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)" (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

Electronic prior authorization (e-PA) is a web application that provides a secure web-based tool for providers to submit prior authorization 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.

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 prior authorization.

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, Tenth Revision (ICD-10) or its successor; other codes);

2. Hospice Certification of Terminal 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**.

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 group (IDG) 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;

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

care, even after an extended period without hospice care, prior authorization will be required. The Notice of Election (NOE), Hospice CTI form, and all prior authorization 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 prior authorization 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 prior authorization 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.