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 recipients.

The Bureau routinely conducts program monitoring to ensure that Medicaid payments being made for services are for eligible recipients, 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 the Bureau, its authorized representatives, representatives of DHH's or the State Attorney General Medicaid Fraud Control Unit, and authorized federal personnel upon reasonable request.

Data on hospices, certifications, and claims may be analyzed for the appropriateness or necessity of review. Providers and recipients, 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 recipients. 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 recipients 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 recipient must have a terminal prognosis and not just certification of terminal illness. Claims may be denied on the basis that a recipient is not terminally ill as defined in federal regulation. These regulations require certification of the recipient's prognosis, rather than diagnosis, i.e. denial is to be based on objective clinical evidence contained in the clinical record regarding the recipient's condition and not on the recipient's diagnosis.

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 professional review of the services provided by the hospice with respect to the following:

- Care being provided to the recipients;

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

Services not documented in the recipient 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 recipient's dates of service. The following documentation is required:

- Physician's certification;
- Plan of care;
- Lab results;
- Medication lists;
- Progress notes for all services rendered; and
- Physician's orders/updated physician orders to plan of care.

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 plan of care 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 recipient's hospice appropriateness should be included. Such documentation should:

- Describe in detail the recipient's condition;
- Describe the recipient'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 recipient's condition for a month, but also show daily and weekly notes;
- Explain why the recipient is considered to be terminal and not chronic;
- Explain why his or her diagnosis has created a terminal prognosis;

- Show how the systems of the body are in a terminal condition;
- Show how the proposed services, specific to that individual, are reasonable and medically necessary; and
- Show that the cause of death was related to the hospice diagnosis, when the recipient has expired, if applicable.

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

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 plan of care are missing, an additional request will only be sent to the hospice for continuous care or general inpatient care categories.

Claims will be reviewed in **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 recipient, for the palliation or management of the terminal illness, will be considered.