MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

March 13, 2014

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: MARTA E. STAGLIANO, CHIEF OF PROGRAM INTEGRITY

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 3200 - HOSPICE

## BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3200 were made to coincide with the Code of Federal Regulations (CFR) Title 42 part 418, Conditions of Participation updates. The Conditions of Participation are mandatory programmatic sections that define Hospice providers operations. The sections define initial and subsequent assessments, physician's determination and documentation of terminal illness, Plans of Care, Recipient's Rights, Quality Management, Infection Control and Clinical records. This revision includes the hospice physician's face-to-face examination and documentation requirements of the hospice patient at the 180th day and every subsequent election period.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These changes are effective April 1, 2014.

| MATERIAL TRANSMITTED | MATERIAL SUPERSEDED |
|---|---|
| MTL 02/14<br>CHAPTER 3200 – HOSPICE | MTL 40/03, 07/06, 41/10<br>CHAPTER 3200 – HOSPICE |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **3200** | **Introduction** | Clarified existing language and added a reference to MSM Chapter 3600 for Managed Care Organization (MCO) recipients and the Nevada Check Up (NCU) Manual for NCU recipients. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **3203.1** | **Policy – Hospice Services** | Updated the section to include the Conditions of Participation (COP) as required by 42 CFR 418. 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 standards of practice. Added chapter reference for revocation and re-election of hospice benefits. |
| **3203.1A.1** | **Policy – Coverage and Limitations – Eligibility Requirements** | Added chapter reference for certification of terminal illness. Refer to Section 3203.1.B.1.d |
| **3203.1A.2** | **Policy Coverage and Limitations – Duration of Hospice Care** | Re-phrased statement to read: An eligible recipient may receive an unlimited number of subsequent 60 day periods, without a break in care as long as certain criteria is met such as: Revised policy to require a hospice physician or nurse practitioner to have face-to-face encounters when determining continued eligibility prior to the 180th day recertification. The practitioner must certify that the recipient has a life expectancy of less than six months; the recipient does not revoke hospice election and remains appropriate for hospice care. |
| **3203.1A.3** | **Policy – Coverage and Limitations – Hospice Care Services** | Moved sentence of bereavement counseling to section 3203.1A.3d (Counseling Services). Added policy that the hospice must designate a registered nurse: "to ensure that the nursing needs of the recipient are met as identified in the recipient's initial assessment, comprehensive assessment, and updated assessment".<br><br>Also added language in Counseling Services that indicates the bereavement counseling for the client's family and significant others as identified in the Plan of Care (POC) is not reimbursable per 42 CFR 418.204 (c). |
| **3203.1A.4.b.1** | **Policy – Coverage and Limitations – Level of Care – Continuous Home Care** | Removed reference to the definition section of the chapter and inserted the definition language for continuous home care into the text of the paragraph. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **3203.1A.4.c.3** | **Policy – Coverage and Limitations – Level of Care – Inpatient Care** | Inserted paragraph clarifying respite care and duration limitations for reimbursement. |
| **3203.1B.1** | **Policy – Provider Responsibility – Recipient Enrollment Process** | Changed the requirement of enrollment forms for pending Medicaid eligibility to be submitted to Quality Improvement Organization (QIO)-like vendor from 15 days to 60 days of the date of decision of eligibility determination.<br><br>Clarified existing policy regarding when the hospice must obtain written certification of a terminal illness and the consequences to reimbursement if the noted time frames are not met.<br><br>Added the documentation requirements for the certification of terminal illness according to 42 CFR 418 – COP.<br><br>Added clarifying language indicating that the hospice agency will not be reimbursed for hospice services unless all signed paperwork has been submitted to QIO – like vendor. |
| **3203.1B.2** | **Policy – Provider Responsibility – Interdisciplinary Group** | Moved from section 3203.1.B.6 for continuity and clarity. Included that the interdisciplinary group will use an interdisciplinary approach to assessing and meeting the physical, medical, psychosocial, emotional and spiritual needs of the hospice recipient and their families facing terminal illness and bereavement.<br><br>Moved the section on Role of Interdisciplinary Group from 3203.1B.6 to this section and expanded the policy to address the assessment of the recipient and the participation of the recipient's attending physician (if any) in the development of the POC and the updating of the POC every 15 days.<br><br>Added policy regarding the Initial and Comprehensive Assessments to include time limits and content for initial, comprehensive and updated assessments. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **3203.1B.4** | **Policy – Provider Responsibility – Plan of Care** | Expanded requirements in the establishment, content, and review of the POC. |
| **3203.1B.5** | **Policy – Provider Responsibility – Recipients' Rights** | Added Recipients' Rights policy. Recipient's rights are particular to hospice services related to palliative care, relief from pain, and property rights. |
| **3203.1B.6** | **Policy – Provider Responsibility – Abuse, Neglect or Mistreatment** | Removed the policy related to Interdisciplinary Group (moved to 3203.1.B.2) and added policy detailing the requirements for hospice employees and contractors report, investigate, and take corrective actions in cases of alleged or verified abuse, neglect or mistreatment. |
| **3203.1B.7** | **Policy – Provider Responsibility – Advanced Directives** | Removed CFR reference, and added policy which states "The hospice must inform and distribute written information to the recipient concerning its policies on advanced directives." |
| **3203.1B.8** | **Policy – Provider Responsibility – Quality Assurance** | Added language indicating that the hospice must develop, implement and maintain an effective, ongoing hospice-wide data driven quality assessment and performance improvement program and added responsibilities for the hospice's governing body to ensure certain program requirements are met.<br>Also added policy that indicates the hospice must maintain written documentation of its quality assessment and performance improvement program and they must be able to demonstrate its operation to the Center for Medicare and Medicaid Services (CMS). |
| **3203.1B.9** | **Policy – Provider Responsibility – Infection Control** | Added policy indicating that the hospice 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 hospice must also provide infection control education to employees, recipients, and family members. |
| **3203.2** | **Policy – Non-Hospice Services** | Removed CFR reference from first paragraph. |

| Manual Section | Section Title | Background and Explanation of Policy Changes, Clarifications and Updates |
|---|---|---|
| **3203.4.a.1** | **Policy – Revoking the Election of Hospice Care** | Reworded existing policy regarding the signed statement from the recipient or representative should they want to revoke the election of coverage for hospice care. |
| **3203.5** | **Policy – Discharge of a Recipient from Hospice** | Added policy indicating that the hospice may discharge a recipient who moves out of the hospice's service area or transfers to another hospice. Added requirements and recipient protections for discharges for cause, and added that prior to discharge the hospice must obtain a written discharge order from the hospice medical director or if a recipient has an attending physician the attending physician must be consulted and their recommendation or decision must be included in the discharge note. |
| **3203.9** | **Policy – Clinical Records** | Added policy that indicates that the clinical records may be maintained electronically and added clarifying language on what each individual record must contain. In addition, added policy regarding the storage of records after the recipient is discharged or deceased. |
| **3203.10** | **Policy – DHCFP Review** | Changed the title of the section from Medicaid Review to DHCFP Review clarified language and removed the following examples of the methods of review that may be included:<br><br>(c) Evaluation of comments from patients, families and providers (can be done at onsite reviews)<br>(d) Concurrent (inspection of ongoing care, adherence to plan of care and records) (can be done at onsite reviews. |

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MEDICAID SERVICES MANUAL
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HOSPICE

# 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.

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.

3202 RESERVED

# 3203 POLICY

## 3203.1 HOSPICE SERVICES

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. 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.

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.

h. 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.

## 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. Determination of Medicaid eligibility by the Division of Welfare and Supportive Services (DWSS);

b. Certification of terminal illness (refer to Section 3203.1B.1.d); and

c. Election of Hospice Care - an 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.

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 months or less.

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.

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 for the client's family and significant others, as identified in the POC, 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.

2. 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.

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.

g. 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.

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 (NF), 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

1. Recipient Enrollment Process

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. Hospice Medicaid Information form;

b. Hospice Ancillary Information form;

c. 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 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.

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.

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.

2. Interdisciplinary Group

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.

b. Role of Interdisciplinary Group: Members of the group interact on a regular basis 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.

c. 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.

3. 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).

c. 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.

c. 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 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.

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.

c. 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 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 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.

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 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 statement to be placed in the medical record that includes the following information:

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:

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 and the Hospice 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

1. Responsibilities of the hospice and the nursing facility

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.

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.

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.

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

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;

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.

## 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.

3203.10A PROVIDER RESPONSIBILITY

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

# 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.