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3200 INTRODUCTION

The Nevada Division of Health Care Financing and Policy (DHCFP) Medicaid Hospice Services program is designed to provide support and comfort for Medicaid eligible recipients who have a terminal illness and have decided to receive end of life care. Covered hospice services address the needs of the individual, their caregivers and their families while maintaining quality of life as a primary focus. The hospice philosophy provides for the physical needs of recipients as well as their emotional and spiritual needs. This care is provided in the recipient's place of residence, which could be a specialized hospice facility, an Intermediate Care Facility (ICF) or in his or her own home. Hospice care incorporates an interdisciplinary team approach which is sensitive to the recipient and family's needs during the final stages of illness, dying and the bereavement period.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000. Refer to Medicaid Services Manual (MSM) Chapter 3600 for Managed Care recipients for differences in Hospice enrollment, claims and payment.

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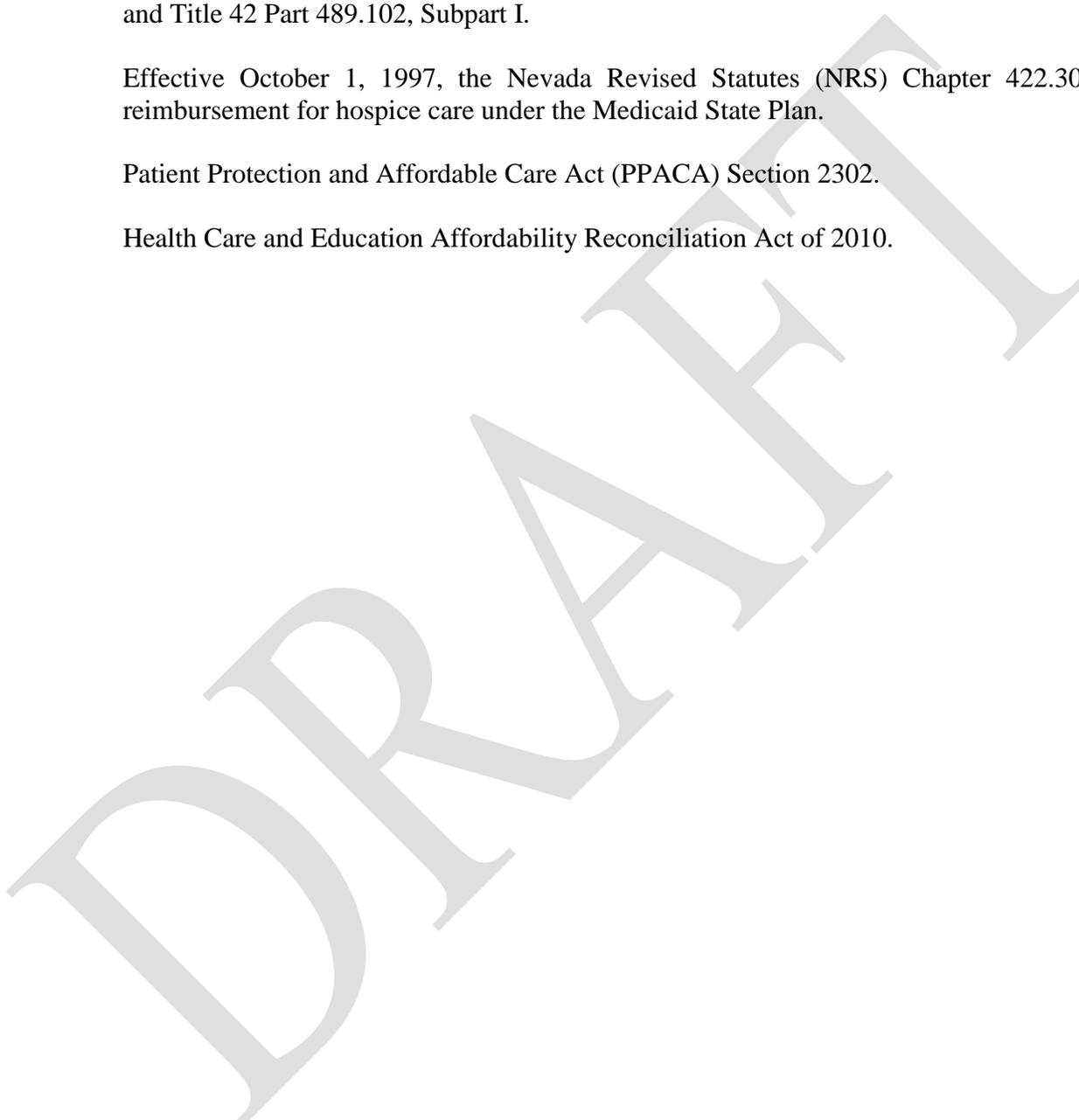
3201 AUTHORITY

Hospice Services are an optional program under the Social Security Act XVIII Sec. 1905.(o)(1)(A), and are governed by The Code of Federal Regulations (CFR) Title 42, Part 418 and Title 42 Part 489.102, Subpart I.

Effective October 1, 1997, the Nevada Revised Statutes (NRS) Chapter 422.304 mandated reimbursement for hospice care under the Medicaid State Plan.

Patient Protection and Affordable Care Act (PPACA) Section 2302.

Health Care and Education Affordability Reconciliation Act of 2010.



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3203 POLICY~~Y~~

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3203.1 HOSPICE SERVICES
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Hospice services must be identified in the established plan of care; maintain a high standard of quality and be reasonable and necessary to palliate or manage the terminal illness and related conditions. *Hospice means a public agency or private organization or subdivision of either of these that is primarily engaged in providing hospice care as defined in this section. Hospice care means a comprehensive set of services identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care. For purposes of this chapter, an adult recipient is considered 21 years of age or older.*

All services must be provided in accordance with recognized professional standards of practice and within the limitations and exclusions hereinafter specified, as described in the Centers for Medicare and Medicaid Services (CMS) – State Operations Manual (SOM) and the Code of Federal Regulations (CFR) Title 42, Part 418 which sets forth the Conditions of Participation (COP). The COP is the eligibility, health and safety requirements that all hospices are required to meet. COPs also provide a guide for continuous quality improvement and current standards of practice.

~~For children under the age of 21, a voluntary election for hospice services shall not constitute a waiver of any rights of the child to be provided with, or to have payment made for, services that are related to the treatment of the child's condition for which a diagnoses of terminal illness has been made.~~

Recipients under the age of 21 are entitled to concurrent care under the Affordable Care Act (ACA), that is curative care and palliative care at the same time while an eligible recipient of the Medicaid Hospice Program. Upon turning 21 years of age, the recipient will no longer have concurrent care benefits and will be subject to the rules governing adults who have elected Medicaid hospice care. Pediatric hospice care is both a philosophy and an organized method for delivering competent, compassionate and consistent care to children with terminal illness and their families. This care focuses on enhancing quality of life, minimizing suffering, optimizing function and providing opportunities for personal and spiritual growth, planned and delivered through the collaborative efforts of an interdisciplinary team with the child, family and caregivers as its center..

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Should a terminally ill adult recipient elect to receive hospice care, he or she must waive all rights to Medicaid payments for the duration of the election of hospice care for any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services:

- a. Provided (either directly or under arrangement) by the designated hospice;
- b. Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services; or
- c. Provided as room and board by a Nursing Facility (NF) if the individual is a resident.
- d. Provided by a Home and Community-Based Waiver (HCBW) whose services do not duplicate hospice services.
- e. ~~Refer to Section 3203.4 for revocation and re-election of hospice benefits.~~

A hospice program may arrange for another individual or entity to furnish services to the hospice's recipients. If services are provided under arrangement, the hospice must meet the following standards:

- f. Continuity of Care: The hospice program assures the continuity of recipient/family care in home, outpatient, and inpatient settings;
- g. Written Agreement: The hospice has a legally binding written agreement for the provision of arranged services. The agreement includes at least the following:
 1. Identification of the services to be provided;
 2. A stipulation that services may be provided only with the express authorization of the hospice;
 3. The manner in which the contracted services are coordinated, supervised, and evaluated by the hospice;
 4. The delineation of the role(s) of the hospice and the contractor in the admission process, recipient/family assessment, and the interdisciplinary group care conferences;
 5. Requirements for documenting services are furnished in accordance with the agreement; and
 6. The qualification of the personnel providing the services.

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Professional Management Responsibility: Professional management responsibility. The hospice retains professional management responsibility for those services and ensures that they are furnished in a safe and effective manner by persons meeting the qualifications, and in accordance with the recipient's Plan of Care (POC) and other requirements.

4. Level of Care (LOC)

- a. Routine Home Care: The reimbursement rate for routine home care is made without regard to the intensity or volume of routine home care services on any specific day.
- b. Continuous Home Care:
 - 1. Continuous home care is only furnished during brief periods of crisis, described as a period in which a recipient requires continuous care to achieve palliation or management of acute medical symptoms, and only as necessary to maintain the terminally ill recipient at home.
 - 2. Nursing care must be provided by an RN or Licensed Practical Nurse (LPN) and the nurse (RN or LPN) must be providing care for more than half of the period of care. HHA or homemaker services or both may be provided on a continuous basis.
 - 3. The hospice payment on a continuous care day varies depending on the number of hours of continuous services provided. The continuous home care rate is divided by 24 to yield an hourly rate. The number of hours of continuous home care day is then multiplied by the hourly rate to yield the continuous home care payment for that day.
- c. Inpatient Care (Respite or General):
 - 1. The appropriate inpatient rate (general or respite) is paid depending on the category of care furnished on any day on which the recipient is an inpatient in an approved facility. The inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days, except the day on which the recipient is discharged. For the day of discharge, the appropriate home care rate is paid unless the recipient is deceased; the discharge day is then paid at the general or respite rate.
 - 2. Inpatient care must be provided by a facility that has a written contract with the hospice. This may be an approved Nursing Facility, hospital or hospice capable of providing inpatient care.

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3. Respite care is short-term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient. Respite care may be provided on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Payment for the sixth and any subsequent day of respite care is made at the routine home care rate.
4. Time limited for reimbursement: In a 12-month period the inpatient reimbursement is subject to the following limitation. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20% of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Refer to the 42 CFR 418.302 for further information on the calculation of the inpatient limitation.
5. Optional Cap on Overall Hospice Reimbursement
 5. The DHCFP may limit overall aggregate payments made to a hospice during a hospice cap period. The cap period runs from November 1st of each year through October 31st of the next year. The total payment made for services furnished to Medicaid beneficiaries during this period is compared to the “cap amount” for this period. Any payments in excess of the cap must be refunded by the hospice.

3203.1A COVERAGE AND LIMITATIONS

~~Persons who are designated Nevada Medicaid recipients, have been certified as terminally ill and have filed an election statement for hospice care are eligible for hospice benefits.~~

1. Eligibility Requirements
 - ~~a.~~ a. Determination of Medicaid eligibility by the Division of Welfare and Supportive Services (DWSS);
 - b.
 - ~~b.~~ Certification of terminal illness: ~~(refer to Section 3203.1B.1.d)~~; and
 - c. Election of Hospice Care - ~~Anan~~ individual who is a designated Nevada Medicaid recipient, and has been certified as terminally ill. may file an election statement with a licensed hospice provider who is contracted with the Division of Health Care Financing and Policy (DHCFP). If the recipient is physically or mentally incapacitated, his or her representative may file the election statement: **A signed hospice election statement which must include the following:**
 1. Identification of the particular hospice that will provide care to the recipient;

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2. The recipient's or representative's acknowledgment he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as related to the individual's terminal illness;
3. Acknowledgment that certain otherwise covered services are waived by the election, except for children under the age of 21;
4. The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date the election statement was executed and the date certification was made; and
5. The signature of the recipient or representative.

The hospice agency will not be reimbursed for hospice services unless all signed paperwork has been submitted to the QIO-like vendor.

e. ———.

2. Duration of Hospice Care

- a. An eligible recipient may elect to receive hospice care during one or more of the following election periods:
 1. An initial 90-day period;
 2. A subsequent 90-day period;
 3. An unlimited number of subsequent 60-day periods.
- b. An eligible recipient may receive an unlimited number of subsequent 60 day periods without a break in care as long as:
 1. The recipient is re-certified by the hospice physician;
 2. A hospice physician or Nurse Practitioner (NP) has a face-to-face encounter with the recipient to determine continued eligibility prior to the 180th day recertification, and prior to each subsequent recertification. The face-to-face encounter must occur no more than 30 calendar days prior to the 180th day benefit period recertification and no more than 30 calendar days prior to every subsequent recertification thereafter. These face-to-face encounters are used to gather clinical findings to determine continued eligibility for hospice services.
 3. The practitioner certifies that the recipient has a life expectancy of six

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months or less **if the illness runs its normal course.-**

4. The recipient does not revoke the election of hospice; and
5. The recipient in the care of a hospice remains appropriate for hospice care.

3. Hospice Care Services

Nursing services, physician services, and drugs and biologicals must be routinely available on a 24-hour basis; all other covered services must be available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions and provide these services in a manner consistent with accepted standards of practice.

The hospice must designate a Registered Nurse (RN) to: coordinate the implementation of the POC; to ensure that the nursing needs of the recipient are met as identified in the recipient's initial assessment, comprehensive assessment, and updated assessments; and coordinate and oversee all services for each recipient.

The following services are included in the hospice reimbursement when consistent with the POC. The services must be provided in accordance with recognized professional standards of practice.

- a. **Nursing Services:** Nursing services must comply with the following: The hospice must provide nursing care and services by or under the supervision of a qualified RN; a qualified RN is one who is authorized to practice as an RN by the Nevada State Board of Nursing or the licensing board in the state in which the RN is employed. Recipient care responsibilities of nursing personnel must be specified.
- b. **Medical Social Services:** Medical Social Services (MSS) must be provided by a qualified social worker, under the direction of a physician. A qualified social worker is a person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education and is licensed to practice social work in the State of Nevada or the state in which the social worker is employed.
- c. **Physician Services:** In addition to palliative care and management of the terminal illness and related conditions, physician employees of the hospice, including the physician member(s) of the interdisciplinary group, must also meet the general medical needs of the recipients to the extent these needs are not met by the attending physician.

1. Reimbursement for physician supervisory and interdisciplinary group services for those physicians employed by the hospice agency is included in the rate paid to the agency.

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2. Costs for administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. These activities include participation in the establishment of POCs and services, periodic review and updating of POCs, and contribute to establishment of governing policies.
 3. Direct recipient care provided by the medical director, hospice-employed physician, or consulting physician should be billed in accordance with the usual Medicaid reimbursement and is paid directly to the physician.
 4. Medicaid reimbursement will be paid directly to an independent attending physician and will be made in accordance with the usual Medicaid reimbursement methodology for physician services and is not based on whether the services are for the terminal illness or an unrelated condition. Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.
- d. Counseling Services: Counseling services are available to both the individual and the family. Counseling includes bereavement counseling, dietary, spiritual and any other counseling services for the individual and family provided while the individual is enrolled in the hospice. Bereavement counseling **means emotional, psychosocial, and spiritual support and services provided before and after the death of the recipient to assist with issues related to grief, loss, and adjustment** for the client's family and significant others, as identified in the POC, **and** must be provided for up to one year after the recipient's death and is not reimbursable per 42 CFR 418.204.(c).
- e. Medical Appliances, Supplies and Pharmaceuticals:
1. Medical supplies include those that are part of the written POC. Only drugs which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are 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 client's terminal illness. Equipment is provided by the hospice for use in the recipient's home while he or she is under hospice care and the reimbursement for this is included in the rates calculated for all levels of hospice care.

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Drugs, supplies and durable medical equipment prescribed for conditions other than for the palliative care and management of the terminal illness are not covered benefits under the Nevada Medicaid hospice program and are to be billed in accordance with the appropriate Medicaid Services Manual (MSM) chapter for those services. **Effective December 1, 2015, all recipients identified as on Hospice in the eligibility system will require a prior authorization approval for pain medications and antineoplastic (chemotherapy). The terminal diagnosis will be required on the PA form. Medication therapy that is related to the terminal illness will be denied because it will be covered by the hospice provider. Medications not related to the terminal illness will be payable by Medicaid. For questions please call Optum at (855)-455-3311.**

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- f. Home Health Aide (HHA), Personal Care Aide (PCA) and Homemaker Services: HHA services and homemaker services when provided under the general supervision of an RN. Services may include personal care services and such household services which may be necessary to maintain a safe and sanitary environment in the areas of the home used by the recipient.

Physical Therapy (PT), Occupational Therapy (OT), Respiratory Therapy and Speech-Language Pathology Services: PT, OT, respiratory therapy and speech-language pathology when provided for the purpose of symptom control, or to enable the recipient to maintain Activities of Daily Living (ADLs) and basic functional skills.

CONDITIONS OF PARTICIPATION: (Refer to CFR 418.52- 418.78)

Condition of participation: Recipient's rights.

The recipient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights.

(a) *Standard: Notice of rights and responsibilities.* (1) During the initial assessment visit in advance of furnishing care the hospice must provide the recipient or representative with verbal (meaning spoken) and written notice of the recipients rights and responsibilities in a language and manner that the recipient understands.

~~(2) The hospice must comply with the requirements of subpart I of part 489 of this chapter regarding advance directives.~~ The hospice must inform and distribute written information to the recipient concerning its policies on advance directives, including a description of applicable State law.

~~(3) The hospice must obtain the patient's or representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities.~~

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~~(b) Standard: Exercise of rights and respect for property and person. (1) The patient has the right:~~

~~(i) To exercise his or her rights as a patient of the hospice;~~

~~(ii) To have his or her property and person treated with respect;~~

~~(iii) To voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and~~

~~(iv) To not be subjected to discrimination or reprisal for exercising his or her rights.~~

~~(2) If a recipient has been adjudged incompetent under state law by a court of proper jurisdiction, the rights of the recipient are exercised by the person appointed pursuant to state law to act on the recipient's behalf.~~

~~(3) If a state court has not adjudged a recipient incompetent, any legal representative designated by the recipient in accordance with state law may exercise the recipient's rights to the extent allowed by state law.~~

~~(4) The hospice must:~~

~~(i) Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the hospice, are reported immediately by hospice employees and contracted staff to the hospice administrator;~~

~~(ii) Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all alleged violations must be conducted in accordance with established procedures;~~

~~(iii) Take appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency; and~~

~~(iv) Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within 5 working days of becoming aware of the violation.~~

~~(c) Standard: Rights of the recipient. The recipient has a right to the following:~~

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(1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness;

(2) Be involved in developing his or her hospice plan of care;

(3) Refuse care or treatment;

(4) Choose his or her attending physician;

~~(5) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.~~

~~(6) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property;~~

(7) Receive information about the services covered under the hospice benefit;

(8) Receive information about the scope of services that the hospice will provide and specific limitations on those services.

Condition of participation: Initial and comprehensive assessment of the recipient.

The hospice must conduct and document in writing a recipient-specific comprehensive assessment that identifies the recipient's need for hospice care and services, and the recipient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.

~~(a) *Standard: Initial assessment.* The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with §418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.)~~

~~(b) *Standard: Timeframe for completion of the comprehensive assessment.* The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24.~~

(c) *Standard: Content of the comprehensive assessment.* The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice recipient's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment must take into consideration the following factors:

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(1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints).

(2) Complications and risk factors that affect care planning.

(3) Functional status, including the recipient's ability to understand and participate in his or her own care.

(4) Imminence of death.

(5) Severity of symptoms.

~~(6) *Drug profile.* A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:~~

~~(i) Effectiveness of drug therapy.~~

~~(ii) Drug side effects.~~

~~(iii) Actual or potential drug interactions.~~

~~(iv) Duplicate drug therapy.~~

~~(v) Drug therapy currently associated with laboratory monitoring.~~

(7) *Bereavement.* An initial bereavement assessment of the needs of the recipient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the recipient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.

~~(8) The need for referrals and further evaluation by appropriate health professionals.~~

~~(d) *Standard: Update of the comprehensive assessment.* The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.~~

~~(e) *Standard: Patient outcome measures.* (1) The comprehensive assessment must include data elements that allow for measurement of outcomes. The hospice must measure and document data in~~

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~~the same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation.~~

~~(2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.~~

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Condition of participation: Interdisciplinary group, care planning, and coordination of services.

~~The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient. The plan of care must specify the hospice care and services necessary to meet the patient and family specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.~~

~~(a) *Standard: Approach to service delivery.* (1) The hospice must designate an interdisciplinary group or groups composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services. The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care. The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:~~

~~(i) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice).~~

~~(ii) A registered nurse.~~

~~(iii) A social worker.~~

~~(iv) A pastoral or other counselor.~~

~~(2) If the hospice has more than one interdisciplinary group, it must identify a specifically designated interdisciplinary group to establish policies governing the day-to-day provision of hospice care and services.~~

~~(b) *Standard: Plan of care.* All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.~~

~~(c) *Standard: Content of the plan of care.* The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management~~

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~~of the terminal illness and related conditions, including the following:~~

~~(1) Interventions to manage pain and symptoms.~~

~~(2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.~~

~~(3) Measurable outcomes anticipated from implementing and coordinating the plan of care.~~

~~(4) Drugs and treatment necessary to meet the needs of the patient.~~

~~(5) Medical supplies and appliances necessary to meet the needs of the patient.~~

~~(6) The interdisciplinary group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.~~

~~(d) Standard: Review of the plan of care. The hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care.~~

~~(e) Standard: Coordination of services. The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to—~~

~~(1) Ensure that the interdisciplinary group maintains responsibility for directing, coordinating, and supervising the care and services provided.~~

~~(2) Ensure that the care and services are provided in accordance with the plan of care.~~

~~(3) Ensure that the care and services provided are based on all assessments of the patient and family needs.~~

~~(4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.~~

~~(5) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.~~

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Condition of participation: Quality assessment and performance improvement.

The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.

~~(a) Standard: Program scope. (1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.~~

~~(2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.~~

~~(b) Standard: Program data. (1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.~~

~~(2) The hospice must use the data collected to do the following:~~

~~(i) Monitor the effectiveness and safety of services and quality of care.~~

~~(ii) Identify opportunities and priorities for improvement.~~

~~(3) The frequency and detail of the data collection must be approved by the hospice's governing body.~~

~~(c) Standard: Program activities. (1) The hospice's performance improvement activities must:~~

~~(i) Focus on high risk, high volume, or problem-prone areas.~~

~~(ii) Consider incidence, prevalence, and severity of problems in those areas.~~

~~(iii) Affect palliative outcomes, patient safety, and quality of care.~~

~~(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the~~

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~~hospice.~~

~~(3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.~~

~~(d) Standard: Performance improvement projects. Beginning February 2, 2009 hospices must develop, implement, and evaluate performance improvement projects.~~

~~(1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations.~~

~~(2) The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.~~

~~(e) Standard: Executive responsibilities. The hospice's governing body is responsible for ensuring the following:~~

~~(1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.~~

~~(2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.~~

~~(3) That one or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated.~~

~~**–Condition of participation: Infection control.**~~

~~The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.~~

~~(a) Standard: Prevention. The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.~~

~~(b) Standard: Control. The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable~~

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~~diseases that—~~

~~(1) Is an integral part of the hospice's quality assessment and performance improvement program; and~~

~~(2) Includes the following:~~

~~(i) A method of identifying infectious and communicable disease problems; and~~

~~(ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.~~

~~(c) *Standard: Education.* The hospice must provide infection control education to employees, contracted providers, patients, and family members and other caregivers.~~

~~**—Condition of participation: Licensed professional services.**~~

~~(a) Licensed professional services provided directly or under arrangement must be authorized, delivered, and supervised only by health care professionals who meet the appropriate qualifications specified under §418.114 and who practice under the hospice's policies and procedures.~~

~~(b) Licensed professionals must actively participate in the coordination of all aspects of the patient's hospice care, in accordance with current professional standards and practice, including participating in ongoing interdisciplinary comprehensive assessments, developing and evaluating the plan of care, and contributing to patient and family counseling and education; and~~

~~(c) Licensed professionals must participate in the hospice's quality assessment and performance improvement program and hospice-sponsored in-service training.~~

~~**—Condition of participation: Core services.**~~

~~A hospice must routinely provide substantially all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section. A hospice may use~~

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~~contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. A hospice may also enter into a written arrangement with another Medicare certified hospice program for the provision of core services to supplement hospice employee/staff to meet the needs of patients. Circumstances under which a hospice may enter into a written arrangement for the provision of core services include: Unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care; and temporary travel of a patient outside of the hospice's service area.~~

~~(a) *Standard: Physician services.* The hospice medical director, physician employees, and contracted physician(s) of the hospice, in conjunction with the patient's attending physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness.~~

~~(1) All physician employees and those under contract, must function under the supervision of the hospice medical director.~~

~~(2) All physician employees and those under contract shall meet this requirement by either providing the services directly or through coordinating patient care with the attending physician.~~

~~(3) If the attending physician is unavailable, the medical director, contracted physician, and/or hospice physician employee is responsible for meeting the medical needs of the patient.~~

~~(b) *Standard: Nursing services.* (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments.~~

~~(2) If State law permits registered nurses to see, treat, and write orders for patients, then registered nurses may provide services to beneficiaries receiving hospice care.~~

~~(3) Highly specialized nursing services that are provided so infrequently that the provision of such services by direct hospice employees would be impracticable and prohibitively expensive, may be provided under contract.~~

~~(c) *Standard: Medical social services.* Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services.~~

~~(d) *Standard: Counseling services.* Counseling services must be available to the patient and family to assist the patient and family in minimizing the stress and problems that arise from the terminal illness, related conditions, and the dying process. Counseling services must include, but are~~

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~~not limited to, the following:~~

~~(1) Bereavement counseling. The hospice must:~~

~~(i) Have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling.~~

~~(ii) Make bereavement services available to the family and other individuals in the bereavement plan of care up to 1 year following the death of the patient. Bereavement counseling also extends to residents of a SNF/NF or ICF/IID when appropriate and identified in the bereavement plan of care.~~

~~(iii) Ensure that bereavement services reflect the needs of the bereaved.~~

~~(iv) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery. A special coverage provision for bereavement counseling is specified in §418.204(c).~~

~~(2) Dietary counseling. Dietary counseling, when identified in the plan of care, must be performed by a qualified individual, which include dietitians as well as nurses and other individuals who are able to address and assure that the dietary needs of the patient are met.~~

~~(3) Spiritual counseling. The hospice must:~~

~~(i) Provide an assessment of the patient's and family's spiritual needs.~~

~~(ii) Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires.~~

~~(iii) Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability.~~

~~(iv) Advise the patient and family of this service.~~

~~**—Condition of participation: Nursing services—Waiver of requirement that substantially all nursing services be routinely provided directly by a hospice.**~~

~~(a) CMS may waive the requirement in §418.64(b) that a hospice provide nursing services directly, if the hospice is located in a non-urbanized area. The location of a hospice that operates in several areas is considered to be the location of its central office. The hospice must provide evidence to CMS that it has made a good faith effort to hire a sufficient number of nurses to provide services.~~

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~~CMS may waive the requirement that nursing services be furnished by employees based on the following criteria:~~

- ~~(1) The location of the hospice's central office is in a non-urbanized area as determined by the Bureau of the Census.~~
- ~~(2) There is evidence that a hospice was operational on or before January 1, 1983 including the following:~~
 - ~~(i) Proof that the organization was established to provide hospice services on or before January 1, 1983.~~
 - ~~(ii) Evidence that hospice-type services were furnished to patients on or before January 1, 1983.~~
 - ~~(iii) Evidence that hospice care was a discrete activity rather than an aspect of another type of provider's patient care program on or before January 1, 1983.~~
- ~~(3) By virtue of the following evidence that a hospice made a good faith effort to hire nurses:~~
 - ~~(i) Copies of advertisements in local newspapers that demonstrate recruitment efforts.~~
 - ~~(ii) Job descriptions for nurse employees.~~
 - ~~(iii) Evidence that salary and benefits are competitive for the area.~~
 - ~~(iv) Evidence of any other recruiting activities (for example, recruiting efforts at health fairs and contacts with nurses at other providers in the area).~~
- ~~(b) Any waiver request is deemed to be granted unless it is denied within 60 days after it is received.~~
- ~~(c) Waivers will remain effective for 1 year at a time from the date of the request.~~
- ~~(d) If a hospice wishes to receive a 1-year extension, it must submit a request to CMS before the expiration of the waiver period, and certify that the conditions under which it originally requested the initial waiver have not changed since the initial waiver was granted.~~

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~~—Condition of participation: Furnishing of non-core services.~~

~~A hospice must ensure that the services described in §418.72 through §418.78 are provided directly by the hospice or under arrangements made by the hospice as specified in §418.100. These services must be provided in a manner consistent with current standards of practice.~~

~~—Condition of participation: Physical therapy, occupational therapy, and speech-language pathology.~~

~~Physical therapy services, occupational therapy services, and speech-language pathology services must be available, and when provided, offered in a manner consistent with accepted standards of practice.~~

~~—Waiver of requirement—Physical therapy, occupational therapy, speech-language pathology, and dietary counseling.~~

~~(a) A hospice located in a non-urbanized area may submit a written request for a waiver of the requirement for providing physical therapy, occupational therapy, speech-language pathology, and dietary counseling services. The hospice may seek a waiver of the requirement that it make physical therapy, occupational therapy, speech-language pathology, and dietary counseling services (as needed) available on a 24-hour basis. The hospice may also seek a waiver of the requirement that it provide dietary counseling directly. The hospice must provide evidence that it has made a good faith effort to meet the requirements for these services before it seeks a waiver. CMS may approve a waiver application on the basis of the following criteria:~~

~~(1) The hospice is located in a non-urbanized area as determined by the Bureau of the Census.~~

~~(2) The hospice provides evidence that it had made a good faith effort to make available physical therapy, occupational therapy, speech-language pathology, and dietary counseling services on a 24-hour basis and/or to hire a dietary counselor to furnish services directly. This evidence must include the following:~~

~~(i) Copies of advertisements in local newspapers that demonstrate recruitment efforts.~~

~~(ii) Physical therapy, occupational therapy, speech-language pathology, and dietary counselor job descriptions.~~

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~~(iii) Evidence that salary and benefits are competitive for the area.~~

~~(iv) Evidence of any other recruiting activities (for example, recruiting efforts at health fairs and contact discussions with physical therapy, occupational therapy, speech language pathology, and dietary counseling service providers in the area).~~

~~(b) Any waiver request is deemed to be granted unless it is denied within 60 days after it is received.~~

~~(c) An initial waiver will remain effective for 1 year at a time from the date of the request.~~

~~(d) If a hospice wishes to receive a 1-year extension, it must submit a request to CMS before the expiration of the waiver period and certify that conditions under which it originally requested the waiver have not changed since the initial waiver was granted.~~

~~**Condition of participation: Hospice aide and homemaker services.**~~

~~All hospice aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Homemaker services must be provided by individuals who meet the personnel requirements specified in paragraph (j) of this section.~~

~~(a) Standard: Hospice aide qualifications. (1) A qualified hospice aide is a person who has successfully completed one of the following:~~

~~(i) A training program and competency evaluation as specified in paragraphs (b) and (c) of this section respectively.~~

~~(ii) A competency evaluation program that meets the requirements of paragraph (c) of this section.~~

~~(iii) A nurse aide training and competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154 of this chapter, and is currently listed in good standing on the State nurse aide registry.~~

~~(iv) A State licensure program that meets the requirements of paragraphs (b) and (c) of this section.~~

~~(2) A hospice aide is not considered to have completed a program, as specified in paragraph (a)(1) of this section, if, since the individual's most recent completion of the program(s), there has been a continuous period of 24 consecutive months during which none of the services furnished by~~

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~~the individual as described in §409.40 of this chapter were for compensation. If there has been a 24-month lapse in furnishing services, the individual must complete another program, as specified in paragraph (a)(1) of this section, before providing services.~~

~~(b) Standard: Content and duration of hospice aide classroom and supervised practical training.~~

~~(1) Hospice aide training must include classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse, or a licensed practical nurse, who is under the supervision of a registered nurse. Classroom and supervised practical training combined must total at least 75 hours.~~

~~(2) A minimum of 16 hours of classroom training must precede a minimum of 16 hours of supervised practical training as part of the 75 hours.~~

~~(3) A hospice aide training program must address each of the following subject areas:~~

~~(i) Communication skills, including the ability to read, write, and verbally report clinical information to patients, care givers, and other hospice staff.~~

~~(ii) Observation, reporting, and documentation of patient status and the care or service furnished.~~

~~(iii) Reading and recording temperature, pulse, and respiration.~~

~~(iv) Basic infection control procedures.~~

~~(v) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor.~~

~~(vi) Maintenance of a clean, safe, and healthy environment.~~

~~(vii) Recognizing emergencies and the knowledge of emergency procedures and their application.~~

~~(viii) The physical, emotional, and developmental needs of and ways to work with the populations served by the hospice, including the need for respect for the patient, his or her privacy, and his or her property.~~

~~(ix) Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist:~~

~~(A) Bed bath.~~

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~~(B) Sponge, tub, and shower bath.~~

~~(C) Hair shampoo (sink, tub, and bed).~~

~~(D) Nail and skin care.~~

~~(E) Oral hygiene.~~

~~(F) Toileting and elimination.~~

~~(x) Safe transfer techniques and ambulation.~~

~~(xi) Normal range of motion and positioning.~~

~~(xii) Adequate nutrition and fluid intake.~~

~~(xiii) Any other task that the hospice may choose to have an aide perform. The hospice is responsible for training hospice aides, as needed, for skills not covered in the basic checklist, as described in paragraph (b)(3)(ix) of this section.~~

~~(4) The hospice must maintain documentation that demonstrates that the requirements of this standard are met.~~

~~(c) *Standard: Competency evaluation.* An individual may furnish hospice aide services on behalf of a hospice only after that individual has successfully completed a competency evaluation program as described in this section.~~

~~(1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (b)(3)(iii), (b)(3)(ix), (b)(3)(x) and (b)(3)(xi) of this section must be evaluated by observing an aide's performance of the task with a patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient.~~

~~(2) A hospice aide competency evaluation program may be offered by any organization, except as described in paragraph (f) of this section.~~

~~(3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate.~~

~~(4) A hospice aide is not considered competent in any task for which he or she is evaluated as unsatisfactory. An aide must not perform that task without direct supervision by a registered nurse until after he or she has received training in the task for which he or she was evaluated as~~

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~~“unsatisfactory,” and successfully completes a subsequent evaluation. A hospice aide is not considered to have successfully completed a competency evaluation if the aide has an “unsatisfactory” rating in more than one of the required areas.~~

~~(5) The hospice must maintain documentation that demonstrates the requirements of this standard are being met.~~

~~(d) *Standard: In-service training.* A hospice aide must receive at least 12 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient.~~

~~(1) In-service training may be offered by any organization, and must be supervised by a registered nurse.~~

~~(2) The hospice must maintain documentation that demonstrates the requirements of this standard are met.~~

~~(e) *Standard: Qualifications for instructors conducting classroom and supervised practical training.* Classroom and supervised practical training must be performed by a registered nurse who possesses a minimum of 2 years nursing experience, at least 1 year of which must be in home care, or by other individuals under the general supervision of a registered nurse.~~

~~(f) *Standard: Eligible competency evaluation organizations.* A hospice aide competency evaluation program as specified in paragraph (c) of this section may be offered by any organization except by a home health agency that, within the previous 2 years:~~

~~(1) Had been out of compliance with the requirements of §484.36(a) and §484.36 (b) of this chapter.~~

~~(2) Permitted an individual that does not meet the definition of a “qualified home health aide” as specified in §484.36(a) of this chapter to furnish home health aide services (with the exception of licensed health professionals and volunteers).~~

~~(3) Had been subjected to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State).~~

~~(4) Had been assessed a civil monetary penalty of \$5,000 or more as an intermediate sanction.~~

~~(5) Had been found by CMS to have compliance deficiencies that endangered the health and safety of the home health agency's patients and had temporary management appointed to oversee the management of the home health agency.~~

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~~(6) Had all or part of its Medicare payments suspended.~~

~~(7) Had been found by CMS or the State under any Federal or State law to have:~~

~~(i) Had its participation in the Medicare program terminated.~~

~~(ii) Been assessed a penalty of \$5,000 or more for deficiencies in Federal or State standards for home health agencies.~~

~~(iii) Been subjected to a suspension of Medicare payments to which it otherwise would have been entitled.~~

~~(iv) Operated under temporary management that was appointed by a governmental authority to oversee the operation of the home health agency and to ensure the health and safety of the home health agency's patients.~~

~~(v) Been closed by CMS or the State, or had its patients transferred by the State.~~

~~(g) Standard: Hospice aide assignments and duties. (1) Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section.~~

~~(2) A hospice aide provides services that are:~~

~~(i) Ordered by the interdisciplinary group.~~

~~(ii) Included in the plan of care.~~

~~(iii) Permitted to be performed under State law by such hospice aide.~~

~~(iv) Consistent with the hospice aide training.~~

~~(3) The duties of a hospice aide include the following:~~

~~(i) The provision of hands-on personal care.~~

~~(ii) The performance of simple procedures as an extension of therapy or nursing services.~~

~~(iii) Assistance in ambulation or exercises.~~

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~~(iv) Assistance in administering medications that are ordinarily self-administered.~~

~~(4) Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and improvement activities. Hospice aides must also complete appropriate records in compliance with the hospice's policies and procedures.~~

~~(h) Standard: Supervision of hospice aides. (1) A registered nurse must make an on-site visit to the patient's home:~~

~~(i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit.~~

~~(ii) If an area of concern is noted by the supervising nurse, then the hospice must make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while he or she is performing care.~~

~~(iii) If an area of concern is verified by the hospice during the on-site visit, then the hospice must conduct, and the hospice aide must complete a competency evaluation in accordance with §418.76(c).~~

~~(2) A registered nurse must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care.~~

~~(3) The supervising nurse must assess an aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria that include, but is not limited to—~~

~~(i) Following the patient's plan of care for completion of tasks assigned to the hospice aide by the registered nurse.~~

~~(ii) Creating successful interpersonal relationships with the patient and family.~~

~~(iii) Demonstrating competency with assigned tasks.~~

~~(iv) Complying with infection control policies and procedures.~~

~~(v) Reporting changes in the patient's condition.~~

~~(i) Standard: Individuals furnishing Medicaid personal care aide-only services under a Medicaid personal care benefit. An individual may furnish personal care services, as defined in §440.167 of this~~

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~~chapter, on behalf of a hospice agency.~~

~~(1) Before the individual may furnish personal care services, the individual must be found competent by the State (if regulated by the State) to furnish those services. The individual only needs to demonstrate competency in the services the individual is required to furnish.~~

~~(2) Services under the Medicaid personal care benefit may be used to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care.~~

~~(3) The hospice must coordinate its hospice aide and homemaker services with the Medicaid personal care benefit to ensure the patient receives the hospice aide and homemaker services he or she needs.~~

~~(j) Standard: Homemaker qualifications. A qualified homemaker is—~~

~~(1) An individual who meets the standards in §418.202(g) and has successfully completed hospice orientation addressing the needs and concerns of patients and families coping with a terminal illness; or~~

~~(2) A hospice aide as described in §418.76.~~

~~(k) Standard: Homemaker supervision and duties. (1) Homemaker services must be coordinated and supervised by a member of the interdisciplinary group.~~

~~(2) Instructions for homemaker duties must be prepared by a member of the interdisciplinary group.~~

~~(3) Homemakers must report all concerns about the patient or family to the member of the interdisciplinary group who is coordinating homemaker services.~~

~~[73 FR 32204, June 5, 2008, as amended at 74 FR 39413, Aug. 6, 2009]~~

~~**Conditions of participation—Volunteers.**~~

~~The hospice must use volunteers to the extent specified in paragraph (e) of this section. These volunteers must be used in defined roles and under the supervision of a designated hospice employee.~~

~~(a) Standard: Training. The hospice must maintain, document, and provide volunteer orientation~~

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~~and training that is consistent with hospice industry standards.~~

~~(b) Standard: Role. Volunteers must be used in day-to-day administrative and/or direct patient care roles.~~

~~(c) Standard: Recruiting and retaining. The hospice must document and demonstrate viable and ongoing efforts to recruit and retain volunteers.~~

~~(d) Standard: Cost saving. The hospice must document the cost savings achieved through the use of volunteers. Documentation must include the following:~~

~~(1) The identification of each position that is occupied by a volunteer.~~

~~(2) The work time spent by volunteers occupying those positions.~~

~~(3) Estimates of the dollar costs that the hospice would have incurred if paid employees occupied the positions identified in paragraph (d)(1) of this section for the amount of time specified in paragraph (d)(2) of this section.~~

~~(e) Standard: Level of activity. Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of a paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked~~

3203.9 CLINICAL RECORDS¹

In accordance with accepted principles of practice, the hospice must establish and maintain a clinical record for every individual receiving care and services. The record must be complete promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval. The clinical record may be maintained electronically.

Each clinical record is a comprehensive compilation of information. Entries are made for all services provided. Entries are made and signed by the person providing the services. The record includes all services whether furnished directly or under arrangements made by the hospice.

Each individual's record must contain:

1. The comprehensive, initial and subsequent assessments;
2. The initial and updated POCs;

¹ see conditions of participation

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3. Identification data;
4. Consent and authorization and election forms;
5. Documentation the client has received and signed a statement of “Recipient Rights”;
6. A complete drug profile; responses to medications, symptom management, treatments and services;
7. Pertinent medical history; Physicians certification and re-certifications of terminal illness and any Advanced Directives; and
8. Complete documentation of all services and events (including evaluations, treatments progress notes, physician orders etc.).

The hospice must safeguard the clinical record against loss, destruction, and unauthorized use. The recipient’s clinical record must be retained after the death or discharge of the recipient for a period of six years. If the hospice discontinues operation, hospice policies must provide for retention and storage of clinical records. The hospice must inform Medicaid and the CMS Regional office where such clinical records will be stored and how they may be accessed.

g.
4. ~~Level of Care (LOC)~~

a. ~~Routine Home Care: The reimbursement rate for routine home care is made without regard to the intensity or volume of routine home care services on any specific day.~~

b. ~~Continuous Home Care:~~

1. ~~Continuous home care is only furnished during brief periods of crisis, described as a period in which a recipient requires continuous care to achieve palliation or management of acute medical symptoms, and only as necessary to maintain the terminally ill recipient at home.~~

2. ~~Nursing care must be provided by an RN or Licensed Practical Nurse (LPN) and the nurse (RN or LPN) must be providing care for more than half of the period of care. HHA or homemaker services or both may be provided on a continuous basis.~~

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~~3. The hospice payment on a continuous care day varies depending on the number of hours of continuous services provided. The continuous home care rate is divided by 24 to yield an hourly rate. The number of hours of continuous home care day is then multiplied by the hourly rate to yield the continuous home care payment for that day.~~

~~e. Inpatient Care (Respite or General):~~

~~1. The appropriate inpatient rate (general or respite) is paid depending on the category of care furnished on any day on which the recipient is an inpatient in an approved facility. The inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days, except the day on which the recipient is discharged. For the day of discharge, the appropriate home care rate is paid unless the recipient is deceased; the discharge day is then paid at the general or respite rate.~~

~~2. Inpatient care must be provided by a facility that has a written contract with the hospice. This may be an approved Nursing Facility, hospital or hospice capable of providing inpatient care.~~

~~3. Respite care is short term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient. Respite care may be provided on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Payment for the sixth and any subsequent day of respite care is made at the routine home care rate.~~

~~4. Time limited for reimbursement: In a 12-month period the inpatient reimbursement is subject to the following limitation. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20% of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Refer to the 42 CFR 418.302 for further information on the calculation of the inpatient limitation.~~

~~5. Optional Cap on Overall Hospice Reimbursement~~

~~The DHCFP may limit overall aggregate payments made to a hospice during a hospice cap period. The cap period runs from November 1st of each year through October 31st of the next year. The total payment made for services furnished to Medicaid beneficiaries during this period is compared to the "cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice.~~

3203.1B PROVIDER RESPONSIBILITY

THE HOSPICE PROVIDER IS RESPONSIBLE FOR THE COORDINATION OF SERVICES TO ENSURE THERE IS NO DUPLICATION OF SERVICES.

1. Recipient Enrollment Process

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All Nevada Medicaid recipients, including those with primary insurance such as Medicare or a private insurance, must be enrolled in Nevada Medicaid's Hospice Program regardless of where hospice services are provided.

NOTE: Enrollment paperwork for hospice recipients who are pending a Nevada Medicaid eligibility determination should not be submitted until Medicaid benefits have been approved. All enrollment forms must be received by the Quality Improvement Organization (QIO)-like vendor within 60 days of the date of decision of eligibility determination.

For the initial election period the DHCFP requires the following documentation be received by the QIO-like vendor within five working days of the hospice admission:

a. **Nevada Medicaid Hospice Election Form; and**

a. ~~Hospice Medicaid Information Election form;~~

b. ~~Hospice Ancillary Information form;~~

e.b.—Physician Certification of Terminal Illness:

1. The hospice must obtain written certification of terminal illness, within two calendar days of initiation of services, signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician. If the recipient does not have an attending physician, this must be indicated on the Hospice Medicaid ~~Information Election~~ Form. If the hospice cannot obtain a written certification within two days a verbal certification may be obtained within these two days, and a written certification obtained no later than eight days after care is initiated. If these requirements are not met, no payment will be made for days prior to the certification. Both the certification and election of hospice services statement must be in place for payment to commence. Ideally, the dates on the certification statement and the election statement should match, but if they differ, the earliest date will be the date payment will begin.

d. The certification of terminal illness must meet the following requirements:

1. The certification must specify that the recipient's prognosis is terminal and life expectancy is six months or less.

2. Clinical information and other documentation that supports the medical prognosis must accompany the certification and must be filed in the medical record with the written certification. Initially, the clinical **information may be provided verbally, and must be documented in the medical record and included as part of the recipient's eligibility assessment.**

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3. The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of six months or less as part of the certification and re-certification.

4. Each pediatric hospice provider will develop a training curriculum to ensure that the hospice's interdisciplinary team members, including volunteers, are adequately trained to provide hospice care to clients who are under 21 years of age. All staff members and volunteers providing pediatric hospice care must receive the training prior to provision of services, and at least annually thereafter. At a minimum, the training will include the following pediatric specific elements:

- (a) Growth and development
- (b) Communication with family, community and interdisciplinary team.
- (c) Psycho-social/spiritual care of children
- (d) Coordination of care with the child's community
- (e) Plans of Care
- (f) Pediatric pain and symptom management
- (g) Loss, grief and bereavement for pediatric families and the child.

HOSPICE RECIPIENTS RESIDING IN A NURSING FACILITY

~~Recipients residing in a Nevada Medicaid approved NF are eligible for hospice care pursuant to policies identified in 3203.1.~~

3203.6A COVERAGE AND LIMITATIONS

The hospice recipient residing in a Skilled Nursing Facility (SNF) must not experience any lack of services or personal care because of his or her status as a hospice recipient. The NF must offer the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. The recipient has the right to refuse any services.

The NF must continue to still comply with all requirements for participation in Medicare and/or Medicaid for hospice-enrolled Nevada Medicaid residents.

1. 3203.6B PROVIDER RESPONSIBILITIES Nursing Facility Screenings

Refer to MSM Chapter 500 for specific guidelines regarding NF screenings.

All hospice enrolled recipients must have a Pre-Admission Screening and Resident Review (PASRR) and a LOC Screening prior to admission to an NF. Requests for these screenings are done by calling the QIO-like vendor.

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The requests can be made by either the NF or the hospice agency.

- a. The NF is responsible for:
 1. Ensuring the hospice recipient has:
 - a. A valid PASRR determination, and
 - b. A LOC screening indicating appropriate NF placement.
 2. Verifies that the necessary screenings are completed prior to admission and must monitor time-limited PASRR and LOC screenings in order to extend Medicaid reimbursement. Medicaid reimbursement is not available when PASRR and LOC screenings are not completed within the specified timeframes, which would be passed on to the NF.
 3. Submitting a Nursing Facility Tracking Form within 72 hours of occurrence.
- b. Prior to NF placement, the hospice agency must verify with the QIO-like vendor or NF that both screenings (PASRR, LOC) have been completed and that the hospice recipient is cleared for placement.

~~In addition to meeting **the conditions of participation** (see *hospice care services*), a hospice that provides hospice care to residents of a SNF/NF or ICF/IID must abide by the following additional standards:~~

~~(a) *Standard: Resident eligibility, election, and duration of benefits.* Recipients receiving hospice services and residing in a SNF, NF, or ICF/IID are subject to the Medicaid/Medicare hospice eligibility criteria set out at §418.20 through §418.30.~~

~~information may be provided verbally, and must be documented in the medical record and included as part of the recipient's eligibility assessment.~~

~~3. The physician must include a brief narrative explanation of the clinical~~

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~~findings that supports a life expectancy of six months or less as part of the certification and re-certification.~~

Non-Cancer Terminal Illness Certification Criteria² To Be Followed

CMS acknowledges that the primary diagnoses of hospice patients have shifted from cancers to non-cancer terminal illnesses.

CMS clarifies that "debility" and "adult failure to thrive" SHOULD NOT be used as principal hospice diagnoses on the hospice claim form. **When reported as a principal diagnosis, these would be considered questionable encounters for hospice care.**

Claims would be **returned to the provider (RTPd)** for a more definitive principal diagnosis. "Debility" and "adult failure to thrive" could be listed on the hospice claim as other, additional, or coexisting diagnoses. CMS expects providers to code the most definitive, contributory terminal diagnosis in the principal diagnosis field with all other related conditions in the additional diagnoses fields for hospice claims reporting.

(a) Hospice Criteria for Adult Failure to Thrive Syndrome

1. Terminal Illness Description: The adult failure to thrive syndrome is characterized by unexplained weight loss, malnutrition and disability. The syndrome has been associated with multiple primary conditions (e.g., infections and malignancies), but always includes two defining clinical elements, namely nutritional impairment and disability. The nutritional impairment and disability associated with the adult failure to thrive syndrome must be severe enough to impact the patient's short-term survival. The adult failure to thrive syndrome presents as an irreversible progression in the patient's nutritional impairment/disability despite therapy (i.e., treatment intended to affect the primary condition responsible for the patient's clinical presentation).

2. Criteria for initial certification or recertification: Criteria below must be present at the time of

initial certification or re-certification for hospice. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less if the terminal illness runs its normal course. Patients must meet **(i) and (ii)** below:

(i) The nutritional impairment associated with the

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adult failure to thrive syndrome must be severe enough to impact a beneficiary's weight. The Body Mass Index (BMI) of beneficiaries electing the Medicaid Hospice Benefit for the adult failure to thrive syndrome must be below 22 kg/m² and the patient must be either declining enteral/parenteral nutritional support or has not responded to such nutritional support.

(ii) The disability associated with the adult failure to thrive syndrome should be such that the individual is significantly disabled. Significant disability must be demonstrated by a Karnofsky or Palliative Performance Scale value less than or equal to 40%.

Both the recipient's BMI and level of disability should be determined using measurements/observations made within six months (180 days) of the most recent certification/recertification date. If enteral nutritional support has been instituted prior to the hospice election and will be continued, the BMI and level of disability should be determined using measurements/observations made at the time of the initial certification and at each subsequent recertification. At the time of recertification recumbent measurement(s) - (anthropometry) such as mid-arm circumference in cm may be substituted for BMI with documentation as to why a BMI could not be measured. This information will be subject to review on a case by case basis.

3. Reasons for Denial(i) Patients not meeting the specific medical criteria

in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

(iv) Patient is not eligible for full Medicaid benefits.

(b) **Hospice Criteria for Adult HIV Disease**

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Criteria for initial certification: Criteria below must be present at the time of **initial certification** for hospice. Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet the following criteria:

HIV Disease (i) and (ii) must be present; factors from (iii) will add supporting documentation)

(i) CD4+ Count less than 25 cells/mcL or persistent

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viral load greater than 100,000 copies/ml, plus **one** of the following:

- (I) CNS lymphoma
 - (II) Untreated, or not responsive to treatment, wasting (loss of 33% lean body mass)
 - (III) Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment, or treatment refused
 - (IV) Progressive multifocal leukoencephalopathy
 - (V) Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy
 - (VI) Visceral Kaposi's sarcoma unresponsive to therapy
 - (VII) Renal failure in the absence of dialysis
 - (VIII) Cryptosporidium infection
 - (IX) Toxoplasmosis, unresponsive to therapy
 - (ii) Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale, of less than or equal to 50
 - (iii) Documentation of the following factors will support eligibility for hospice care:
 - (I) Chronic persistent diarrhea for one year
 - (II) Persistent serum albumin less than 2.5 gm/dl
 - (III) Age greater than 50 years
 - (IV) Absence of antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease
 - (V) Advanced AIDS dementia complex
 - (VI) Toxoplasmosis
 - (VII) Congestive heart failure, symptomatic at rest, New York Heart Association (NYHA) classification Stage IV
3. Criteria for recertification: Criteria below must be present at the time of **recertification** for hospice. Both (i) and (ii) must be met. Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet one of the conditions in (i) and meet the requirement in (ii):
- (i) Persistent viral load greater than 100,000
 - (I) CNS lymphoma
 - (II) Untreated, or not responsive to treatment, wasting (loss of 33% lean body mass)
 - (III) Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment, or treatment refused
 - (IV) Progressive multifocal leukoencephalopathy
 - (V) Systemic lymphoma, unresponsive or partially responsive to chemotherapy
 - (VI) Visceral Kaposi's sarcoma unresponsive to therapy
 - (VII) Renal failure in the absence of dialysis
 - (VIII) Cryptosporidium infection

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(IX) Toxoplasmosis, unresponsive to therapy

(ii) Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale, of less than or equal to 50

(iii) Documentation of the following factors will support eligibility for hospice care:

(I) Chronic persistent diarrhea for one year

(II) Persistent serum albumin less than 2.5 gm/dl

(III) Age greater than 50 years prophylactic drug therapy related specifically to HIV disease

(V) Advanced AIDS dementia complex

(VI) Toxoplasmosis

(VII) Congestive heart failure, symptomatic at rest, New York Heart Association (NYHA) classification Stage IV

4. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy

(ii) Absence of supporting documentation of progression or rapid decline

(IV) Absence of antiretroviral, chemotherapeutic and (iii) Failure to document terminal status of six months or less.

(iv) Patient on antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease.

(v) Patient is not eligible for full Medicaid benefits.

(c) **Hospice Criteria for Adult Pulmonary Disease**

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Criteria for initial certification: Criteria below must be present at the time of **initial certification** for hospice. Patients will be considered to be in the terminal stage of pulmonary disease (life expectancy of six months or less) if they meet the following criteria. The criteria refer to patients with various forms of advanced pulmonary disease who eventually follow a final common pathway for end stage pulmonary disease:

(i) and (ii) must be present; documentation of (iii), (iv) and/or (v) will lend supporting documentation:

(i) Severe chronic lung disease as documented by both factors below:

(I) Patient with Forced Expiratory Volume in one second [FEV1], after bronchodilator, less than 30% of predicted and disabling dyspnea at rest, poorly responsive to

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bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough (documentation of Forced Expiratory Volume in one second [FEV1], after bronchodilator, less than 30% of predicted is objective evidence for disabling dyspnea and must be provided when performed). If the FEV1 has not been performed, the clinical condition must support an FEV1 less than 30% of predicted.

(II) Progression of end stage pulmonary disease as documented by two or more episodes of pneumonia or respiratory failure requiring ventilatory support within the last six months. Alternatively, medical record documentation of serial decrease in FEV1 greater than 40 ml/year for the past two years can be used to demonstrate progression.

(ii) Hypoxemia at rest on room air, with a current ABG PO2 at or below 59 mm Hg or oxygen saturation at or below 89% taken at rest or hypercapnia, as evidenced by PCO2 greater than or equal to 50 mmHg (these values may be obtained from recent hospital records).

(iii) Cor pulmonale and right heart failure (RHF) secondary to pulmonary disease (e.g. not secondary to left heart disease or valvulopathy).

(iv) Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.

(v) Resting tachycardia greater than 100/min.

3. Criteria for recertification: Criteria below must be present at the time of **recertification** for hospice. Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet (i) and (ii) below:

(i) Severe disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough.

(ii) Hypoxemia at rest on room air, with a current ABG PO2 at or below 59 mm Hg or oxygen saturation at or below 89% taken at rest or hypercapnia as evidenced by PCO2 greater than or equal to 50 mm Hg.

4. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

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(v) Patient is not eligible for full Medicaid benefits.

(d) **Hospice Criteria for Adult Alzheimer's Disease & Related Disorders**

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less. Alzheimer's disease and related disorders are further substantiated with medical documentation of a progressive decline in the Reisburg Functional Assessment Staging (FAST) Scale, within a six-month period of time, prior to the Medicaid hospice election.

2. Criteria below must be present at the time of **initial certification** and recertification for hospice.

Alzheimer's disease and related disorders may support a prognosis of six months or less under many clinical scenarios. The structural and functional impairments associated with a primary diagnosis of Alzheimer's disease are often complicated by co morbid and/or secondary conditions. Co-morbid conditions affecting beneficiaries with Alzheimer's disease are by definition distinct from the Alzheimer's disease itself- examples include coronary heart disease (CHD) and chronic obstructive pulmonary disease (COPD). Secondary conditions on the other hand are directly related to a primary condition - in the case of Alzheimer's disease examples include delirium and pressure ulcers. The Reisberg Functional Assessment Staging (FAST) Scale has been used for many years to describe Medicare beneficiaries with Alzheimer's disease and a prognosis of six months or less. The FAST Scale is a 16-item scale designed to parallel the progressive activity limitations associated with Alzheimer's disease. Stage 7 identifies the threshold of activity limitation that would support a six-month prognosis; however at least 4 of the 6-substage FAST scale indicators must be present. The FAST Scale does not address the impact of co-morbid or secondary conditions. The presence of secondary conditions is thus considered separately by this policy. Patients must meet (i) and (ii) below:

(i) To be eligible for hospice, the individual must have documentation of a FAST scale level equal to 7 and documentation of at least 4 or 6 substage FAST scale indicators under level 7.

FAST Scale Items:

Stage #1: No difficulty, either subjectively or objectively

Stage #2: Complains of forgetting location of objects; subjective work difficulties

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Stage #3: Decreased job functioning evident to coworkers;
difficulty in traveling to new locations
Stage #4: Decreased ability to perform complex tasks (e.g.,
planning dinner for guests; handling finances) Stage #5: Requires
assistance in choosing proper clothing
Stage #6: Decreased ability to dress, bathe, and toilet
independently:
Sub-stage 6a: Difficulty putting clothing on properly
Sub-stage 6b: Unable to bathe properly; may develop fear of
bathing
Sub-stage 6c: Inability to handle mechanics of toileting(e.g., forgets to
flush the toilet, does not wipe properly)
Sub-stage 6d: Urinary incontinence
Sub-stage 6e: Fecal incontinence
Stage #7: Loss of speech, locomotion, and consciousness:
Sub-stage 7a: Ability to speak limited to approximately a
half dozen intelligible different words or fewer, in the course
of an average day or in the course of an intensive interview
Sub-stage 7b: All intelligible vocabulary lost (Speech
ability limited to the use of a single intelligible word in an
average day or in the course of an intensive interview - the
person may repeat the word over and over)
Sub-stage are not lateral rests [arms] on the chair)
7c: Non-ambulatory (Ambulatory ability lost -
cannot walk without personal assistance)
Sub-stage7d: Unable to sit up independently (Cannot sit up
without assistance - e.g., the individual will fall over if there
are not lateral rests [arms] on the chair)
Sub-stage 7e: Loss of ability to smile
Sub-stage 7f: Loss of ability to hold head up independently
(ii) Documentation of specific secondary condition(s)
related to Alzheimer's Disease must be present, including but not
limited to, Contractures, Pressure Ulcers, recurrent UTI,
Dysphagia, Aspiration Pneumonia.

3. Reasons for Denial
(i) Patients not meeting the specific medical criteria
in this policy.
(ii) Absence of supporting documentation of progression
or rapid decline. (iii) Failure to document terminal status of six months
or less.
(iv) Patient is not eligible for full Medicaid
benefits.
(e) **Hospice Criteria for Adult Stroke and/or Coma**
1. Terminal Illness Description: An individual is

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considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Criteria below must be present at the time of **initial certification** and recertification for hospice. The medical criteria listed below would support a terminal prognosis for individuals with a diagnosis of stroke. Patients must meet

(i) and (ii) below:

(i) A Palliative Performance Scale (PPS) of less than or equal to 40.

(I) Degree of ambulation-Mainly in bed

(II) Activity/extent of disease-not able to do work; extensive disease

(III) Ability to do self-care -Mainly Assistance

(IV) Food/fluid intake-Normal to reduced

(V) State of consciousness -Either fully conscious or drowsy/confused

(ii) Inability to maintain hydration and caloric intake with any one of the following:

(I) Weight loss greater than 10% during previous 3 months

(II) Weight loss greater than 7.5% in previous 6 weeks

(III) Serum albumin less than 2.5 gm/dl

(IV) Current history of pulmonary aspiration without

effective response to speech language pathology interventions to improve dysphagia and decrease aspiration events. (V) Calorie counts documenting inadequate

caloric/fluid intake. (Patient's height and weight-caloric intake is too low to maintain normal BMI or fewer calories than necessary to maintain normal BMI - determine with caloric counts)

(VI) Dysphagia severe enough to prevent the patient from receiving food and fluids necessary to sustain life in a patient who declines or does not receive artificial nutrition and hydration.

(iii) The medical criteria for 3 listed below would support a terminal prognosis for individuals with a diagnosis of coma (any etiology):

(I) Comatose patients with any 3 of the following on day three or after of coma:

I. abnormal brain stem response

II. absent verbal response

III. absent withdrawal response to pain

IV. increase in serum creatinine greater than 1.5mg/dl

3. Reasons for Denial

(i) Patients not meeting the specific medical criteria

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in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

(iv) Patient is not eligible for full Medicaid benefits

(f) **Hospice Criteria for Adult Amyotrophic Lateral Sclerosis (ALS)**

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Criteria for initial certification: Criteria below must be present at the time of **initial certification** for hospice. ALS tends to progress in a linear fashion over time. The *overall* rate of decline in each patient is fairly constant and predictable, unlike many other non-cancer diseases. No *single* variable deteriorates at a uniform rate in all patients. Therefore, multiple clinical parameters are required to judge the progression of ALS. Although ALS usually presents in a localized anatomical area, the location of initial presentation does not correlate with survival time. By the time patients become end-stage, muscle denervation has become widespread, affecting all areas of the body, and initial predominance patterns do not persist. In end-stage ALS, two factors are critical in determining prognosis: ability to breathe, and to a lesser extent ability to swallow. The former can be managed by artificial ventilation, and the latter by gastrostomy or other artificial feeding, unless the patient has recurrent aspiration pneumonia. While not necessarily a contraindication to hospice care, the decision to institute either artificial ventilation or artificial feeding will significantly alter six-month prognosis. Examination by a neurologist within three months of assessment for hospice is required, both to confirm the diagnosis and to assist with prognosis. Patients will be considered to be in the terminal stage of ALS (life expectancy of six months or less) if they meet the following criteria (must fulfill **i, ii, or iii**): (i) The patient must demonstrate critically impaired breathing capacity
(I) Critically impaired breathing capacity as demonstrated by **all** the following characteristics occurring within the 12 months preceding initial hospice certification:
I. Vital capacity (VC) less than 30% of normal

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II. Continuous dyspnea at rest

III. Hypoxemia at rest on room air, with a current ABG PO2 at or below 59mm HG or oxygen saturation at or below 89%

IV. Patient declines artificial ventilation

(ii) Patient must demonstrate **both** rapid progression of ALS and critical nutritional impairment

(I) Rapid progression of ALS as demonstrated by **all** the following characteristics occurring within the 12 months preceding initial hospice certification: I. Progression from independent ambulation to wheelchair or bed bound status

II. Progression from normal to barely intelligible or unintelligible speech

III. Progression from normal to pureed diet

IV. Progression from independence in most or all activities of daily living (ADLs) to needing major assistance by caretaker in **all** ADLs.

(II) Critical nutritional impairment as demonstrated by **all** the following characteristics occurring within the 12 months preceding initial hospice certification:

I. Oral intake of nutrients and fluids insufficient to sustain life

II. Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.

(iii) Patient must demonstrate **both** rapid progression of ALS and life-threatening complications

(I) Rapid progression of ALS, see (ii) (I) above

(II) Life-threatening complications as demonstrated by one of the following characteristics occurring within the 12 months preceding initial hospice certification: II. Upper urinary tract infection (pyelonephritis)

Sepsis

III. Other medical complications not identified above will be reviewed on a case-by-case basis with appropriate medical justification

3. Criteria for recertification: Criteria below must be present at the time of **recertification** for hospice. Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet (i) and (ii) below:

(i) The patient must demonstrate critically impaired breathing capacity

(I) Critically impaired breathing capacity as

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demonstrated by **all** the following characteristics:

I. Two or more episodes of recurrent aspiration pneumonia (with or without tube feedings) I. Continuous dyspnea at rest

II. Hypoxemia at rest on room air with a current ABG PO2 at or below 59 mm Hg or oxygen saturation at or below 89%

III. Patient declines artificial ventilation

(ii) Patient must demonstrate rapid progression of ALS and at least one life-threatening complication.

(I) Life-threatening complications as demonstrated by one of the following characteristics:

I. Two or more episodes of recurrent aspiration pneumonia (with or without tube feedings)

II. Upper urinary tract infection (pyelonephritis)

Sepsis

III. Other medical complications not identified above

will be reviewed on a case-by-case basis with appropriate medical justification

4. Reasons for Denial(i) Patients not meeting the specific medical criteria

in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

(iv) Patient is not eligible for full Medicaid benefits

(g) **Hospice Criteria for Adult Cancer**

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Criteria for initial certification or recertification: Criteria below must be present at the time of **initial certification or re-certification** for hospice. Patients

will be considered to be in the terminal stage of cancer (life expectancy of six months or less) if (i) **or (ii)** below are(i) Documentation of metastasis or final disease stage

is required with evidence of progression as documented by worsening clinical status, symptoms, signs and/or laboratory results.

(ii) Progression from an earlier stage of disease to metastatic disease with either:

(I) A continued decline in spite of therapy, that is, aggressive treatment, or

(II) Patient declines further disease directed therapy.

3. Reasons for Denial

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(i) Patients not meeting the specific medical criteria in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

(iv) Patient is not eligible for full Medicaid benefits

(h) **Hospice Criteria for Adult Heart Disease**

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Criteria for initial certification or recertification: Criteria below must be present at the time of **initial certification or re-certification** for hospice. The medical criteria listed below would support a terminal prognosis for individuals with a diagnosis of heart disease. Medical criteria **(i) and (ii)** must be present as they are important indications of the severity of heart disease and would thus support a terminal prognosis if met.

(i) When the recipient is approved or recertified the:

(I) Patient is already optimally treated with diuretics **and** vasodilators, which may include angiotensin converting enzymes (ACE) inhibitors or the combination of hydralazine and nitrates. If side effects, such as hypotension or hyperkalemia, **or** evidence of treatment failure prohibit the use of ACE inhibitors **or** the combination of hydralazine and nitrates, **or** patient voluntarily declines treatment the documentation must be present in the medical records **or** with lab results and medical records submitted upon request.

(ii) The patient has significant symptoms of recurrent congestive heart failure (CHF) at rest, and is classified as a New York Heart Association (NYHA) Class IV:

(I) Unable to carry on any physical activity without symptoms

(II) Symptoms are present even at rest

(III) If any physical activity is undertaken, symptoms are increased

(iii) Documentation of the following factors may provide additional support for end stage heart disease:

(I) Treatment resistant symptomatic supraventricular

or ventricular arrhythmias (II) History of cardiac arrest or resuscitation

(III) History of unexplained syncope

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(IV) Brain embolism of cardiac origin
(V) Concomitant HIV disease
(VI) Documentation of ejection fraction of 20% or less
(VII) Angina pectoris, at rest

3. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy.
(ii) Absence of supporting documentation of progression or rapid decline.
(iii) Failure to document terminal status of six months or less.
(iv) Patient is not eligible for full Medicaid benefits

(i) **Hospice Criteria for Adult Liver Disease**¹. Terminal Illness Description: Coverage of hospice care depends upon a physician's certification of an individual's prognosis of a life expectancy of six months or less if the terminal illness runs its normal course.

2. Criteria for initial certification and recertification: Criteria below must be present at the time of **initial certification/recertification** for hospice. Patients will be considered to be in the terminal stage of liver disease (life expectancy of six months or less) if they meet the following criteria. Documentation in the record must support both **(i) and (ii)**.

(i) Documentation of progression with active decline as evidenced by worsening clinical status, symptoms, signs and laboratory results. The patient's terminal condition must be supported by one or more of the items below:

(I) Clinical Status

I. Recurrent or intractable infections such as pneumonia, sepsis or upper urinary tract.
II. Documented progressive inanition(II) Symptoms

I. Dyspnea with increasing respiratory rate
II. Nausea/vomiting poorly responsive to treatment
III. Diarrhea, intractable
IV. Pain requiring increasing doses of major analgesics more than briefly.

(III) Signs

I. Ascites
II. Edema
III. Weakness(IV) Laboratory (When available. Lab testing is not required to establish hospice eligibility.)

I. Increasing pCO₂ or decreasing pO₂ or decreasing SaO₂
II. Increasing liver function studies

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III. Progressively decreasing or increasing serum sodium

(V) Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) due to progression of disease.

(VI) Progression to dependence on assistance with additional activities of daily living.

(VII) History of increasing ER visits, hospitalizations, or physician visits related to the hospice primary diagnosis prior to election of the hospice benefit.

(ii) End stage liver disease is present and the patient shows at least **one** of the following:

IV. Change in level of consciousness(I) ascites, refractory to treatment or patient non-complaint

(II) spontaneous bacterial peritonitis

(III) hepatorenal syndrome (elevated serum creatinine and BUN with oliguria (<400ml/day) and urine sodium concentration less than10 mEq/l

(IV) hepatic encephalopathy, refractory to treatment, or patient non-compliant

(V) recurrent variceal bleeding, despite intensive therapy

(iii) Documentation of the following factors will also support eligibility for hospice care:

(I) progressive malnutrition

(II) muscle wasting with reduced strength and endurance(III) continued active alcoholism (>80 gm ethanol/day)

(IV) hepatocellular carcinoma

(V) HBsAg (Hepatitis B) positivity

(VI) Hepatitis C refractory to interferon treatment3. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

(iv) Patient is not eligible for full Medicaid benefits

(j) **Hospice Criteria for Adult Renal Disease**

1. Terminal Illness Description: An individual is considered to be terminally ill if the medical prognosis indicates a life expectancy of six months or less.

2. Criteria for initial certification: Criteria

below must be present at the time of **initial certification** for

hospice. Patients will be considered to be in the terminal stage

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of renal disease (life expectancy of six months or less) if they meet the following criteria:

(i) **Acute renal failure (I) and (II)** must be present)

(I) Creatinine clearance less than 10 cc/min (less than 15 cc/min. for diabetes)

(II) Serum creatinine greater than 8.0 mg/dl (greater than 6.0 mg/dl for diabetes)

(ii) **Chronic renal failure (I), (II), and (III)** must be present)

(I) Creatinine clearance less than 10 cc/min (less than 15cc/min for diabetes)

(II) Serum creatinine greater than 8.0 mg/dl (greater than 6.0 mg/dl for diabetes)

(III) Glomerular filtration rate (GFR) less than 30 ml/min

3. Criteria for recertification: Criteria below must be present at the time of **recertification** for hospice. Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet the following criteria:

(i) **Chronic renal failure (I), (II), or (III)** must be present)

(I) Creatinine clearance less than 10 cc/min (less than 15cc/min for diabetes)

(II) Serum creatinine greater than 8.0 mg/dl (greater than 6.0 mg/dl for diabetes)

(III) Glomerular filtration rate (GFR) less than 30 ml/min

4. Reasons for Denial

(i) Patients not meeting the specific medical criteria in this policy.

(ii) Absence of supporting documentation of progression or rapid decline.

(iii) Failure to document terminal status of six months or less.

(iv) Patient is on dialysis.

(v) Patient is not eligible for full Medicaid benefits

A person who reaches a point of stability and is no longer considered terminally ill must not be recertified for hospice services. The individual must be discharged to traditional Medicaid benefits

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~~e. A signed hospice election statement which must include the following:~~

- ~~1. Identification of the particular hospice that will provide care to the recipient;~~
- ~~2. The recipient's or representative's acknowledgment he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as related to the individual's terminal illness;~~
- ~~3. Acknowledgment that certain otherwise covered services are waived by the election, except for children under the age of 21;~~
- ~~4. The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date the election statement was executed and the date certification was made; and~~
- ~~5. The signature of the recipient or representative.~~

~~The hospice agency will not be reimbursed for hospice services unless all signed paperwork has been submitted to the QIO like vendor.~~

Interdisciplinary Group^[r1]

~~The hospice must designate an interdisciplinary group or groups composed of individuals who use an interdisciplinary approach to assessing and meeting the physical, medical, psychosocial, emotional and spiritual needs of the hospice recipients and families facing terminal illness and bereavement. The interdisciplinary group provides or supervises the care and services offered by the hospice.~~

- ~~a. Composition of Group: The hospice must have an interdisciplinary group or groups composed of or including at least the following individuals who are employees of the hospice:~~
- ~~1. A doctor of medicine or osteopathy;~~
 - ~~2. A registered nurse;~~
 - ~~3. A social worker;~~
 - ~~4. A pastoral or other counselor; and~~
 - ~~5. Trained volunteer.~~

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b. ~~Role of Interdisciplinary Group: Members of the group interact on a regular basis³ and have a working knowledge of the assessment and care of the recipient/family unit. The interdisciplinary group is responsible for the following:~~

~~1. Conduct a comprehensive assessment of the recipient and update the assessments at the required times. The group in consultation with the recipient's attending physician (if any) must prepare a written POC for each hospice recipient that reflects recipient and family goals and interventions based on the needs identified in the initial, comprehensive and updated assessments;~~

~~2. Provision of supervision of hospice care and services;~~

~~3. Develop and maintain a system of communication, coordination and integration of services that ensures that the POC is reviewed every 15 calendar days, and updated as needed.~~

~~4. Establishment of policies governing the day-to-day provision of hospice care and services.~~

~~e. If a hospice has more than one interdisciplinary group, it must document in advance the group it chooses to execute the functions for each recipient.~~

~~d. Coordinator: The hospice must designate an RN to coordinate the implementation of the POC for each recipient.~~

~~Initial and Comprehensive Assessments~~

~~a. The hospice RN must complete an initial assessment within 48 hours after the election of hospice (unless the physician, recipient, or representative request that the initial assessment be completed in less than 48 hours).~~

~~b. A comprehensive and person centered assessment must be conducted no later than five calendar days after the election of hospice care by the hospice interdisciplinary group, in consultation with the recipient's attending physician (if any).~~

³ ~~see Conditions of Participation~~

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- e. ~~The comprehensive assessment must identify the recipient's needs for hospice care and the physical, psychosocial, emotional, and spiritual needs related to the terminal illness. All these areas must be addressed in order to promote the hospice recipient's well being, comfort, and dignity, throughout the dying process.~~
- d. ~~An initial bereavement assessment of the needs of the recipient's family and other individuals focusing on the social, spiritual and cultural factors that may impact their ability to cope with the recipient's death. Information gathered from the initial bereavement assessment must be incorporated into the POC.~~
- e. ~~An update of the comprehensive assessment must be completed by the hospice interdisciplinary group (in collaboration with the recipient's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information in the recipient's progress towards desired outcomes, as well as a re-assessment of the recipient's response to care. The assessment update must be accomplished as frequently as the condition of the recipient requires, but no less frequently than every 15 days.~~

4. ~~Plan of Care~~

~~A written POC must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance with the plan.~~

- a. ~~Establishment of Plan of Care: All hospice care and services furnished to recipients and their families must follow an individualized written POC established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the recipient or representative, and the primary caregiver(s) in accordance with the recipient's needs if any of them so desire. The hospice must ensure that each recipient and the primary caregiver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and service provided in the POC.~~
- b. ~~Content of Plan of Care: The POC must reflect recipient and family goals and interventions based on problems identified in the initial, comprehensive and updated comprehensive assessments. The POC must include all services necessary for the palliation and management of the terminal illness and related conditions.~~
- e. ~~Review of Plan of Care: The hospice interdisciplinary group (in collaboration with the recipient's attending physician (if any)) must review, revise and document the~~

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~~individualized POC as frequently as the recipient's condition requires, but no less frequently than every 15 days. A revised POC must include information from the recipient's updated comprehensive assessment and must note the recipient's progress towards outcomes and goals specified in the POC.~~

~~5. Recipients' Rights~~

~~The recipient must be informed of their rights during the initial assessment, and prior to furnishing care, and the hospice must protect and promote the exercise of these rights.~~

- ~~a. The recipient or their representative must be provided with verbal and written notice of the recipient's rights and responsibilities in a language and manner that the recipient understands.~~
- ~~b. The hospice must obtain the recipient's or their representative's signature confirming that they have received a copy of the notice of rights and responsibilities.~~

~~The recipient has the right to:~~

- ~~1. Exercise his or her rights as a recipient of the hospice;~~
- ~~2. Have his or her property and person treated with respect;~~
- ~~3. Voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and~~
- ~~4. Not be subjected to discrimination or reprisal for exercising his or her rights.~~

~~In addition the recipient has the right to:~~

- ~~1. Receive effective pain management and symptom control from the hospice provider for conditions related to the terminal illness.~~
- ~~2. Be involved in the development of his or her POC.~~
- ~~3. Refuse care or treatment.~~
- ~~4. Choose his or her attending physician.~~
- ~~5. Have a confidential Clinical record.~~

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~~6. To be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source and misappropriation of the recipient's property.~~

~~7. Receive information about the services covered under the hospice benefit.~~

~~8. Receive information about the scope of services that the hospice will provide and specific limitations on those services.~~

~~e. If a recipient has been adjudicated incompetent, the rights of the recipient are exercised by the person appointed to act on the recipient's behalf. If the recipient has not been adjudicated as incompetent any legal representative designated by the recipient may exercise the recipient's rights.~~

6. Abuse, Neglect or Mistreatment

~~In situations of abuse, neglect or mistreatment the hospice must:~~

~~a. Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of the recipient's property by anyone furnishing services on behalf of the hospice, are reported immediately by hospice employees and contracted staff to the hospice administrator.~~

~~b. Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is verified. Investigations and/or documentation of all alleged violations must be conducted within the hospice's established procedures.~~

~~c. Ensure that verified violations are reported and take appropriate corrective action, if the alleged violation is verified by the hospice administrator.~~

7. Advanced Directives

~~The hospice must comply with all requirements stipulated in 42 CFR 489, Subpart I regarding Advanced Directives (AD). The hospice must inform and distribute written information to the recipient concerning its policies on ADs.~~

8. Quality Assurance

~~The hospice must develop, implement and maintain an effective, ongoing hospice wide data driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program:~~

~~a. Involves all hospice services (including those services under contract or~~

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arrangement);

- b. ~~Focuses on indicators related to palliative outcomes; and~~
- c. ~~Takes action to demonstrate improvement in hospice performance.~~

~~The hospice must maintain written documentation of its quality assessment and performance improvement program and must be able to demonstrate its operation to the CMS.~~

9. ~~Infection Control~~

~~The hospice provider must maintain and document an effective infection control program that protects recipients, families, visitors and hospice personnel by preventing and controlling infections and communicable diseases. The infection control program must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions to include an agency wide program for the surveillance, identification, prevention, control and investigation of infectious and communicable diseases.~~

~~The hospice must provide infection control education to employees, contracted providers, recipients and family members, and other caregivers.~~

3203.1C RECIPIENT RESPONSIBILITY

The Medicaid recipient is responsible for signing the election statement to receive hospice care. The election statement may be signed by the recipient's representative.

The recipient is responsible to comply with the POC as established by the hospice interdisciplinary group.

3203.2 NON-HOSPICE SERVICES

Nevada Medicaid recipients continue to be eligible for applicable state benefits for services unrelated to the terminal illness for which hospice was elected pursuant to Section 3203.1 of this Chapter. "The hospice must develop and maintain a system of communication" to "provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions." Therefore the hospice provider is expected to be the lead case coordinator and maintain communication with other services.

- a. Personal Care Services (PCS) for Recipients Enrolled in Hospice: PCS may be provided for recipients enrolled in hospice when the need for PCS is unrelated to the terminal

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condition, and the personal care needs exceed the personal care services provided under the hospice benefit.

If a recipient enrolls in hospice, the DHCFP or its designee will conduct an evaluation of an individual's comprehensive personal care needs. The evaluation will differentiate between personal care needs unrelated to the terminal condition and those needs directly related to hospice, clearly documenting total personal care needs. PCS provided under hospice will be subtracted from total PCS needs to document any personal care needs not met by hospice services and which may be provided by the Personal Care Agency. The PCS provided by a personal care agency to a recipient because of needs unrelated to the terminal condition may not exceed State Plan program limitations. Refer to MSM Chapter 3500 for regulations regarding PCS.

- b. HCBW Services for recipients enrolled in hospice: refer to section 3203.7 of this chapter.

3203.2A COVERAGE AND LIMITATIONS

1. Services unrelated to the terminal illness are subject to related program limitations as indicated in the MSM.
2. Typical services available that are not covered by the hospice benefit but payable by the DHCFP may include but are not limited to:
 - a. Attending physician care (e.g., office visits, hospital visits, etc.);
 - b. Optometric services;
 - c. Any services, drugs, equipment, or supplies for a condition other than the recipient's terminal illness.
3. Neither the hospice nor Nevada Medicaid is responsible for payment for curative services related to an adult's terminal illness.

3203.2B PROVIDER RESPONSIBILITY

It is essential for all Medicaid service providers to check a recipient's Medicaid eligibility each time a service is provided to identify Medicaid recipients enrolled in the hospice benefit plan.

1. It is the responsibility of the hospice provider to ensure that prior authorization is obtained for services unrelated to the hospice benefit. The hospice agency must coordinate this process with the recipient's non-hospice providers. Request for the prior authorization must be submitted to the QIO-like vendor.

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3203.2C RECIPIENT RESPONSIBILITY

The recipient is responsible for communicating fully with the hospice agency regarding all services unrelated to the terminal illness to ensure continuity of care.

3203.3 CHANGING THE DESIGNATED HOSPICE

An individual or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received.

- a. The change of the designated hospice is not a revocation of the hospice election for the period in which it was made.
- b. To change the designation of hospice agencies, the individual or representative must file, with the hospice agency from which care has been received and with the newly designated hospice, a **Hospice Action Form** ~~notice of transfer~~ that includes the following:
 1. The name of the hospice from which the individual has received care;
 2. The name of the hospice from which he or she plans to receive care;
 3. The effective date of the transfer of hospice care.
- c. The transferring hospice agency files the notice in the medical record and faxes one copy to the receiving hospice and faxes one copy to the QIO-like vendor along with a Hospice Medicaid Information form.
- d. The receiving hospice agency must fax an updated Hospice Medicaid Information form, Hospice Ancillary Information form, a signed election statement, and a signed copy of the physician's certification of terminal illness to the QIO-like vendor.
- e. If a hospice recipient is residing in an NF, the transferring hospice agency is required to submit a copy of the transfer statement to the NF for their records.

3203.4 REVOKING THE ELECTION OF HOSPICE CARE

An individual or representative may revoke the election of hospice care at any time during an election period.

- a. To revoke the election of hospice care, the recipient or representative must file with the hospice a **Hospice Action Form** ~~statement~~ to be placed in the medical record that includes the following information:

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1. Signed statement that the recipient or representative revokes the recipient's election for coverage of hospice care for the remainder of that election period with the date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made);
 2. The hospice agency is required to fax the QIO-like vendor the signed copy of the revocation notice and a Medicaid Hospice Information form/Notice of Revocation within 72 hours, once the revocation notice has been signed.
- b. If the hospice recipient is residing in an NF, the hospice agency is required to immediately submit to the NF a signed copy of the notice of revocation for their medical records.
 - c. An individual, upon revocation of the benefit election of hospice care for a particular election period:
 1. Is no longer covered for hospice care for that election period;
 2. Resumes eligibility for all Medicaid covered services as before the election to hospice; and
 3. May at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible to receive.

3203.5 DISCHARGE OF A RECIPIENT FROM HOSPICE

With adequate documentation explaining cause, a hospice may discharge a recipient.

- a. Reasons for discharge may include:
 1. Noncompliance with hospice POC;
 2. Moves out of the hospice's service area or transfers to another hospice;
 3. No longer meets the criteria for hospice;
 4. No longer eligible for Medicaid; or
 5. Request of recipient, or representative.
- b. The hospice must have policies in place to address disruptive, abusive or uncooperative behavior, on the part of the recipient or other individuals in the home, to the extent that delivery to the recipient or the ability of the hospice to operate is seriously impaired. The hospice must do the following prior to discharge for cause:

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1. Advise the recipient that a discharge for cause is being considered.
 2. Make a serious effort to resolve the problem(s) presented by the recipient's behavior or situation.
 3. Ascertain that the recipient's proposed discharge is not due to the recipient's use of necessary services; and
 4. Document the problem(s) and efforts made to resolve the problems(s) and enter this documentation into its medical records.
- c. Prior to discharge, the hospice must obtain a written discharge order from the hospice medical director. If a recipient has an attending physician, the physician must be consulted and his/her recommendation or decision must be included in the discharge note.
 - d. A copy of the signed discharge notice, **physician's discharge order**, and the Hospice **Action Form Medicaid Information form/Notice of Discharge** are required to be faxed to the QIO-like vendor within 72 hours of the discharge. A copy is retained in the client's record at the hospice.
 - e. If the hospice recipient is residing in an NF the hospice is required to immediately submit a copy of the signed discharge notice to the facility for their records the day the discharge notice has been signed. The hospice agency is required to also verbally inform the NF staff of the discharge.

~~3203.6 HOSPICE RECIPIENTS RESIDING IN A NURSING FACILITY~~

~~Recipients residing in a Nevada Medicaid approved NF are eligible for hospice care pursuant to policies identified in 3203.1.~~

~~3203.6A COVERAGE AND LIMITATIONS~~

~~The hospice recipient residing in a Skilled Nursing Facility (SNF) must not experience any lack of services or personal care because of his or her status as a hospice recipient. The NF must offer the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. The recipient has the right to refuse any services.~~

~~The NF must continue to still comply with all requirements for participation in Medicare and/or Medicaid for hospice enrolled Nevada Medicaid residents.~~

~~3203.6B PROVIDER RESPONSIBILITIES~~

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In addition to meeting ~~the conditions of participation~~ (see ~~hospice care services~~), a hospice that provides hospice care to residents of a SNF/NF or ICF/IID must abide by the following additional standards.

~~(a) Standard: Resident eligibility, election, and duration of benefits.~~ Recipients receiving hospice services and residing in a SNF, NF, or ICF/IID are subject to the Medicaid/Medicare hospice eligibility criteria set out at §418.20 through §418.30.

~~(b) Standard: Professional management.~~ The hospice must assume responsibility for professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to §§418.100 and 418.108.

~~(c) Standard: Written agreement.~~ The hospice and SNF/NF or ICF/IID must have a written agreement that specifies the provision of hospice services in the facility. The agreement must be signed by authorized representatives of the hospice and the SNF/NF or ICF/IID before the provision of hospice services. The written agreement must include at least the following:

~~(1) The manner in which the SNF/NF or ICF/IID and the hospice are to communicate with each other and document such communications to ensure that the needs of patients are addressed and met 24 hours a day.~~

~~(2) A provision that the SNF/NF or ICF/IID immediately notifies the hospice if—~~

~~(i) A significant change in a patient's physical, mental, social, or emotional status occurs;~~

~~(ii) Clinical complications appear that suggest a need to alter the plan of care;~~

~~(iii) A need to transfer a patient from the SNF/NF or ICF/IID, and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary related to the terminal illness and related conditions; or~~

~~(iv) A patient dies.~~

~~(3) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.~~

~~(4) An agreement that it is the SNF/NF or ICF/IID responsibility to continue to furnish 24-hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected.~~

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~~(5) An agreement that it is the hospice's responsibility to provide services at the same level and to the same extent as those services would be provided if the SNF/NF or ICF/IID resident were in his or her own home.~~

~~(6) A delineation of the hospice's responsibilities, which include, but are not limited to the following: Providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary and bereavement); social work; provision of medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.~~

~~(7) A provision that the hospice may use the SNF/NF or ICF/IID nursing personnel where permitted by State law and as specified by the SNF/NF or ICF/IID to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient's family in implementing the plan of care.~~

~~(8) A provision stating that the hospice must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the SNF/NF or ICF/IID administrator within 24 hours of the hospice becoming aware of the alleged violation.~~

~~(9) A delineation of the responsibilities of the hospice and the SNF/NF or ICF/IID to provide bereavement services to SNF/NF or ICF/IID staff.~~

~~(d) Standard: Hospice plan of care. In accordance with §418.56, a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/IID representatives. All hospice care provided must be in accordance with this hospice plan of care.~~

~~(1) The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care.~~

~~(2) The hospice plan of care reflects the participation of the hospice, the SNF/NF or ICF/IID, and the patient and family to the extent possible.~~

~~(3) Any changes in the hospice plan of care must be discussed with the patient or representative, and SNF/NF or ICF/IID representatives, and must be approved by the hospice before implementation.~~

~~(e) Standard: Coordination of services. The hospice must:~~

~~(1) Designate a member of each interdisciplinary group that is responsible for a patient who is a resident of a SNF/NF or ICF/IID. The designated interdisciplinary group member is responsible for:~~

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~~(i) Providing overall coordination of the hospice care of the SNF/NF or ICF/IID resident with SNF/NF or ICF/IID representatives; and~~

~~(ii) Communicating with SNF/NF or ICF/IID representatives and other health care providers participating in the provision of care for the terminal illness and related conditions and other conditions to ensure quality of care for the patient and family.~~

~~(2) Ensure that the hospice IDG communicates with the SNF/NF or ICF/IID medical director, the patient's attending physician, and other physicians participating in the provision of care to the patient as needed to coordinate the hospice care of the hospice patient with the medical care provided by other physicians.~~

~~(3) Provide the SNF/NF or ICF/IID with the following information:~~

~~(i) The most recent hospice plan of care specific to each patient;~~

~~(ii) Hospice election form and any advance directives specific to each patient;~~

~~(iii) Physician certification and recertification of the terminal illness specific to each patient;~~

~~(iv) Names and contact information for hospice personnel involved in hospice care of each patient;~~

~~(v) Instructions on how to access the hospice's 24-hour on-call system;~~

~~(vi) Hospice medication information specific to each patient; and~~

~~(vii) Hospice physician and attending physician (if any) orders specific to each patient.~~

~~(f) *Standard: Orientation and training of staff.* Hospice staff must assure orientation of SNF/NF or ICF/IID staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements.~~

~~2. Responsibilities of the hospice and the nursing facility~~

~~1.3.~~

~~The hospice agency and the NF must have a written agreement under which the hospice is responsible for the professional management of the recipient's hospice care. The NF is responsible to provide room and board to the recipient.~~

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- a. ~~Room and board includes:~~
- ~~1. Performance of personal care services;~~
 - ~~2. Assistance in the ADLs;~~
 - ~~3. Socializing activities;~~
 - ~~4. Administration of medication;~~
 - ~~5. Maintaining the cleanliness of a resident's room; and~~
 - ~~6. Supervising and assisting in the use of Durable Medical Equipment (DME) and prescribed therapies.~~
- b. ~~Hospice Professional Management includes:~~
- ~~1. Physician services;~~
 - ~~2. Nursing services;~~
 - ~~3. Medical social services; and~~
 - ~~4. Counseling.~~

~~2. Nursing Facility Screenings~~

~~Refer to MSM Chapter 500 for specific guidelines regarding NF screenings.~~

~~All hospice enrolled recipients must have a Pre-Admission Screening and Resident Review (PASRR) and a LOC Screening prior to admission to an NF. Requests for these screenings are done by calling the QIO-like vendor.~~

~~The requests can be made by either the NF or the hospice agency.~~

- a. ~~The NF is responsible for:~~
- ~~1. Ensuring the hospice recipient has:

 - ~~a. A valid PASRR determination, and~~
 - ~~b. A LOC screening indicating appropriate NF placement.~~~~

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~~2. Verifies that the necessary screenings are completed prior to admission and must monitor time-limited PASRR and LOC screenings in order to extend Medicaid reimbursement. Medicaid reimbursement is not available when PASRR and LOC screenings are not completed within the specified timeframes, which would be passed on to the NF.~~

~~3. Submitting a Nursing Facility Tracking Form within 72 hours of occurrence.~~

~~b. Prior to NF placement, the hospice agency must verify with the QIO-like vendor or NF that both screenings (PASRR, LOC) have been completed and that the hospice recipient is cleared for placement.~~

3203.7 HOSPICE COVERAGE AND WAIVER RECIPIENTS

As part of the admission procedure it is the responsibility of the hospice agency to obtain information regarding recipient enrollment in HCBW programs.

3203.7A COVERAGE AND LIMITATIONS

When a Waiver recipient is enrolled in the hospice program there can be no duplication of hospice covered services, such as PCA services, homemaker services, home health services, respite, or companion services. Close case coordination between the hospice agency and the waiver case manager is required to prevent any duplication of services.

This also includes all HCBW recipients who have Medicare as their primary insurance and Medicare is paying for the hospice services.

3203.7B PROVIDER RESPONSIBILITY

The hospice agency must immediately notify the QIO-like vendor of any new hospice admissions who are receiving services through a Medicaid HCBW.

3203.8 MANAGED CARE AND HOSPICE RECIPIENTS

Managed care participants who elect hospice care must be disenrolled from their managed care program.

a. The hospice is responsible for notifying the QIO-like vendor in such situations.

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- b. The recipient electing the hospice benefit will then return to Fee-for-Service (FFS) Medicaid.
- c. There should be no delay in enrolling managed care recipients in hospice services.

3203.9 ~~CLINICAL RECORDS~~⁴

~~In accordance with accepted principles of practice, the hospice must establish and maintain a clinical record for every individual receiving care and services. The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval. The clinical record may be maintained electronically.~~

~~Each clinical record is a comprehensive compilation of information. Entries are made for all services provided. Entries are made and signed by the person providing the services. The record includes all services whether furnished directly or under arrangements made by the hospice.~~

~~Each individual's record must contain:~~

- ~~1.9. The comprehensive, initial and subsequent assessments;~~
- ~~2.10. The initial and updated POCs;~~
- ~~3.11. Identification data;~~
- ~~4.12. Consent and authorization and election forms;~~
- ~~5.13. Documentation the client has received and signed a statement of "Recipient Rights";~~
- ~~6.14. A complete drug profile; responses to medications, symptom management, treatments and services;~~
- ~~7.15. Pertinent medical history; Physicians certification and re-certifications of terminal illness and any Advanced Directives; and~~
- ~~8.16. Complete documentation of all services and events (including evaluations, treatments, progress notes, physician orders etc.).~~

~~The hospice must safeguard the clinical record against loss, destruction, and unauthorized use. The recipient's clinical record must be retained after the death or discharge of the recipient for a period of six years. If the hospice discontinues operation, hospice policies must provide for~~

⁴~~-see conditions of participation~~

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~~retention and storage of clinical records. The hospice must inform Medicaid and the CMS Regional office where such clinical records will be stored and how they may be accessed.~~

3203.10 DHCFP REVIEW

The DHCFP may conduct a review of a hospice provider to ensure appropriateness of care and accuracy of claims.

The methods of review may include but are not limited to:

- a. On-site visits with recipients and family at their residence;
- b. Chart reviews at the hospice agency;
- c. Post-payment review of claims data;
- d. The DHCFP desk review; and
- e. On-site review in facilities.

f. Independent Physician Review for Extended Care

Medicaid hospice benefits are reserved for terminally ill patients who have a medical prognosis to live no more than six (6) months if the illness runs its normal course.

When an adult patient (21 years of age or older) reaches 12 months in hospice care, an independent face to face physician review is required. Independent reviews are subsequently required every 12 months thereafter if the patient continues to receive extended hospice care. Hospice agencies should advise patients of this requirement and provide **the Independent Physician Review for Extended Care** form to take with them to each independent review.

3203.10A PROVIDER RESPONSIBILITY

The hospice provider being reviewed must comply with the DHCFP staff on providing all information requested in a timely manner.

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3204 HEARINGS

All Medicaid recipients and providers have rights to hearings regarding reimbursement and treatment issues. Please refer to Medicaid Services Manual (MSM) Chapter 3100, Hearings for the hearing process.

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