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.

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:

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. Lab results;

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 his or her 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.

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.