PRIOR AUTHORIZATION PROCESS

Prior authorization (PA) is required upon the initial request for hospice coverage. PA requests 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 ended, reimbursement will not be available for the days prior to receipt. Reimbursement will be effective the date the Prior Authorization Unit receives the proper documentation if approved.

The completed PA (see Required Documentation) which includes the updated and signed BHSF Form Hospice- Certificate of Terminal Illness (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 Hospice Program if the request is approved. This policy also applies to PA packets received after a Medicaid eligibility has ended. It is the responsibility of the provider to verify eligibility on a monthly basis. Prior authorization only approves the existence of medical necessity, not recipient eligibility.

All requests for hospice prior authorization must be submitted to Molina Medicaid Solution through their e-PA system. No other form or substitute will be accepted.

Electronic Prior Authorization (e-PA)

Electronic-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 (Prior Authorization Unit).

NOTE: PA is not required for dual eligible recipients (Medicare primary) during the two 90-day election periods and the subsequent 60-day election periods. However, they must send in a copy of the Medicare Common Working File screen showing the hospice segment through the e PA system.

Required Documentation

Documentation should paint a picture of the recipient's condition by illustrating the recipient'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 recipient's condition for a month). In addition, documentation should show daily and weekly notes; why the recipient is considered to be terminal and not **CHRONIC.** Explain why the recipient'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)

- Hospice Election Form (ICD 9/10 principal diagnosis code; other codes);
- Certificate of Terminal Illness Form (BHSF Form Hospice – TI);
- Clinical/medical information;
- Hospice provider Plan of Care:
  a. Progress notes (hospital, home health, physician's office, etc.);
  b. Physician orders for plan of care; and
  c. Include Minimum Data Set (MDS) form (original & current) if recipient is in a facility; weight chart; laboratory tests; physician & nursing progress notes; and
- Documentation to support patient's hospice appropriateness:
  - Paint picture of patient's condition
  - Illustrate why patient is considered terminal and not chronic
  - Explain why his/her diagnosis has created a terminal prognosis
  - 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 following packet to the Prior Authorization Unit at (see Appendix D for Contact/Referral Information):

- A letter of request including the dates of coverage on the hospice letterhead;
- An **updated** Certification of Terminal Illness form (BHSF Form Hospice-CTI) and a face-to-face encounter signed and dated by the hospice medical director or physician member of the IDG for the 3rd and subsequent requested PA periods;
- **An updated** plan of care;
- **Updated** physician's orders;
- **List of current medications (within last 60 days);**
- **Current laboratory/test results (within last 60 days if available);**
- Description of hospice diagnosis;
- Description of changes in diagnoses;
- Progress notes for all services rendered (daily/weekly physician, nursing, social worker, aide, volunteer, and chaplain) ;
- A social evaluation;
- An updated scale such as: Karnofsky Performance Status Scale, Palliative Performance Scale, or the Functional Assessment Tool (FAST); and

- The recipient's current weight, vital sign ranges, lab tests, and any other documentation supporting the continuation of hospice services. Documentation must illustrate the recipient's decline in detail. Compare last month's status to this month's status.
- Original MDS; current MDS form if recipient is a resident in a facility.

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

For PA, the prognosis of terminal illness will be reviewed. **A recipient must have a terminal prognosis in addition to a completed certification of terminal illness and proof of the face-to-face encounter**. Authorization will be made on the basis that a recipient 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 recipient's condition and not simply on the recipient'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 recipient receives hospice care during an initial 90-day period and is discharged or revokes his/her election of hospice care during a subsequent 90-day period, thus losing any remaining days in that election period. If this recipient chooses to elect a subsequent period of hospice care, even after an extended period without hospice care, prior authorization will be required. The NOE, CTI, 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 program manager if receipt is past 10 days.

A provider, who anticipates the possibility of providing hospice care for a recipient beyond the initial 90-day election period, must submit a prior authorization packet to the Prior Authorization Unit. The required information and any supporting documentation must be sent.

Written Notice of Prior Authorization Decision

PA requests will be reviewed and approved or denied within five working days. Once the review process has been completed and a decision has been made, the provider and the nursing facility (if applicable) will receive a written notification of the decision. Denial does not represent a determination that further hospice care would not be appropriate, but that based on the documentation provided, the recipient 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.

Reconsideration

If a recipient 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. When submitting a reconsideration request, providers must include the following:

- A copy of the prior authorization notice with the word "Recon" written across the top and include the reason the reconsideration is being requested written across the bottom,
- All original documentation submitted from the original request, and
- Any new information or documentation which supports medical necessity.