

HOSPICE PRIOR AUTHORIZATION PROCESS

Effective 05/01/2012, 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 Initial PA is approved, it covers 90 days. If another 90 day election period (or subsequent 60 day election periods) is required, the Hospice provider must submit a PA request **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.

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 Molina Hospice Prior Authorization Unit at 1-800-877-0666 and press Option 2.

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 or Initial Benefit Period (90 days)

- ePA electronic demographics submitted via web based system(PA Type 88) creates an encrypted bar-coded page and all of the following information will be faxed behind the encrypted bar-coded page to the ePA fax number (225-927-6536) on the web
- 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.
- Documentation to support patient's hospice appropriateness:
 - Paint picture of patient's condition
 - Illustrate why patient is considered terminal & 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 submit the following information via ePA we-base system to the Prior Authorization Unit at Molina:

- ePA electronic demographics submitted via web based system (PA Type 88) creates a bar-coded page and all of the following information will be faxed behind the bar-coded page to the ePA fax number (225-927-6536) on the web.
- 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, but may be able to elect a subsequent period at any time after the revocation. 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 through ePA 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 (business) days from the date and time of receipt of the request in the Molina work queues via ePA transaction.**

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. The Hospice provider can also check the ePA automated system to view the results of their prior authorization request on a daily basis. This system is updated daily with the results of all reviews once Molina staff enters the information in the system.

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 of a Denied Prior Authorization Request

If the hospice 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 date and time of receipt of the request in the Molina work queues via ePA transaction.** When submitting a reconsideration request, providers must include the following:

- All “RECONSIDERATION” requests must be entered via ePA transaction using the prior authorization number of the original request. See ePA manual on Louisiana Medicaid web site for further instructions.
- Any new information or documentation which supports medical necessity not sent with the original request

What documents must the Hospice Provider submit for a Revocation or Discharge of Services?

- All “Revocations or Discharge” of service must be submitted to Molina Prior Authorization within 72-hours of revocation. Any revocation submitted after the three-day limit will become effective on the date of receipt by Molina PA. The hospice provider becomes responsible for all bills if not submitted within the 72-hour time frame. All transactions must be entered via ePA transaction using the prior authorization number of the Initial or Subsequent Election periods. Providers should use the “RECON” ePa process to submit the request and send the following information:
 - a. Hospice Recipient Election/Cancellation/Discharge Notice
 - b. Statement of Revocation signed and dated by the recipient or legal representative. The revocation statement must include the date the revocation is to be effective and state why the revocation is chosen.
 - c. Discharges must be submitted once the provider receives a revocation statement from the recipient or upon discovery the recipient is not terminally ill.

Who can submit a request for Prior Authorization to Molina Hospice Prior Authorization Unit?

The **Hospice Medicaid Provider** must submit **all requests** (Initial, Subsequent Election Periods and Reconsiderations) for Prior Authorization no matter where the recipient resides or being discharged from a hospital.

What is the expected time for a determination to be made?

Molina will review and resolve all Hospice prior authorization within **5-five working (business) days from the date and time of receipt in the Molina ePA working queues.**

If a recipient elects hospice on the weekend or on a holiday; the 5-five working (business) day will begin on a Monday or the next working day after the holiday.

REMINDER: The **Hospice PA request will not move to the working queues** until the Hospice provider faxes the information/documents **behind the encrypted bar-coded page with the demographic information and the two are merged in the ePA system.**

What does the Hospice Provider submit to Molina PA for Dual Eligible Recipients (Medicare Primary)?

Prior Authorization **is not required** for dual recipients (Medicare Primary) during the two 90-day election periods and the subsequent 60-day election periods. However the following is a requirement:

Submit an ePA electronic transaction via web based system (PA Type 88). This will create an encrypted bar-coded page and the following documentation must be faxed behind the encrypted page to the ePA fax number (225-927-6536):

A copy of the Medicare Common Working File screen showing the hospice segment

How will the new Prior Authorization Process effect currently enrolled hospice patients?

The Hospice segment currently approved will remain untouched for the remainder of the election period that is currently on file and in effect; however, **if subsequent election periods are required they must go through the Prior Authorization process** describe above. The request for subsequent periods must be submitted through the ePA automated process with all required documentation **at least 10 days prior** to the end of the current election period.

Can you clarify who is meant by the ‘referring’ physician and the ‘attending’ physician?

A referring physician would be one that refers the patient. The attending must be actively in charge of the patient’s treatment and billing claims for the treatment of the patient.

How will the prior authorization impact current hospice care for Medicaid patients with any waiver programs?

There should be no additional impact on persons in waivers and hospice except for the new PA process.

NOTE: Long Term Personal Care Services (LTC/PCS) is a state plan program and these services are not covered when the recipient is in Hospice.

If Prior Authorization is approved, will it ensure payment?

Prior Authorization approval **is not** a guarantee of payment. There are hundreds of edits a claim must clear in order for a provider to receive payment (ex. Recipient must be eligible, etc).

Will there be additional information required when submitting claims/bills?

The **submission of claims have not changed**, providers will submit the same information as required in the past. **DO NOT PUT THE PA NUMBER ON THE UB-04 CLAIM FORM.**

Is there going to be an appeal process for general inpatients who may need more than five days GIP care?

The Hospice provider will be able to appeal the denial of claims and submit documentation to show the additional days were medically necessary.

Will Molina on line be accessible 24/7?

Yes, the ePA automated system is available 24/7 for providers to submit information

Do we have to submit an ePA transaction every time the patient is enters a new cert period or can we re-use the same cover sheet with the barcode each time we fax that patient's recert to Medicaid?

Yes each election will require a new ePA transactions and will be assigned a new prior authorization number.

You will only use the same Prior Authorization number when submitting "Reconsiderations" for a request that has been denied or to submit a revocation or discharge of services.

If a patient has Medicare/ Medicaid pending, do we continue to check eligibility every day until we get approval and receive a Medicaid number. Then once we receive the Medicaid number we can submit an ePA and fax over a CTI and Benefit Election?

Yes, the ePA transactions will not allow a recipient number that is not in our system to process.

Currently hospice providers are mandated that all patients enrolling in hospice to sign the Medicaid Election form plus submit the physician certification sheet. Providers have been instructed that if anytime a patient should become Medicaid eligible, i.e., Medicare hospice patient that resides in a nursing home, if the mandated forms are not submitted at the time of admit hospices will be not be reimbursed for room and board payments. Providers are placed in an awkward position when attempting to explain this mandate to patients and/or patients' legal representative especially when the patient will never be Medicaid eligible. Some patients/legal representatives take great offense. Please provide clarification.

Under the new system we are not requiring that all patients' information be sent in regardless of Medicaid eligibility. In fact, through using the ePA system providers will not be allowed to submit for someone who has not been found eligible for Medicaid. The provider will have to monitor Medicaid eligibility and submit the hospice PA request once they are Medicaid eligible. The PA will be handled retrospectively with the begin date for service being the date of the hospice election or the date of Medicaid eligibility whichever is the latter.

An ambulance company is holding the hospice responsible for a Medicaid patients transportation to home from the hospital. The ambulance company has been advised by Molina and DHH that if the transport occurred on the day the patient was admitted to hospice, regardless of the circumstances, the hospice was responsible for the ambulance cost. Under Medicare guidelines paying for an ambulance service could be perceived as Medicare fraud, i.e., enticement, if the patient has yet to be admitted to hospice services. Please provide clarification.

Charges incurred by patients 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 patient elects/elected hospice the services are the responsibility of the hospice provider. The time of day is not factored in when patient 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.

So if the patient elects hospice while in the facility all transportation and other charges for that day forward are the responsibility of the hospice. If the patient elects hospice after they have been brought home the hospice provider would not be responsible for the transportation. However, when the transportation provider bills the claims, **they should document that the**

recipient elected hospice after they were brought home. Molina reviewers have no way of knowing what time of the day the recipient elected hospice.

What is required for a change in level of care from Routine Home Care to General Inpatient Care?

Will we have to recertify a GIP patient every 5-five days as discussed in the proposed regulations?

The 5-five day limit is edited in claims processing. The Prior Authorization would not change.

If the Hospice provider obtains a verbal approval from the recipient on one day and a written approval afterwards, when will the election period begin?

If the recipient meets medical criteria for Hospice services, the election period would begin on the date of the verbal approval.

Dual recipient (Medicare Primary/Medicaid Secondary)revokes one hospice and elects another one. Second hospice provider cannot obtain approval from Medicare until the first provider completes billing with Medicare. How will Medicaid handle this type of situation?

Once the second provider obtains approval from Medicare, they should complete the ePA process and fax a copy of the Medicare Common Working File behind the bar-coded document and Medicaid will approve the days approved by Medicare from the CWF.

Clarification on Edit 328 (NOT COVERED FOR RECIPIENT IN NH/ICF-DD). When a Medicaid hospice recipient is discharged from the Nursing Home/ICF-DD Facility for admission to the hospital for General Inpatient Care; whose responsibility is it to notify DHH of the discharge?

The Nursing Home or ICF-DD facility has the responsibility of notifying DHH for all discharges.