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:

- Unanticipated period of an increase in the number of beneficiaries;
- Staffing shortages due to illness; or

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 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 group (IDG), 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

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, his/her 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 regiments) 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 him/her 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.**

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 IDG 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 respites for the individual's family or other persons caring for the individual at home. Care for these services must not exceed five days in any election period. Medicaid payments cannot be made for inpatient hospice care provided in a nursing or intermediate care facility for individuals with intellectual disabilities (ICF/ID) 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 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 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.

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 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 he or she is 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:

- A licensed nurse or physician;
- An employee who has completed a state-approved training program in medication administration;
- The beneficiary if his/her attending physician has approved; or
- 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 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.

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 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 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 are:

- Routine Home Care;
- Continuous Home Care;
- Inpatient Respite Care; and
- General Inpatient Care.

NOTE: Refer to Section 24.9 - Reimbursement for an explanation of the four levels of care.

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, he/she has 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, he/she should not elect hospice. He/she 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 waiver services 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:

- The medical consultant with the fiscal intermediary (FI) determines which services rendered are actually hospice related;
- Services rendered to a beneficiary on the same day an election for hospice is made; and

- Charges incurred by beneficiaries who receive services while in an inpatient facility (hospital, long term care acute care facility, etc.) or other services (transportation) if the services are/were rendered on the same day a beneficiary 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:

- A statement/letter from the physician confirming that the services were not related to the beneficiary's terminal illness;
- Documentation of the procedure and diagnosis which illustrates why the service was not related to the beneficiary's terminal illness; and
- 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 is required for any covered Medicaid services not related to the treatment of the terminal condition, the prior authorization 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.

Claims submitted by the non-hospice provider will go through a physician review at the fiscal intermediary, 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.*