome/1/n/10 MedWeb@la.gov
General Medicaid Information for Providers	www.lamedicaid.com
Health Standards Section (HHS)	P.O. Box 3767 Baton Rouge, LA 70821 Phone: (225) 342-0138 Fax: (225) 342-5073 HSS.Mail@la.gov
Long Term-Personal Care Services (LT-PCS)	P.O. Box 2031 Baton Rouge, LA 70821 Phone: 1-877- 456-1146 Fax: (225) 219-0202 E-mail: MedWeb@la.gov http://ldh.la.gov/index.cfm/subhome/12/n/327
Louisiana Children's Health Insurance Program (LaCHIP)	(225) 342-0555 (Local) (877) 252-2447 (Toll Free) http://ldh.la.gov/index.cfm/page/222
Office of Aging and Adult Services (OAAS) State Office	Office of Aging and Adult Services P. O. Box 2031 Baton Rouge, LA 70821-2031 Phone: 1-866-758-5035 Fax: (225) 219-0202 OAAS.Inquiries@la.gov http://ldh.la.gov/index.cfm/subhome/12
OAAS Regional Offices	http://new.dhh.louisiana.gov/index.cfm/directory/category/141
Office of Management and Finance Bureau of Health Services Financing (BHSF)- MEDICAID	P.O. Box 91030 Baton Rouge, LA 70810-9030 http://ldh.la.gov/index.cfm/page/23

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Office for Citizens with Developmental Disabilities (OCDD)	628 N. Fourth Street P.O. Box 3117 Baton Rouge, LA 70821-3117 Phone: (225) 342-0095 (Local) Phone: (866) 783-5553 (Toll-free) E-mail: ocddinfo@la.gov
Pharmacy Program – POS	P.O. Box 91019 Baton Rouge, LA 70821 Phone: (800) 648-0790 (Toll Free) Phone: (225) 216-6381 (Local) *After hours, please call REVS
Rate Setting and Audit Hospital Services	P.O. Box 91030 Baton Rouge, LA 70821 Phone: 225-342-0127 225-342-9462
Beneficiary Assistance for Authorized Services	Phone: (888) 342-6207 (Toll Free)
Recovery and Premium Assistance Third-Party Liability (TPL) Unit TPL Recovery, Trauma	P.O. Box 91030 Baton Rouge, LA 70821-9030 Phone: (225) 342-8662 Fax: (225) 342-1376

Fraud Hotline

TYPE OF ASSISTANCE	CONTACT INFORMATION
To report fraud	Medicaid Program Integrity P.O. Box 91030 Baton Rouge, LA 70821-9030 Fraud and Abuse Hotline: (800) 488-2917 Fax: (225) 219-4155 http://dhh.louisiana.gov/index.cfm/page/219

CHAPTER 24: HOSPICE SERVICES**APPENDIX D: CONTACT/REFERRAL INFORMATION****PAGE(S) 4****Appeals**

TYPE OF ASSISTANCE	CONTACT INFORMATION
To file an appeal	Division of Administrative Law (DAL) - Health and Hospitals Section Post Office Box 4189 Baton Rouge, LA 70821-4189 (225) 342-0443 (225) 219-9823 (Fax) Phone for oral appeals: (225) 342-5800

Other Helpful Contact Information:

TYPE OF ASSISTANCE	CONTACT INFORMATION
Adult/ Protective Services (APS) (Office to contact to report suspected cases of abuse, neglect, exploitation or extortion of adults ages 18-59 and emancipated minors.)	Phone #: 1-800-898-4910
Elderly Protective Services (EPS) (Office to contact to report suspected cases of abuse, neglect, exploitation or extortion involving adults age 60 and older.)	Phone #: 1-833-577-6532
Centers for Medicare and Medicaid Services (CMS) OASIS, CMS-485 Form	www.cms.gov
Governor's Office of Homeland Security and Emergency Preparedness (GOSHEP)	http://gohsep.la.gov/
Southeastern Transportation Inc. Transportation Call Center (Non-emergency transportation) (All Medicaid beneficiaries who are covered under a managed care plan should contact their respective plans to schedule a ride).	To schedule transportation (855) 325-7576 NEMT Provider information (225) 342-2126 Medical Provider Line (855) 325-7576
Federal Depository Library Program Superintendent of Documents	http://www.fdlp.gov/about-the-fdlp/supdocs
International Classification of Disease (ICD) Conversion Link Convert ICD-9-CM Codes to ICD-10-CM/PCS, or Convert ICD-10-CM/PCS Codes to ICD-9-CM	http://www.icd10data.com/Convert

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APPENDIX E: UB-04 FORM AND INSTRUCTIONS**PAGE(S) 1**

UB-04 FORM AND INSTRUCTIONS

The UB-04 claim form is required for billing Medicaid and is suitable for billing most third-party payers (both government and private), because it serves the needs of many payers, some data elements may not be needed by a particular payer. Detailed information is given only for items required for Medicaid hospice claims. Items not listed need not be completed, although you may complete them when billing multiple payees.

Claims for hospice services must be filed by electronic claims submission 837I or on the UB-04 claim form.

The most recent instructions for completing the UB-04 form along with samples of UB-04 claim forms for hospice services routine billing are located on the home page of the Louisiana Medicaid website. The billing instructions and examples may also be accessed at http://www.lamedicaid.com/provweb1/billing_information/UB04_Hospice.pdf.