



Utah Medicaid Hospice Care Provider Training

Presented By:

The Division of Medicaid and Health Financing
Bureau of Authorization and Community Based Services
October 2012

Hospice Training Topics



- Client eligibility and hospice election
- Prior authorization
- Plans of care
- Service coverage
- Physician services
- Pediatric hospice care
- Health Plan and HCBS waiver participants
- Discharge/revocation
- Provider enrollment
- Reimbursement
- Helpful links and contact information

Any reference to pediatric hospice care in the slide presentation will be indicated with this figure in the corner:



When this figure is seen on a slide, the first person to raise their hand and yell out “**concurrent care**” will receive a raffle ticket for a chance to win a prize.

Hospice comes from the recognition that a client's terminal condition warrants a shift in focus from curative care to palliative care.

Recent adjustment in the approach to treating children: no longer requires a shift in focus from curative to palliative care. Children may receive both concurrently.

Medicaid clients who have a terminal illness with a life expectancy of 6 months or less may elect hospice care.

- 6 months is an estimation based on the anticipated course of the terminal condition.
- Requires a face-to-face assessment by a physician conducted no more than 90 days prior to the date of hospice enrollment.
- Eligibility is the same for adults and children.

Physician's certification of terminal illness

- Following the face-to-face assessment, the physician must certify in writing that the client has a terminal condition with a life expectancy of 6 months or less.
- Hospice agencies may not seek Medicaid reimbursement until the date of the physician's certification
 - Verbal certification is permitted initially, with written certification following no more than eight (8) days later.

Patient's name: _____ Medicaid ID: _____

- Certification for *first* 90-day election period Effective date: _____
- Recertification for *second* 90-day election period Effective date: _____
- Recertification for a subsequent 60-day election period Effective date: _____

I have performed a medical evaluation of the above mentioned patient and certify that he/she is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Terminal diagnosis description (not codes): _____

Provide a brief summary of clinical information and other medical documentation to support the patient's medical prognosis and life expectancy of six months or less:

Signature -- Hospice Medical Director, confirming that this certification and narrative is based on his/her direct review of the patient's medical record and/or examination of the patient.

Date signed

Signature -- Attending Physician, confirming that this certification and narrative is based on his/her direct review of the patient's medical record and/or examination of the patient.

Date signed (Attending physician signature only required for the initial certification, and only when the patient has an attending physician.)

- Name & ID
- Terminal illness
- Brief summary to support prognosis
- Physician signature & date

Client Access to Hospice Care



- Election of hospice
 - An eligible client must file a written election statement with the selected hospice agency
 - Medicaid reimbursement is not available prior to the day that the election was filed.

– Election statements must include:

1. Identification of the hospice agency,
2. Acknowledgement of the palliative nature of hospice,
3. Acknowledgement that the client waives rights to Medicaid funded treatment for the terminal condition (adults only),
4. Acknowledgement that the client may revoke the election of hospice care at any time in the future, thereby restoring waived Medicaid benefits, and
5. The client's signature and date.

How is election different for children?

- Providers must have distinct election statements for clients under the age of 21
- Election statements must inform pediatric clients that they are entitled to all Medicaid benefits concurrently with hospice care until their 21st birthday.

Dual eligibility (Medicare and Medicaid)

- If a client elects hospice care with Medicare, he/she must also elect hospice care with Medicaid
 - Medicare covers hospice services
 - Medicaid is available to pay Medicare coinsurance and/or hospice room and board

All Medicaid hospice services must be prior authorized by the Division of Medicaid and Health Financing.

1. Routine home care
2. Continuous home care
3. Inpatient respite care
4. General inpatient care
5. Room and board

Utah Medicaid Prior Authorization Request for Hospice Services



Hospice Provider Name:	
NPI Provider Number:	
Initial Hospice Admission Date: <small>(No matter the funding source)</small>	
Is the client Medicaid eligible upon initial admission?	<input type="checkbox"/> Yes (Submit <u>this form</u> and a copy of the <u>signed election statement</u> and <u>physician certification statement</u> to Medicaid within 10 calendar days. If this form is not received timely, Medicaid will not reimburse for hospice services rendered prior to the date the PA request is received.)
	<input type="checkbox"/> No (Complete <u>this form</u> & attach copies of the <u>initial plan of care</u> , <u>physician certification statement</u> and <u>signed election statement</u> but DO NOT submit anything to Medicaid until after client becomes Medicaid eligible. Medicaid will then require all three documents when determining post payment authorization.)
Who Signed the Election Statement?	<input type="checkbox"/> Client <input type="checkbox"/> Legal Representative as defined in R414-14A
Client's Name:	Last: _____ First: _____
Medicaid ID Number:	
Client's Social Security Number:	
Client's Date of Birth:	
Diagnosis(es) Description: <small>(Not codes)</small>	
Physician:	Last: _____ First: _____
Hospice Contact Person:	
Contact Person Phone Number:	
Nursing Facility or ICF/ID Name:	
NF or ICF/ID Admission Date:	
Children only: Has UDOH approved an add-on rate? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>(If yes, 10A #: _____)</small>	
Hospice Benefit Requested:	<input type="checkbox"/> Routine <input type="checkbox"/> Room & Board <input type="checkbox"/> Other _____
Prior Auth Effective Dates:	_____ to _____ PA # _____ _____ to _____ PA # _____
Discharge date: ____/____/____	Date of death: ____/____/____ Date client revoked: ____/____/____
<small>(Send a copy of the revocation form signed by the client or legal representative.)</small>	

Initial admission date

Medicaid eligibility upon admission

Diagnosis(es)

PA effective dates and PA number

Date of death or date of revocation

- Call in to: 801-538-6634
- Or fax to: 801-536-0157

Prior Authorization



Send these items along with the PA Request Form:

1. A copy of the signed election statement,
2. A copy of the physician's certification statement,
and
3. For general inpatient hospice only, additional clinical records are required detailing the client's condition at the time of the request.

Prior Authorization

PA grace period:

Hospice agencies are permitted to begin provision of services to a new Medicaid hospice client for a grace period of up to ten (10) calendar days before submitting the PA Request Form to the Division of Medicaid and Health Financing.

Before the end of the grace period, the PA Request Form must be submitted.

Untimely requests will result in loss of Medicaid reimbursement.

Hospice PA vs. 10A Process

- Non-hospice nursing facility residents must go through the 10A approval process for Medicaid reimbursement. This is the nursing facility's responsibility.
- The 10A process does not serve as prior authorization for Medicaid hospice room and board.
- Always communicate with the nursing facility to find out how your client's room and board is being funded.
- Because the Medicaid payment to the NF is directly tied to the 10A process, it is critical for the hospice to notify the NF in writing if a client is discharged from hospice.

Post-payment for retroactive Medicaid eligibility

- If a non-Medicaid client is admitted to hospice care and becomes Medicaid eligible at a later date, post-payment is permitted if the following requirements are met:
 1. Hospice care met the PA criteria at the time of delivery, and
 2. The hospice agency reimburses Medicaid for treatment related to the client's terminal illness delivered during the retroactive period.
- Post Authorization cannot be earlier than the first day of financial Medicaid eligibility, even if the client elected hospice care before that date.

Post-payment for retroactive Medicaid eligibility

- To request post-payment, please submit these documents:
 1. Prior Authorization Request Form
 2. Signed election statement
 3. Physician's certification statement
 4. Initial hospice plan of care

Medicaid eligibility check

The hospice agency is responsible to verify client Medicaid eligibility status.

- Access Now (801) 538-6155 or
(800) 662-9651
- If Access Now says “ineligible,” double check with Suzanne Slaughter: (801) 538-6634
- Check every month!

Essential core services must be provided at the frequency determined appropriate by the attending physician and the hospice interdisciplinary team.

Services and frequency must be specified in the patient's plan of care.

Plans of Care

- Plans of care must be consistent with the hospice philosophy of care.
- Plans of care must be established on the same day as the face-to-face assessment and certification IF the day of assessment and certification is to be a covered day of hospice care.

- Essential core services included in routine hospice (T2042):
 1. Nursing care
 2. Medical social services
 3. Administrative and general supervisory activities performed by physicians
 4. Counseling services for the patient and family members

Other services covered by routine hospice:

1. Medical appliances (including durable medical equipment) and supplies including drugs and biologicals for the relief of pain and symptom control related to the terminal illness
2. Home health aide and homemaker services including provision of personal care when appropriate
3. PT, OT, and speech-language pathology for the purposes of symptom control or to enable client's maintenance of ADLs/functionality

Other services covered by routine hospice, continued:

4. Bereavement counseling for the family after the patient's death
5. Special modalities such as chemotherapy, radiation therapy and other modalities for the purpose of palliative care.

No additional Medicaid reimbursement is available for any of these services.

- How is routine hospice care different for children?
 - Benefits available through hospice care are the same for children and adults.
 - Ask yourself: Would my agency be expected to cover this particular service or medical supply for an adult in hospice care?
 - Nutritional shakes (such as Ensure) are not available through Medicaid State Plan

- How are Medicaid State Plan “curative” services accessed for children?
 - Prior authorization is required for many State Plan services
 - For hospice care, Suzanne Slaughter
 - The treating provider is responsible to know and follow Medicaid procedures
 - To find out if PA is needed for another service, refer to the specific provider manual OR call the Utah Medicaid HelpLine
 - (801) 538-6155, option 3 then 3 then 0
 - (800) 662-9651, option 3 then 3 then 0

- Additional hospice services are distinctly funded by Medicaid when deemed appropriate and necessary:
 1. Continuous home care (T2043)
 2. Inpatient respite care (T2044)
 3. General inpatient care (T2045)
 4. Room and board (T2046)

Continuous Home Care (T2043):

- May be authorized during a period of acute medical crisis in which a patient requires at least 8 hours of primarily nursing care in a 24-hour day
- Only available to clients residing at home, not in a nursing facility
- More than 50% of the service must be nursing care (RN or LPN)
- 8 service hours need not be “continuous” in the 24-hour period

Continuous Home Care (T2043), continued:

- The goal of continuous home care is to manage the medical crisis and maintain the client at home.



Inpatient respite care (T2044):

- May be furnished up to five (5) days at a time
- Not available for residents of nursing facilities, ICFs/ID or freestanding hospice inpatient facilities
- Clinical log notes will be requested with PA requests
- Log notes should reflect caregiver burnout

Inpatient respite care (T2044), continued:

- The goal of inpatient respite care is to provide rest and stress relief for family members or others that are caring for the client at home.



General inpatient care (T2045):

- Short term general inpatient care (GIP) for pain control or acute or chronic symptom management which cannot be managed at home or in another outpatient setting
- Services must conform to the written plan of care

General inpatient care (T2045), continued:

- Client's preference to die in an inpatient setting is not an acceptable criterion for GIP
- GIP may not be authorized due to the breakdown of the primary care giving living arrangements or the collapse of other supports

GIP is unique in the prior authorization process.

- 10 calendar day grace period is permitted for GIP prior authorization requests.
- Clinicians at the Dept of Health must review clinical records in order to approve GIP care.
- Hospice agencies are at risk if the clinical records do not justify the need for GIP.

General inpatient care (T2045), continued:

- The goal of GIP is to provide short term intensive inpatient treatment in an effort to gain control of acute pain or other extreme symptomology related to the terminal condition.



Room and board (T2046):

- Extended stay residents of nursing facilities, ICFs/ID, or freestanding hospice inpatient units who elect hospice care may receive Medicaid reimbursement for hospice room and board.
- Prior authorization must be obtained within 10 calendar days
- Medicare does NOT reimburse room and board

Room and board (T2046), continued:

- Medicaid pays room and board to the hospice agency
- The hospice agency is responsible to pass the room and board payment to the facility
- Withholding the room and board reimbursement constitutes Medicaid Fraud and will be reported

Agreement between hospices and the NF or ICF/ID:

- Written agreement which clearly defines the roles and responsibilities of each entity
- Hospice agencies are responsible for professional management of the client's hospice care
- Facility is responsible to provide room and board:
 1. Personal care services
 2. Socializing activities
 3. Administration of medication
 4. Maintaining cleanliness of the client's room
 5. Supervising and assisting in the use of equipment and therapies

Record keeping for residents of NFs or ICFs/ID:

- Hospice agencies must establish and maintain a clinical record for every client in their care, including residents of facilities.
- Records must include all services furnished.
- The survey team will look for necessary documentation during audits



Physician services:

- Costs for administrative and general supervisory activities performed by physicians who are employees of the hospice are included in the hospice rates



1. Establishing plans of care
2. Supervising care and services
3. Periodic review and updating of plans of care
4. Establishing governing policies

Physician services, continued:

- Direct patient care by the medical director, hospice-employed physician or consulting physician may be reimbursed in the usual Medicaid reimbursement policy for physician services.
- Services by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.



In-home physician services:

- Permitted only if the attending physician determines that direct management of the client in the home setting is necessary to achieve the goals associated with the hospice approach to care.
- Residents of nursing facilities, ICFs/ID or freestanding inpatient hospice units are not eligible to receive in-home physician services



HOSPICE PRIOR AUTHORIZATION FOR PHYSICIAN IN-HOME VISITS



Date of Service: _____
 (MM) (DD) (YY)

Name of Recipient: _____
 (First Name) (Last Name)

Recipient's Medicaid Number: _____

Social Security Number: _____ (If no Medicaid Number)

Recipient's Home Address: _____

Attending Physician: _____
 (First Name) (Last Name)

Physician's Medicaid Provider Number: _____

Name of Hospice Provider: _____

Hospice Provider Contact Person : _____

Phone Number: _____

Requested Code: _____

This form is used to obtain prior authorization for physician in-home visits.

Complete all fields and send the form to Suzanne Slaughter.

<u>Code</u>	<u>Service Unit</u>	<u>Code</u>	<u>Service Unit</u>
New Patient		Established Patient	
99341	20 min face-to-face	99347	15 min face-to-face
99342	30 min face-to-face	99348	25 min face-to-face
99343	45 min face-to-face	99349	40 min face-to-face
99344	60 min face-to-face	99350	60 min face-to-face
99345	75 min face-to-face		

Limitations
 Description: Codes 99341-99350 are used for a home visit by the primary managing physician for the evaluation and management of a new hospice patient, which requires (a) a problem focused history, (b) a problem focused examination, and (c) straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Limitations: Codes 99341 through 99350 will only be reimbursed for one physician functioning as the primary managing physician per hospice patient.

Clients under 21 years of age who elect to receive Medicaid hospice care may also receive concurrent Medicaid State Plan treatment for the terminal illness and other related conditions.



Pediatric Hospice

- Medicaid will reimburse the appropriate Medicaid enrolled medical care providers directly through the usual and customary Medicaid billing procedures.
- With the exception of room and board, hospice agencies are not responsible to reimburse medical care providers for life prolonging treatment rendered to children.

Pediatric Hospice

- Hospice agencies wishing to provide care for children must enroll to become a pediatric hospice provider.
- Pediatric hospice providers must demonstrate they have adopted the National Hospice and Palliative Care Organization's standards.
- Pediatric hospice providers must develop a training curriculum to ensure all team members are adequately trained to provide hospice care to children.

If a hospice recipient is enrolled in a health plan, the hospice provider must have a contract with the health plan.

The health plan will be responsible for reimbursement of hospice services.

HCBS Waiver Participants



- Clients enrolled in a 1915(c) HCBS waiver program are permitted to receive hospice care concurrently.
- Hospices are responsible to provide medically necessary care directly related to the terminal condition.
- The waiver is able to provide services unrelated to the terminal condition.
- It is crucial for the hospice to meet with the waiver case management agency at the initiation of hospice services in order to develop a coordinated plan of care.

Revocation

- The client/representative may voluntarily revoke the election of hospice care at any time
- A written revocation statement must be signed by the client/representative and sent to the Department
- The client may re-elect hospice for any future election periods
- The next possible election period begins no earlier than one day after the date of revocation
 - The client cannot revoke and re-elect on the same day

Hospice agencies may not initiate discharge except in the following circumstances:

1. The client moves out of the provider's service area or transfers to another agency by choice
2. The hospice determines that the client is no longer eligible for hospice care
3. The hospice determines that the client's behavior (or the behavior of others in the client's home) is disruptive, abusive or uncooperative to the extent that service delivery is seriously impaired.
 - Number 3 is considered "for cause discharge"

Steps required when discharging for cause:

1. Advise the client that discharge for cause is being considered.
2. Make a diligent effort to resolve the problem(s).
3. Ascertain that the discharge is not due to the client's use of necessary hospice services.
4. Document the problems and resolution efforts in the client's medical record.
5. Consult the attending physician.
6. Obtain a written discharge order from the hospice provider's medical director.

Hospice agencies are responsible to notify UDOH within 10 days of the following events:

1. A client is enrolled in hospice care (initially and for each election period thereafter).
2. A client's needs warrant a change to a different hospice service.
3. A client becomes retroactively eligible for Medicaid benefits.
4. A client revokes his/her election of hospice care.
5. A client changes to a different hospice provider.
6. A client dies or is otherwise discharged.
7. A client has been determined by Medicare to no longer be eligible for Medicare hospice.

Pediatric Hospice Provider Enrollment:

- Please complete the following forms and return to BACBS:
 1. Provider Application
 2. Signed Pediatric Hospice Provider Attachment (provided by BACBS)
 3. Copy of your training curriculum
 4. Department of Health license as a Hospice
 5. Current Medicare certification as a Hospice
 6. Ownership Disclosure form
 7. W-9
 8. Provider Agreement

Enrollment forms can be found on the Medicaid website:
<http://health.utah.gov/medicaid>

Pediatric Hospice Provider Attachment

ENROLLMENT

Hospice care for clients under 21 years of age.

Provider Name: _____

Effective Date: _____

FOR DMHF USE ONLY

Provider #: _____

Provider Type: _____

Category of Service: _____

In accordance with R414-14A-10, pediatric hospice providers will develop a training curriculum to ensure that the hospice's interdisciplinary team members, including volunteers, are adequately trained to provide services to clients under 21 years of age. All staff members and volunteers providing pediatric hospice care must receive the training prior to provision of services to clients who are under 21 years of age, and at least annually thereafter. At a minimum, the training will include the following pediatric specific elements:

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

Agencies wishing to enroll as a pediatric hospice provider must submit a copy of their training curriculum and this certification attachment along with their enrollment application to the Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services.

The undersigned Provider Representative certifies that all staff members and volunteers providing pediatric hospice care have received (or will receive) the required training prior to provision of services to clients under 21 years of age.

Signature of Provider Representative

Date

The Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services, has determined that the above provider meets all qualifications listed in R414-14A-10 for provision of pediatric hospice care. The undersigned Bureau Representative certifies that the above designated category of service and provider type are accurate.

Signature of Representative
DMHF, Bureau of Authorization and Community Based Services

Date



This form requires the hospice agency to certify that all staff members and volunteers providing pediatric hospice care have or will receive training prior to provision of services to children.

Hospice Re-Enrollment:

- Due to the CMS mandate (CFR 455.104) Utah Medicaid will require all providers to re-enroll every three to five years.
- Please return the following items to Medicaid when you receive a letter requesting re-enrollment with Medicaid:
 1. Ownership Disclosure Form (Please write 're-enroll' at the top of the form)
 2. New signed Provider Agreement
 3. Department of Health license as a Hospice
 4. Copy of your current Medicare certification

Hospice Provider Enrollment



Fax, send, or email your completed forms and certification to Utah Medicaid, Provider Enrollment:

- Fax number: 801-536-0471
- Address: Medicaid Operations,
Attn: Provider Enrollment
PO Box 143106
Salt Lake City, UT 84114-3106
- Email: providerenroll@utah.gov

If you have any questions, please contact Utah Medicaid, Provider Enrollment at 801-538-6155 or toll free 1-800-662-9651, menu option 3, then 4.

Closure due to inactivity:

- Utah Medicaid closes provider contracts when a provider is inactive (no billing) for more than 2 years. If your contract is closed, new enrollment forms will be required to reinstate your contract.



A word about NPIs:

Many Hospices and Home Health Agencies share the same NPI number. If this is the case, a taxonomy code will need to be supplied to Provider Enrollment for each Medicaid contract (the taxonomy codes will need to be different). Your biller will need to bill with this taxonomy code as well.

Example:

- ABC Hospice NPI: 1234567899 Taxonomy code: 123G45670X
- ABC Home Health NPI: 1234567899 Taxonomy code: 214D521450X

NPIs, continued:

If the Hospice and Home Health Agencies have their own NPI number, a taxonomy code is not needed for billing purposes.

Example:

- ABC Hospice NPI: 1234567899
- ABC Home Health NPI: 1587458112

Taxonomy codes can be found at the following website:

<http://www.wpc-edi.com/reference/>

Change of Ownership:

- If your hospice changes ownership, and Medicare deems it a change of ownership, please notify Provider Enrollment of this change.
- A new application packet will need to be completed with the new information.
- The Medicaid enrollment cannot be processed until Medicare has completed the change of ownership.
- The current policy states that “the effective date of the new contract will be the date all needed documentation is received by Provider Enrollment.”

Billing codes for Medicaid Hospice Care:

- Routine code is... T2042
- Continuous home care code is... T2043
- Respite care code... T2044
- GIP billing code is... T2045
- Room and board code is... T2046

Date of discharge:

- Do hospice providers get paid for date of discharge from hospice care?
- Does the hospice agency get paid for date of death?
- What happens if hospice is revoked same day as elected?

Timely filing:

- Providers are given 365 days from date of service to bill and correct any claims
- Claims that are not billed and/or corrected within the 365 days will be denied



Code issues:

- GIP (T2045) includes both routine hospice care and room and board
- Routine Hospice (T2042) -- bill with the county rate of the client's residence
- Room and Board (T2046) -- please use the correct facility rate. Pricing Hospice R&B claims is a manual process.
 - When billing both T2046 and T2042, it is best billed on the same claim, otherwise you risk one denying.

Medicaid Links



PA Form, letters & rates:

<http://health.utah.gov/ltc/Hospice/HospiceHome.html>

Provider Manual:

<http://health.utah.gov/medicaid/manuals/directory.php?p=Medicaid Provider Manuals/Hospice/>

R414-14A, Hospice Care:

<http://www.rules.utah.gov/publicat/code/r414/r414-14a.htm>

Medicaid Information Bulletins:

<http://health.utah.gov/medicaid/manuals/directory.php?p=Medicaid Information Bulletins/>

Contact Information



- Prior Authorization: Suzanne Slaughter
(801) 538-6634
- Policy questions: Trecia Carpenter
(801) 538-6861
- Hospice Fax #: (801) 536-0157

Medicaid Helpline



Monday through Friday, 8:00 a.m. - 5:00 p.m.

- In the Salt Lake City area, call 801-538-6155
- In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona, and Nevada, call toll-free 1-800-662-9651
- From other states, call 1-801-538-6155

Questions?

