Department: Utilization Management	**Policy and Procedure No:**	
Policy and Procedure Title: Hospice Clinical Coverage Policy		
Process Cycle: Annually	**Responsible Departments:** Clinical	
Approved By: Patricia Jones, RN	**Issue Date:** 1/1/23	**Revised:**

PURPOSE: The purpose of this policy is to define Hospice services and the criteria for medical necessity for Humana Healthy Horizons in Louisiana.

POLICY AND PROCEDURE:

Policy: Hospice Clinical Coverage Policy

Procedure:

Criteria for Hospice Care

A member must be terminally ill in order to receive Medicaid hospice care. An individual is considered terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

PRIOR AUTHORIZATION PROCESS

Election Periods

Hospice services are covered on the basis of periods and require prior authorization. A member 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; and
3. Subsequent periods of 60 days each .

Prior authorization (PA) is required upon the initial request for hospice coverage. Requests for PA must be submitted within 10 calendar days of the hospice election date. If the PA is approved, it covers 90 days. If another 90-day election period is required, the PA request must be submitted at least 10 days prior to the end of the current election period. This will ensure that requests are received and approved/denied before the preceding period ends. If this requirement is not met and the period ends, reimbursement will not be available for the days prior to receipt of the new request. If approved, reimbursement will be effective the date the Managed Care Organizaton (MCO) receives the proper documentation.

The completed PA (see Required Documentation in this section,) which includes the updated and signed "Hospice Certification of Terminal Illness (CTI)" (BHSF Form Hospice CTI) and all related documents, must be received before the period ends. Any PA request received after the period has ended will become effective on the date the request is received by the MCO if the request is approved. This policy also applies to PA packets received after Medicaid eligibility has ended. It is the responsibility of the provider to verify eligibility on a monthly basis. The PA only approves the existence of medical necessity, not member eligibility.

Department: Utilization Management	**Policy and Procedure No:**	
Policy and Procedure Title: Hospice Clinical Coverage Policy		
Process Cycle: Annually	**Responsible Departments:** Clinical	
Approved By: Patricia Jones, RN	**Issue Date:** 1/1/23	**Revised:**

Required Documentation

Documentation should paint a picture of the member's condition by illustrating the member's decline in detail (e.g. documentation should show last month's status compared to this month's status and should not merely summarize the member's condition for a month).
In addition, documentation should show daily and weekly notes and illustrate why the member is considered to be terminal and not "chronic". Explanation should include the reason the member's diagnosis has created a terminal prognosis and show how the systems of the body are in a terminal condition. Telephone courtesy calls are not considered face-to-face encounters and will not be reviewed for prior authorization.

The following information will be required upon the initial request for hospice services.

Certification of Terminal Illness
The hospice provider must obtain written certification of terminal illness (BHSF Form HospiceCTI) for each of the election periods, even if a single election continues in effect for two or more periods. Written certifications may be completed two weeks before the beginning of each election period.

First Benefit Period (90 days)

1. Hospice Election Form (primary diagnosis code(s) using the International Classification of Disease, Tenth Revision (ICD-10) or its successor; other codes);
2. Hospice Certification of Terminal Illness form (BHSF Form Hospice – CTI) including Physician Narrative;
3. Clinical/medical information;
4. Hospice provider plan of care (POC) includes the following:
    a. Progress notes (hospital, home health, physician's office, etc.);
    b. Physician orders for POC; and
    c. Include Minimum Data Set (MDS) or jRaven form (original and current) if member is in a facility; weight chart; laboratory tests; physician and nursing progress notes. The MDS/jRaven form (original and current) is not required if the member has been in a long-term care facility less than 30 days. The MDS/jRaven form must be provided upon the subsequent request for continuation of hospice services.
5. Documentation to support member's hospice appropriateness must include the following:
    a. Paint picture of member's condition;
    b. Illustrate why member is considered terminal and not chronic;
    c. Explain why his/her diagnosis has created a terminal prognosis; and
    d. Show how the body systems are in a terminal condition.

Note:

Written certifications may be completed two weeks before the beginning of each election period.

Nurse practitioners cannot certify a terminal diagnosis or the prognosis of six months or less, if the illness or disease runs it normal course, or re-certify terminal diagnosis or prognosis. In the event that a member's attending physician is a nurse practitioner, the hospice medical director and another physician designee must certify or re-certify the terminal illness. When a NP performs the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of six months or less, should the illness run its normal course. Regulations require the narrative to be composed by the certifying physician only.

Second and Subsequent Periods

Providers requesting PA for the second period, and each subsequent period, must send the request packet to the MCO that includes the following:

1. MDS/jRaven forms (original and current) are required; weight chart; laboratory tests; physician and nursing progress notes if the member resides in a nursing facility;
2. An updated Hospice CTI form (BHSF Form Hospice-CTI) and a face-to-face encounter signed and dated by the hospice provider's medical director or physician member of the interdisciplinary group (IDG) for the third and subsequent requested PA periods;
3. An updated POC;
4. Updated physician's orders;
5. List of current medications (within last 60 days);
6. Current laboratory/test results (within last 60 days if available);
7. Description of hospice diagnosis
8. Description of changes in diagnoses;
9. Progress notes for all services rendered (daily/weekly physician, nursing, social worker, aide, volunteer and chaplain);
10. A social evaluation;
11. An updated scale such as: Karnofsky Performance Status Scale, Palliative Performance Scale or the Functional Assessment Tool (FAST);
12. The member's current weight, vital sign ranges, lab tests and any other documentation supporting the continuation of hospice services. Documentation must illustrate the member's decline in detail. Compare last month's status to this month's status; and
13. Original MDS/jRaven; current MDS/jRaven form if member is a resident in a facility.

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

For PA, the prognosis of terminal illness will be reviewed. A member must have a terminal prognosis in addition to a completed Hospice CTI form and proof of the face-to-face encounter. Authorization will be made on the basis that a member is terminally ill as defined in federal regulations. These regulations require certification of the prognosis, rather than diagnosis. Authorization will be based on objective clinical evidence in the clinical record about the member's condition and not simply on the member's diagnosis.

A cover letter attached to the required information will not suffice for supporting documentation.

The supporting information must be documented within the clinical record with appropriate dates and signatures.

Example: A member receives hospice care during an initial 90-day period and is discharged or revokes his/her election of hospice care during a subsequent 90-day period, thus losing any remaining days in that election period. If this member chooses to elect a subsequent period of hospice care, even after an extended period without hospice care, prior authorization will be required. The Notice of Election (NOE), Hospice CTI form, and all prior authorization documentation are due within the 10 day time frame. Reimbursement will be effective the date the required information is received by the MCO if receipt is past 10 days.

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

Levels of Care

Payment rates are determined at one of four levels for each day of a member's hospice care. The four levels of care are:

1. Routine home care;
2. Continuous home care;
3. Inpatient respite care; and
4. General inpatient care

Routine Home Care (Revenue Code 651)

A routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous home care. The routine home care rate is paid for each day the member is under the care of the hospice and not receiving one of the other categories of care. This rate

is paid without regard to the volume or intensity of routine home care services provided on any given day.

Service Intensity Add-On Rate (SIA) (Revenue Code 659)
A service intensity add-on (SIA) payment will be reimbursable for a visit by a registered nurse (RN) or a social worker, when provided during routine home care (HR651) in the last seven days of a patient's life. The SIA payment is in addition to the routine home care rate.

Claims for SIA services must be billed in units. Each unit is equal to 15 minutes. The maximum number of reimbursable units per day is 16 units. The seven-day maximum number of reimbursable units is 112 units. All claims must be submitted with documentation demonstrating the necessity of the services provided. Documentation submitted should reflect the arrival and departure time of the professional providing the services. Visits for the pronouncement of death only will not be reimbursed as an eligible visit.

Continuous Home Care (Revenue Code 652)
The individual receiving hospice care is not in an inpatient facility and receives care consisting predominantly of nursing care on a continuous basis at home. Continuous home care is only furnished during brief periods of medical crisis and only as necessary to maintain the terminally ill member at home. Routine home care code must be billed if less skilled care is needed on a continuous basis to enable the member to remain at home. Services should reflect direct member care during a period of crisis and should not reflect time related to staff working hours, time taken for meal breaks, time used for educating staff or time use for reporting. Continuous home care is not paid during a hospital, skilled nursing facility or inpatient hospice facility stay.

Criteria for continuous home care include the following:

1. A period of medical crisis is when a member requires continuous care, which is primarily nursing care, to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either an RN or a licensed practical nurse (LPN), and a nurse must be providing care for more than half of the period of care. Nursing care can include skilled observation and monitoring when necessary, and skilled care needed to control pain and other symptoms; or
2. A minimum of eight hours of care must be provided during a 24-hour day which begins and ends at midnight. If fewer than eight hours of continuous care are provided, the services are covered as routine care rather than continuous home care. This care need not be continuous (i.e. four hours could be provided in the morning and another four hours provided in the evening of that day). The care must be predominantly nursing care provided by either an RN or LPN. Homemaker and aide services may also be provided to supplement the nursing care. Care by a hospice aide and/or homemaker cannot be discounted or provided "at no charge" in order to qualify for continuous home care.

NOTE: The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate.

Inpatient Respite Care (Revenue Code 655)
An inpatient respite care day is a day on which the individual receives care in an approved facility on a short-term basis to relieve the family members or other persons caring for the individual at home.

NOTE: An approved facility is one that meets the standards provided in 42 Code of Federal Regulations (CFR), Section 418.98(b). The inpatient respite care rate is paid for each day the member is in an approved inpatient facility and is receiving respite care. Payment is made for respite care for a maximum of five continuous days at a time in any election period, including the date of admission, but not counting the date of discharge. Payment for the sixth day, and any subsequent days, is made at the routine home care rate. Respite care may not be provided when the hospice member is a resident in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

Criteria for Inpatient Respite Care:

1. If the member, who resides in the home, goes into a nursing facility for respite care and returns home after the respite care, the member need not be in a nursing facility Medicaid bed;
2. Medicaid will pay the inpatient respite care rate for the day of death;
3. Services provided in the facility must conform to the hospice's plan of care (POC); and
4. The hospice is the professional manager of the member's care despite the physical setting of the care or the level of care.

General Inpatient Care (Revenue Code 656)
A general inpatient care day is a day on which an individual receives general inpatient care in an inpatient facility that meets the standards as provided in 42 CFR 418.98(a) and for the purpose of pain control or acute or chronic symptom management which cannot be managed in other settings. General inpatient care is a short-term level of care and is not intended to be a permanent solution to a negligent or absent caregiver or considered to be a member's permanent or temporary residence. Once symptoms are under control, a lower level of care must be billed. Payment is made for inpatient care for a maximum of five continuous days at a time, including the date of admission, but not counting the date of discharge. Extended periods of stay at the facility are considered the member's permanent or temporary residence. Routine home care shall be billed.

Criteria for general inpatient care include the following:

1. General inpatient care and room and board in a nursing facility or ICF/IID cannot be reimbursed for the same member on the same covered days of service;
2. The hospice must have a contract with the inpatient facility, delineating the roles of each provider in the member's POC; and

3. Services provided in the facility must conform to the hospice's POC. The hospice is the professional manager of the member's care despite the physical setting of the care or the level of care.

SERVICE LIMITATIONS

Services Unrelated to Terminal Illness

Once a member elects to receive hospice services, the hospice provider is responsible for either providing or paying for all covered services related to the treatment of the member's terminal illness and related conditions. Although a member may present with multiple medical conditions, the attending physician certifies that at least one condition has created a terminal situation with a life expectancy of less than six months. It is incorrect to state a patient can elect hospice for one diagnosis and not another. A member must be enrolled in hospice for a terminal illness. If the member elects hospice, he/she has given up the option for therapeutic care for any and all of the related conditions. For example, if the member has cancer and chronic obstructive pulmonary disease (COPD) and wants active treatment for the COPD, he/she should not elect hospice. He/she should stay in regular Medicaid/Medicare. Members (and more particularly providers) cannot pick and choose among their diagnoses for hospice election; it is the life expectancy related to the member's overall terminal condition that is the controlling factor.

Members under 21 years of age who are approved for hospice may continue to receive life prolonging therapies that are focused on treating, modifying, or curing a medical condition so that the member may live as long as possible, even if that medical condition is also the hospice qualifying diagnosis. (Refer to Section 24.2 – Election of Hospice Care of this manual chapter for members under 21 years of age). The hospice agency is responsible for either providing or paying for all hospice services. The hospice provider is not responsible for reimbursement for life prolonging therapies. Reimbursement for concurrent care shall be to the providers furnishing the care and made separately from the hospice per diem.

Members under Age 21 Receiving Concurrent Care Hospice

Members under 21 years of age who elect hospice shall be eligible for the concurrent care model of hospice. Concurrent care allows the member to elect to receive life-prolonging therapies. Life-prolonging therapies consist of any aspects of the member's medical plan of care that are focused on treating, modifying, or curing a medical condition so that the member may live as long as possible, even if that medical condition is also the hospice qualifying diagnosis. When the member turns 21 years of age, the concurrent care benefit is no longer available. Members and families may change their election between standard and concurrent care anytime with the hospice during the hospice benefit period. The hospice provider is responsible for making a daily visit available and optional to all members under 21 years of age and for coordinating care to ensure there is no duplication of services. If a daily visit is declined by the member, or their family, then the hospice provider must maintain documentation of the

date and reason for not making a visit. The daily visit is not required if the person is not in the home due to hospitalization or inpatient respite stays.

All questionable services and/or treatments will be sent for medical review. All treatments and therapies must be included in the POC. Documentation of therapies and treatment as well as progress notes are required upon each request for a continuation of hospice care and upon the initial request for hospice care if the member is already receiving curative treatment(s)

Change of Designated Hospice Provider

A member or his/her legal representative is allowed to change the designation of the particular hospice provider from which hospice care will be received once in each election period. The change of the designated hospice provider is not a revocation of the election for the period in which it is made. To change the designation of hospice providers, the member or his/her legal representative must file with the hospice provider from which care has been received and the newly designated hospice provider, a signed statement that includes the following:

1. The name of the hospice provider from which the member has received care and the name of the hospice provider from which he/she plans to receive care; and
2. The effective date of the change.

Within five (5) calendar days following receipt of the filed change form, the new hospice provider must submit a BHSF Notification of Election/Revocation/Discharge/Transfer (81C/82C) to the Prior Authorization Unit when a member is transferring from the original hospice provider within five (5) calendar days.

HOSPICE REVOCATION AND DISCHARGE

Revocations

A member or his/her legal representative may revoke the election of hospice care at any time during an election period. This is a right that belongs solely and exclusively to the member or legal representative.

At no time is the hospice provider to demand a revocation. In addition, the hospice member or legal representative must not be asked to sign a blank form to be completed by the hospice provider prior to submission to the Plan. In the event it is discovered during the verification process that a hospice provider encouraged revocation for the purpose of potentially avoiding hospice related charges, and the member or legal representative is in agreement, the revocation will not be honored.

Required Statement of Revocation

When a member revokes or is discharged alive during an election period, the member or legal representative must sign and date a statement acknowledging that he or she is aware of the revocation and state reason the revocation is chosen. This written statement must be in the hand writing of the member or legal representative and include the member's contact information. The statement must be submitted to the hospice MCO for verification and follow up. A signed statement must include the date the revocation is to be effective. A member or his/her legal representative cannot designate an effective date earlier than the date that the revocation is made. The date of signature and proper written statement must also be included. This revocation shall be received by the hospice MCO within five calendar days of revocation. At no time will the effective date be earlier than the date the request is signed. Revocations that are back dated will be forwarded to the Medicaid Program Integrity Section for investigation for possible fraudulent activity. A verbal revocation of benefits is NOT acceptable.

Discharges

A hospice provider must discharge a member from hospice care upon receipt of a revocation statement or upon discovery the member is not terminally ill.

Reasons for Discharge

Members must be discharged only in the following circumstances:

1. There is a change in terminal status;
2. The member relocates from the hospice's geographically defined service area;
3. The safety of the member or of the hospice staff is compromised. The hospice provider must make every effort to resolve these problems satisfactorily before discharge, and efforts must be documented in detail in the member's clinical record;
4. Medicaid-only members who enter a non-contracted nursing home or hospital and all options have been exhausted (a contract is not attainable, the member chooses not to transfer to a facility with which the hospice provider has a contract, or to a hospice provider with which the skilled nursing facility (SNF) has a contract). The hospice provider must notify the payer source to document that all options have been pursued and that the hospice provider is not discharging the member without due cause; and
5. The hospice provider determines that the member's (or other persons in the member's home) behavior is disruptive, abusive or uncooperative to the extent that delivery of care to the member, or the ability of the hospice staff to operate effectively, is seriously impaired.

The hospice provider must do the following before it seeks to discharge a member for cause:

1. Advise the member that a discharge for cause is being considered;
2. Make a serious effort to resolve the problem(s) presented by the member's behavior or situation;
3. Ascertain that the member's proposed discharge is not due to the member's use of necessary hospice services;

4. Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into the member's clinical record; and
5. Obtain a written physician's discharge order from the hospice medical director prior to discharging a member for any reason.

NOTE: If a member has an attending physician involved in his/her care, the physician should be consulted before discharge with his/her review and decision included in the discharge note. This order shall be submitted to the hospice MCO with the required Medicaid discharge forms within five calendar days.

Documentation of Discharge
The hospice provider must clearly document why it was necessary to discharge the member. Within five calendar days after discharge, the provider must submit the Notice of Termination with type bill 81B or 82B via the BHSF Form Hospice – Notice of Election through so the files may be updated in a timely manner.

Discharge/Revocation Due to Hospital Admit
It is against Medicaid hospice policy to encourage members to revoke hospice services when they have an inpatient admission, emergency room visit, ambulance transport or other outpatient services and re-elect hospice after services are delivered. These cases will be verified and closely monitored by the Plan.

ADDITIONAL RESOURCES:

Louisiana Department of Health, Hospice Provider Manual, Chapter twenty-four of the Medicaid Services Manual; Hospice.pdf (lamedicaid.com). Accessed August 16, 2022.

VERSION CONTROL:

Version.Review.Approval History				
Department:	**Purpose of Review**	**Reviewed and Approved By:**	**Date:**	**Additional Comments:**
Clinical	Policy Development	Tiffany LeBlanc	8/18/2022	
Clinical	Policy Review	Patricia Jones/Cali Brou	8/22/2022	
Clinical	Policy Review	Dr. Ian Nathanson, VP Medicaid Clinical	8/22/2022	

Department: Utilization Management	**Policy and Procedure No:**	
Policy and Procedure Title: Hospice Clinical Coverage Policy		
Process Cycle: Annually	**Responsible Departments:** Clinical	
Approved By: Patricia Jones, RN	**Issue Date:** 1/1/23	**Revised:**

Clinical	Adoption Review	Medicaid Quality Governance Committee	8/25/2022	Committee approved. Ben Thompson, Committee Chair

DISCLAIMER:

Humana follows all federal and state laws and regulations. Where more than one state is impacted by an issue, to allow for consistency, Humana will follow the most stringent requirement.

This document is intended as a guideline. Situations may arise in which professional judgment may necessitate actions that differ from the guideline. Circumstances that justify the variation from the guideline should be noted and submitted to the appropriate business area for review and documentation. This (policy/procedure) is subject to change or termination by Humana at any time. Humana has full and final discretionary authority for its interpretation and application. This (policy/procedure) supersedes all other policies, requirements, procedures or information conflicting with it. If viewing a printed version of this document, please refer to the electronic copy maintained by CMU to ensure no modifications have been made.

NON-COMPLIANCE:

Failing to comply with any part of Humana's policies, procedures, and guidelines may result in disciplinary actions up to and including termination of employment, services or relationship with Humana. In addition, state and/or federal agencies may take action in accordance with applicable laws, rules and regulations.

Any unlawful act involving Humana systems or information may result in Humana turning over all evidence of unlawful activity to appropriate authorities. Information on handling sanctions related to non-compliance with this policy may be found in the Expectations for Performance, and Critical Offenses policies, both of which may be found in the Associate Support Center via Humana's secure intranet of Hi! (Workday & Apps/Associate Support Center).