



# **HOSPICE PROVIDER MANUAL**

*Chapter twenty-four of the Medicaid Services Manual*

**Issued April 15, 2012**

**State of Louisiana  
Bureau of Health Services Financing**

---

**CHAPTER 24: HOSPICE**

---

---

<b>SECTION:</b>	<b>TABLE OF CONTENTS</b>	<b>PAGE(S) 5</b>
-----------------	--------------------------	------------------

---

**CHAPTER 24  
HOSPICE  
TABLE OF CONTENTS**

<b>SUBJECT</b>	<b>SECTION</b>
<b>OVERVIEW</b>	<b>24.0</b>
<b>Criteria for Hospice Care</b>	
<b>RECIPIENT REQUIREMENTS</b>	<b>24.1</b>
<b>Medicare and Medicaid (Dual Eligibles)</b>	
<b>ELECTION OF HOSPICE</b>	<b>24.2</b>
<b>Reporting the Election of Hospice Care</b>	
<b>Pending Medicaid Eligibles</b>	
Attending Physician	
Election Statement Requirements	
Legal Representatives	
Definition of Relatives	
Election Periods	
Duration of Election	
<b>Change of Designated Hospice</b>	
<b>Waiver of Other Medicaid Covered Services</b>	
<b>Waiver Recipients</b>	
Service Coordination	
Long Term-Personal Care Services	
Community Choices Waiver	
<b>The Program of All-Inclusive Care for the Elderly</b>	
<b>COVERED SERVICES</b>	<b>24.3</b>
<b>Core Services</b>	
Physician Services	
Nursing Services	
Medical Social Services	
Counseling Services	
Dietary Counseling	
Bereavement Counseling	

**CHAPTER 24: HOSPICE**

**SECTION: TABLE OF CONTENTS PAGE(S) 5**

**Other Covered Services**

- Pastoral Care
- Short-Term Inpatient Care
- Medical Appliances and Supplies
- Hospice Aide and Homemaker Services
- Therapy Services

**Other Items and Services**

- Hospice Agency Service Requirements
- Waiver of Service Requirements
- Levels of Care

**RESERVED 24.4**

**PROVIDER REQUIREMENTS 24.5**

- Licensure
- Provider Responsibilities
- Interdisciplinary Group
- Plan of Care
- Physician Certification and Narrative
- Nurse Practitioners as Attending Physician
- Certification of Terminal Illness
  - Certification of Initial period
  - Verbal Certification
  - Sources of Certification
- Face-to-Face Encounters
- BHSF Written Notice of Hospice Decision
- Disaster Operations

**PRIOR AUTHORIZATION PROCESS 24.6**

- Electronic Prior Authorization
- Required Documentation
- Prior Authorization – 60 Day Period
- Written Notice of Prior Authorization Decision
- Reconsideration

**HOSPICE REVOCATION, DISCHARGE AND TRANSFER 24.7**

- Revocations
- Required Statement of Revocation
- Re-election of Hospice

---

**CHAPTER 24: HOSPICE**

---

**SECTION: TABLE OF CONTENTS PAGE(S) 5**

---

**Discharges**

- Reason for Discharge
- Documentation of Discharge
- Discharge/Revocation Due to Hospital Admit
- Service Availability upon Revocation or Discharge

**Notice of Transfer**

**RECORD KEEPING 24.8**

- Contract Services**
- Review by State and Federal Agencies**
- Administrative Files**
- Personnel Records**
- Recipient Clinical Records**
- Confidentiality and Protection of Records**

**REIMBURSEMENT 24.9**

- Claim Form**
- Levels of Care**
  - Routine Home Care (Revenue Code 651)
  - Continuous Home Care (Revenue Code 652)
  - Inpatient Respite Care (Revenue Code 655)
  - General Inpatient Care (Revenue Code 656)
- Payment for Physician Services**
  - Provision of Physician Services
  - Attending Physician
  - Consulting Physician
- Payment for Long Term Care Facility Residents**
  - Provider of First Choice
- Non-Emergency Transportation for Non-Hospice Related Medical Appointments**
- Emergency Transportation for Non-Hospice/Hospice Related Medical Conditions**
- Medicare Coinsurance**
  - Drugs and Biologicals Coinsurance (Dual Eligibles)
  - Respite Care Coinsurance (Dual Eligibles)
- Telephone Calls and Consultations**
- Non-covered Days**
- Hospice Services to Medicaid/Medicare/Veteran’s Eligible Beneficiaries**

---

**CHAPTER 24: HOSPICE**

---

**SECTION: TABLE OF CONTENTS PAGE(S) 5**

---

<b>CLAIMS RELATED INFORMATION</b>	<b>24.10</b>
<b>Diagnosis Codes</b>	
<b>Revenue Codes</b>	
<b>Frequency of Billing</b>	
<b>Claims Submission for Recipients Residing In the Home</b>	
<b>Claims Submissions for Recipients Residing In a Long Term Care Facility</b>	
<b>Claims Submissions for Schedule (Room and Board ONLY)</b>	
<b>Levels of Care Billing</b>	
<b>Third Party Liability</b>	
<b>Timely Filing Guidelines</b>	
<b>PROGRAM MONITORING</b>	<b>24.11</b>
<b>Review of Medical Eligibility</b>	
<b>Utilization Review Visits</b>	
<b>Requests for Clinical Records</b>	
<b>APPEALS</b>	<b>24.12</b>
<b>RESERVED</b>	<b>24.13</b>
<b>ACRONYMS/DEFINITIONS/TERMS</b>	<b>24.14</b>
<b>RECIPIENT NOTICE OF ELECTION/REVOCAION/DISCHARGE/TRANSFER</b>	<b>APPENDIX A</b>
<b>Purpose of Form</b>	
<b>Notifications and Type of Bill</b>	
<b>Instructions for Completing the BHSF Form Hospice-Notice of Election</b>	
<b>CERTIFICATE OF TERMINAL ILLNESS</b>	<b>APPENDIX B</b>
<b>HOSPICE DIAGNOSIS CODES</b>	<b>APPENDIX C</b>
<b>CONTACT/REFERRAL INFORMATION</b>	<b>APPENDIX D</b>
<b>UB-04 FORM AND INSTRUCTIONS</b>	<b>APPENDIX E</b>
<b>Blank UB-04</b>	

---

**CHAPTER 24: HOSPICE**

---

**SECTION: TABLE OF CONTENTS**

---

**PAGE(S) 5**

**UB-04 Instructions for Hospice Providers**

**UB-04 Sample for Hospice**

**UB-04 Samples for Long Term Care (LTC) Providers**

Nursing Facilities

Intermediate Care Facilities

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.0: OVERVIEW**

---

**PAGE(S) 1**

---

**OVERVIEW**

Hospice care is an alternative treatment approach that is based on recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and support for the family. Palliative care focuses on comfort care and the alleviation of physical, emotional and spiritual suffering. Instead of hospitalization, its focus is on maintaining the terminally ill patient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible.

The hospice concept grew out of a belief that many of the physical, sociological, spiritual, educational and emotional needs of the terminally ill patient and family were not being met by the existing health care system. The dying person fears pain, loss of body and self control, and loss of family and friends. For the spouse there are fears about what will happen to me; adult children must deal with role reversal as the parent becomes more dependent.<sup>1</sup> Hospice care is an interdisciplinary approach to the delivery of care with attention to such needs.

**Criteria for Hospice Care**

A recipient 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.

1 Kilburn, L., Hospice Operations Manual: A Guide to Organizational Development, Management, Care Planning, Regulatory Compliance and Financial Services, National Hospice Organization, Arlington Virginia, 1988.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.1: RECIPIENT REQUIREMENTS**

**RECIPIENT REQUIREMENTS**

To be eligible to elect hospice, a recipient must meet all Louisiana Medicaid eligibility criteria and be certified as terminally ill. “Terminally ill” is defined as a medical prognosis of limited expected survival, of approximately six months or less at the time of referral to a hospice, of an individual who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone are no longer appropriate.

Both the BHSF-Form Hospice-CTI (Certification of Terminal Illness) (See Appendix B) and the BHSF-Form Hospice-NOE (Notice of Election) (See Appendix A) must be completed, and a plan of care must be established. Prior authorization requirements stated in Section 24.6 – *Prior Authorization* of this chapter are applicable to all election periods.

**Medicare and Medicaid (Dual Eligibles)**

If the recipient is eligible for Medicare as well as Medicaid, the hospice care must be either elected or revoked simultaneously under both programs. Medicare is the primary payer.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.2: ELECTION OF HOSPICE CARE**

**ELECTION OF HOSPICE CARE**

An election statement for hospice care must be filed by the recipient or by a person authorized by law to consent to medical treatment for the recipient (see Appendix A for details regarding the Notice of Election (NOE) form). For dual eligible recipients, hospice care must be elected for both the Medicaid and Medicare programs simultaneously.

**Reporting Election of Hospice Care**

When a recipient elects Medicaid hospice, the provider must report initial hospice election to the hospice unit at DXC Technologies within 10 calendar days. Documentation to report recipient election of hospice must include the following \*completed forms:

- Bureau of Health Services Financing (BHSF) Form Hospice-Notice of Election (NOE) with type bill 81A or 82A; and
- BHSF Form Hospice-Certification of Terminal Illness (CTI) (see Appendix B).

A prior authorization packet, which includes the NOE, CTI and medical documentation is required upon the initial election of hospice or if the recipient is re-electing hospice during any hospice benefit period.

It is the responsibility of the hospice provider to make sure the NOE, CTI and any necessary attachments are properly completed prior to submitting to the hospice unit at DXC Technologies. The diagnosis code on the NOE and the diagnosis description on the CTI must match. The attending/referring physician's name on the NOE and CTI must match.

**\*All fields must be completed and submitted on the NOE and CTI within the 10 calendar day time frame. The top portion of the NOE form must be completed by the recipient or his/her legal representative only. The hospice provider cannot enter any information in the top section of the form.**

If these requirements are not met, reimbursement will not be available for the days prior to receipt. Reimbursement will be effective the date that BHSF receives the proper documentation. Providers

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.2: ELECTION OF HOSPICE CARE**

are advised to contact the hospice unit at DXC Technologies to confirm receipt of NOE/CTI and any documentation submitted if a letter is not received within 30 days of the hospice election date.

**Pending Medicaid Eligibles**

The electronic prior authorization (e-PA) system required for prior authorization will not allow a provider to enter a request until the Medicaid eligibility information is placed on the Medicaid Eligibility Verification Systems (MEVS) and Recipient Eligibility Verifications Systems (REVS) file. The hospice provider will not be able to request prior authorization until the recipient is deemed eligible for Medicaid. At the time a recipient is determined eligible for Medicaid, the request can be submitted for a retrospective review through the e-PA system. The begin date will be the hospice date of election or begin date of Medicaid eligibility whichever is the later date.

**Attending Physician**

The attending physician is the physician most involved with the recipient’s care at the time of referral and prior to the election of hospice services. If the attending physician and the medical director of the hospice provider are one and the same, then a physician member of the interdisciplinary group (IDG) must also sign the BHSF Form Hospice-Certification of Terminal Illness (CTI). (See Section 24.5 – *Provider Requirements* for IDG requirements.)

The attending physician is the physician identified within the Medicaid system as the provider to which claims have been paid for services prior to the time of the election of hospice.

If a recipient (or legal representative) wants to change his or her designated attending physician during an elected benefit period the recipient (or legal representative) must file a signed statement, with the hospice provider, that identifies the new attending physician in enough detail so that it is with enough detail to clearly indicate which physician or nurse practitioner (NP) was designated as the new attending physician. The statement needs to include:

- The date the change is to be effective;
- The date that the statement is signed; and
- The recipient’s (or legal representative’s) signature, along with an acknowledgement that this change in the attending physician is the patient’s (or legal representative’s) choice.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.2: ELECTION OF HOSPICE CARE**

**PAGE(S) 9**

---

**NOTE:** There must be two different signatures on the BHSF Form Hospice-Certification of Terminal Illness (CTI) for recipients electing hospice services. (See Section 24.5 – *Provider Requirements* for detailed information on the CTI.)

**Election Statement Requirements**

The election statement must include:

- Identification of the hospice provider that will provide care;
- The recipient’s or his/her legal representative's signature acknowledging that he/she has been informed and fully understands the palliative rather than curative nature of hospice care, as it relates to the recipient’s terminal illness and related conditions. The legal representative must indicate the relationship to the recipient, date the form and list a daytime phone number;
- Acknowledgment that certain Medicaid services are waived by the election; and
- The effective date of the election. This date must not be earlier than the date of the election statement and the recipient’s or legal representative’s signature. The recipient or legal representative must enter the date of admission on the top portion of the form. Hospice providers cannot complete this section. Forms submitted not meeting this requirement will be considered incomplete.

The hospice election statement must include the patient’s choice of attending physician after the election of hospice services. The recipient has the option to keep his or her current physician after hospice has been elected or designate a physician member of the hospice team to act as their attending physician once hospice services have been elected. The election form should include an acknowledgement by the recipient (or legal representative) that the designated attending physician or NP was the recipient’s (or legal representative’s) choice.

**In cases where a recipient signs the NOE form with an “X”; there must be two witnesses to sign next to his/her mark. The witnesses must also indicate relationship to the recipient and list daytime phone numbers. Hospice provider representatives cannot sign as witnesses. Verbal elections are prohibited.**

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.2: ELECTION OF HOSPICE CARE**

**Legal Representatives**

When known relatives exist but persons other than relatives sign the BHSF Form Hospice-Notice of Election, the non-relative must have legal rights (e.g. a medical power of attorney) to make medical decisions for recipients who are physically or mentally incapacitated. Proof of these rights must be submitted at the time the election for hospice is made. Verbal elections are prohibited.

**Definition of Relatives**

For purposes of this section, a relative is defined as all persons related to the recipient by virtue of:

- Blood;
- Marriage;
- Adoption; or
- Legal guardians as court appointed.

**Election Periods**

Hospice services are covered on the basis of periods and require prior authorization. A recipient may elect to receive hospice care during one or more of the following election periods:

- An initial 90-day period;
- A subsequent 90-day period; and
- Subsequent periods of 60 days each (requires prior authorization).

The periods of care are available in the order listed and may be used consecutively or at different times during the recipient's life span. The hospice IDG must help manage the recipient's hospice election periods by continually assessing the appropriateness for hospice care, especially before the recipient enters a new election period.

Hospice services will end when a recipient's Medicaid eligibility (including Medically Needy Spend Down, etc.) ends. A new NOE form and CTI form is required with updated signatures whenever the recipient is recertified for Medicaid. A prior authorization packet is also required for recipients whose eligibility ended in a subsequent period. If the recipient's Medicaid eligibility

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.2: ELECTION OF HOSPICE CARE**

ends during a benefit (Spend Down, etc.) all required forms and documentation signed and dated within the day timeframe must be held by the provider in the recipient’s records. Once eligibility is reestablished, a completed packet can then be submitted timely for retrospective authorization.

Providers are encouraged to communicate with family members regarding the recipient’s Medicaid coverage.

**NOTE:** It is the responsibility of the provider to verify the recipient’s Medicaid eligibility. A copy of the Medicaid eligibility approval letter should be included in request for prior authorization.

**Duration of Election**

An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the recipient remains in the care of a hospice provider.

A recipient who revokes or is discharged alive during an existing election period will lose the remaining days in the election period. The recipient may at any future time elect to receive hospice coverage for any other hospice periods for which he/she is eligible.

**Change of Designated Hospice Provider**

A recipient 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 recipient 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 name of the hospice provider from which the recipient has received care and the name of the hospice provider from which he/she plans to receive care; and
- The date the change is to be effective.

Within five 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) (See Appendix A) to the Prior Authorization Unit at DXC Technologies through e-PA.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.2: ELECTION OF HOSPICE CARE**

A BHSF Notification of Election/Revocation/Discharge/Transfer (81C/82C) must be sent to the Prior Authorization Unit through e-PA when a recipient is transferring from the original hospice provider within five calendar days.

**NOTE:** The BHSF Form Hospice-NOE is also used to update changes in the recipient’s condition and status.

**Medicaid Covered Services that are Waived**

For the duration of an election of hospice care, a recipient waives all rights to the following Medicaid covered services:

- Hospice care provided by a hospice provider other than the hospice provider designated by the recipient; and
- 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 provided by:
  - The designated hospice provider; either directly or under arrangements;
  - Another hospice provider under arrangements made by the designated hospice provider; and
  - The recipient’s attending physician if that physician is not an employee of the designated hospice provider or receiving compensation from the hospice provider for those services.

**Waiver Recipients**

Once a recipient elects hospice and a provider is chosen that hospice provider assumes all responsibility for the healthcare needs of the recipient related to the hospice illness. The hospice provider must coordinate all services to ensure there is no duplication of services. The Office of Aging and Adult Services (OAAS) and hospice providers must ensure that all waiver recipients considering hospice are counseled thoroughly enough to make an informed decision.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.2: ELECTION OF HOSPICE CARE****PAGE(S) 9**

---

**Service Coordination**

Medicaid expects the hospice provider to interface with other non-hospice providers depending on the need of the recipient to ensure that the recipient's overall care is met and that non-hospice providers do not compromise or duplicate the hospice plan of care. This expectation applies to Medicaid hospice recipients and Medicare/Medicaid (dual eligible) hospice recipients. The hospice provider must ensure a thorough interview process is completed when enrolling a Medicaid or Medicare/Medicaid recipient to identify all other Medicaid or other state and/or federally funded program providers of care.

**Long-Term Personal Care Services**

Long-Term Personal Care Services (LT-PCS) are provided under the Medicaid State Plan and are not included as a waiver service. LT-PCS are services that provide assistance with the distinct tasks associated with the performance of the activities of daily living (ADL) and the instrumental activities of daily living (IADL).

Recipients who elect hospice services may choose to elect LT-PCS and hospice services concurrently. The hospice provider and the long-term care access services contractor must coordinate LT-PCS and hospice services when developing the recipient's plan of care (POC). All core hospice services must be provided in conjunction with LT-PCS.

When electing both services, the hospice provider must develop the POC with the recipient, the recipient's care giver and the LT-PCS provider. The POC must clearly and specifically detail the LT-PCS and hospice services that are to be provided along with the frequency of services by each provider to ensure that services are non-duplicative, and the recipient's daily needs are being met. This will involve coordinating services where the recipient may receive visits each day of the week.

The hospice provider must provide all hospice services as defined in 42 CFR Part 418 which includes nurse, physician, hospice aide/homemaker services, medical social services, pastoral care, drugs and biologicals, therapies, medical appliances and supplies and counseling. Once the hospice program requirements are met, then LT-PCS can be utilized for those personal care tasks covered in the LT-PCS program for which the recipient requires assistance. (See the *Medicaid Services Manual*, Chapter 30 *Personal Care Services*, Section 30.2 for a full description of LT-PCS covered services. <http://www.lamedicaid.com/provweb1/Providermanuals/manuals/PCS/pcs.pdf>). Recipients who are 21 years of age and older may be eligible for additional personal care services as defined in the Medicaid State Plan. Services furnished under the personal care services benefit

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.2: ELECTION OF HOSPICE CARE****PAGE(S) 9**

---

may be used to the extent that the hospice provider would routinely use the services of the hospice recipient's family in implementing the recipient's POC.

The hospice provider must provide services to the recipient that are comparable to the services they received through Medicaid prior to their election of hospice. These services include, but are not limited to:

- Pharmaceutical and biological services;
- Durable medical equipment; and
- Any other services required by federal law.

**NOTE:** The above services are for illustrative purposes only. The hospice provider is not exempt from providing care if an item or category is not listed.

**Community Choices Waiver**

Community Choices Waiver (CCW) recipients who elect to receive hospice services, may only receive the companion care component of the waiver. The hospice provider must provide all hospice services as defined in 42 CFR Part 418 which includes nurse, physician, hospice aide/homemaker services, medical social services, pastoral care, drugs and biologicals, therapies, medical appliances and supplies and counseling. Once the hospice program requirements are met, then CCW Personal Assistance Services (PAS) can be utilized for those personal care tasks covered in the CCW program for which the recipient requires assistance. (See the *Medicaid Services Manual*, Chapter 7, Section 7.1 for a full description of CCW covered services. <http://www.lamedicaid.com/provweb1/Providermanuals/manuals/CCW2/CCW.pdf>.)

**Program of All-Inclusive Care for the Elderly**

Individuals eligible for enrollment in the Program of All-Inclusive Care for the Elderly (PACE) are persons at least age 55 years or older and certified to need nursing facility level of care. The PACE interdisciplinary team performs an assessment and develops an individualized POC. PACE programs bear financial risk for all medical support services required for enrollees.

Medicaid will not reimburse a hospice provider for services rendered to recipients participating in the PACE Program. Hospice providers must contact the PACE provider for direction before

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.2: ELECTION OF HOSPICE CARE**

rendering services to a PACE participant. PACE must prior authorize all services. Unauthorized services provided will result in non-payment for services rendered.

**Recipients under Age 21 Receiving Hospice and Concurrent Care**

Recipients under 21 years of age may continue to receive curative treatments for their terminal illness. However, the hospice provider is responsible for and must coordinate ALL curative treatments related to the terminal illness and related conditions. No additional payment may be made regardless of cost of service for curative care treatment.

The hospice provider is responsible for making a daily visit to ALL recipients under 21 years of age and to coordinate care to ensure there is no duplication of services. 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 recipient is already receiving curative treatment(s).

**Curative Care/Treatments**

C Curative care consists of medical treatment and therapies provided to a patient with the intention to improve symptoms and cure the patient's medical problem. Antibiotics, chemotherapy, and a cast for a broken limb are examples of curative care.

**Durable Medical Equipment**

The hospice provider is responsible for providing durable medical equipment or contracts for the provision of durable medical equipment.

**Other Services**

Personal care services and extended home health must be coordinated with hospice services as outlined in the POC.

Recipients who elect hospice services may also receive early and periodic screening, diagnosis and treatment (EPSDT) and personal care services (PCS) concurrently. The hospice provider and the PCS provider must coordinate services and develop the patient's POC.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.3: COVERED SERVICES**

**COVERED SERVICES**

Hospice care includes services necessary to meet the needs of the recipient as related to the terminal illness and related conditions.

**Core Services**

Core services must routinely be provided directly by hospice employees, with the exception of physician’s services and counseling services, which may be provided through contract. A hospice provider may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of the recipient under extraordinary or other non-routine circumstances. A hospice provider may also enter into a written arrangement with another Medicaid certified hospice provider for the provision of core services to supplement employee/staff to meet the needs of recipients. Circumstances under which a hospice provider may enter into a written arrangement for the provision of core services include:

- Unanticipated period of an increase in the number of recipients;
- Staffing shortages due to illness; or
- Other short-term temporary situations that interrupt recipient care.

If contracting is used for any core services, professional, financial and administrative responsibility for the services must be maintained and regulatory qualification requirements of all staff must be assured.

An overview of core services is included below.

**Physician Services**

These are the services performed by a physician as defined in 42 CFR 410.20. In addition to palliation and management of the terminal illness and related conditions, physician employees of the hospice and those under contract, including the physician members of the interdisciplinary group (IDG), must also meet the general medical needs of the recipients to the extent that these needs are not met by the attending physician.

**Nursing Services**

Nursing services are defined as nursing care provided by or under the supervision of a registered nurse (RN). Any nursing service provided by a licensed practical nurse (LPN) or licensed

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.3: COVERED SERVICES**

vocational nurse (LVN) must be under the supervision of the RN and must be reasonable and necessary to the treatment of the recipient's illness or injury.

This can also include services included under nursing care provided by a nurse practitioner (NP) who is not the recipient's attending physician. For example, in the absence of an NP, an RN would provide the services. Since the services are nursing in nature, payment is encompassed in the hospice per diem rate and may not be billed separately regardless of whether the services are provided by an NP or an RN.

**Medical Social Services**

Medical social services are provided by a social worker who has at a minimum a master's degree from a school of social work accredited by the Council on Social Work Education, and who is working under the direction of a physician.

**Counseling Services**

Counseling services must be available to the terminally ill individual, his/her family members, or other persons caring for the individual at home or in another nursing facility. Counseling includes bereavement counseling provided after the recipient's death as well as dietary, spiritual and any other counseling services (compliant with medication regimens) for the individual and family provided while the individual is enrolled in hospice.

**Dietary Counseling**

Dietary counseling may be provided for the purposes of training the recipient's family or other care-givers how to provide and prepare meals for the recipient. This can also be used in helping the individual and those caring for him/her to adjust to the recipient's approaching death. Dietary counseling, when required, must be provided by a qualified individual.

**Bereavement Counseling**

The hospice provider must have an organized program for the provision of bereavement services under the supervision of a qualified professional. The plan of care (POC) for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to one year following the death of the recipient). **Bereavement counseling is a required hospice service but it is not reimbursable.**

---

CHAPTER 24: HOSPICE

---

SECTION 24.3: COVERED SERVICES

**Other Covered Services**

The following additional services must also be provided directly by, or coordinated by, the hospice provider.

**Pastoral Care**

The hospice must make reasonable efforts to arrange for visits of clergy and other members of religious organizations in the community to recipients who request such visits and must advise recipients of this opportunity.

**NOTE:** Additional counseling may be provided by other members of the IDG as well as by other qualified professionals as determined by the hospice provider.

**Short-Term Inpatient Care**

Short-term inpatient care is provided in a participating hospice inpatient unit or a participating hospital that additionally meets the special hospice standards regarding staffing and recipient areas. Services provided in an inpatient setting must conform to the written POC. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respites for the individual's family or other persons caring for the individual at home. Care for these services must not exceed five days in any election period. Medicaid payments cannot be made for inpatient hospice care provided in a nursing or intermediate care facility for individuals with intellectual disabilities (ICF/ID) and a Veterans Administration (VA) medical facility to Medicaid only or Medicaid/Medicare recipients who are eligible to receive veteran's health services.

**Inpatient Respite Care**

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.

An approved facility is one that meets the standards as provided in 42 CFR Section 418.98(b). The inpatient respite care rate is paid for each day the recipient 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 sixth day and any subsequent days is made at the routine home

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.3: COVERED SERVICES****PAGE(S) 9**

---

care rate. Respite care may not be provided when the hospice recipient is a resident in a nursing facility or ICF/IID facility.

**Medical Appliances and Supplies**

Medical appliances and supplies, including drugs and biologicals as defined in section 1861(t) of the Social Security Act, and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness is 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 recipient's terminal illness and related conditions. Equipment is provided by the hospice for use in the recipient's home while he or she is under hospice care. Medical supplies include those that are part of the written POC.

The hospice must have a written policy for the disposal of controlled drugs maintained in the recipient's home when those drugs are no longer needed by the recipient.

Drugs and biologicals must be administered only by:

- A licensed nurse or physician;
- An employee who has completed a state-approved training program in medication administration;
- The recipient if his/her attending physician has approved; or
- Any other individual in accordance with applicable state and local laws.

Each drug and biological authorized for administration must be specified in the recipient's POC.

**Hospice Aide and Homemaker Services**

Home health and homemaker services must be provided by qualified aides. Home health services may only be provided by individuals who have successfully completed a home health aide training and competency evaluation program. These services may be provided by an employee of the hospice or may be contracted out.

Hospice aides/home health aides may provide personal care services included in the POC. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the recipient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the recipient. Aide services must be provided under the general

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.3: COVERED SERVICES****PAGE(S) 9**

---

supervision of a RN. Written instructions for recipient care must be prepared by a RN. A RN must visit the home site when aide services are being provided, and the visit must include an assessment of the aide services.

**Therapy Services**

Physical therapy, occupational therapy and speech-language pathology services are provided for the purpose of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

**Other Items and Services**

Any other item or service whether or not included in the POC, and is reimbursable under Medicaid, is a hospice covered service. The hospice provider is responsible for providing any and all services indicated in the POC as necessary for the palliation and management of the terminal illness and related conditions.

**Example:** A hospice provider determines that a recipient's condition has worsened and has become medically unstable. A hospital inpatient stay will be necessary for proper palliation and management of the condition. The hospice adds this inpatient stay to the POC and decides that due to the recipient's fragile condition the recipient will need to be transported to the hospital by ambulance. In this case, the ambulance service becomes a covered hospice service.

**Hospice Provider Service Requirements**

The hospice provider must make nursing services, physician services, drugs and biologicals routinely available on a 24-hour basis. The hospice is also required to make all other covered services available on a 24-hour basis to the extent necessary to meet the needs of the recipient. This care must be reasonable and necessary for the palliation and management of terminal illness and related conditions.

**Waiver of Service Requirements**

If located in a non-urbanized area (as defined by the Bureau of the Census), a hospice provider may apply for a waiver of the core nursing, physical therapy, occupational therapy, speech language pathology, and dietary counseling requirements if a good faith or diligent effort to hire these specialties can be demonstrated (as determined by Centers for Medicare and Medicaid Services (CMS)).

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.3: COVERED SERVICES**

A waiver of the requirement that the hospice provider make physical therapy, occupational therapy, speech language pathology services and dietary counseling available (as needed) on a 24-hour basis may be obtained under certain conditions from CMS. These waivers are available only to a provider or organization that is located in an area which is not an urbanized area (as defined by the Bureau of Census) and that can demonstrate to CMS that it has been unable, despite diligent efforts, to recruit appropriate personnel. Hospice providers will be required to submit evidence to establish diligent efforts.

Waiver applications should be sent to the regional CMS office. Any waiver request is deemed to be granted unless it is denied within 60 calendar days after it is received by CMS. Waivers will remain effective for one year at a time. CMS may approve a maximum of two one-year extensions of each initial waiver. To receive a one-year extension, the hospice provider must request the extension prior to each additional year and certify that the employment market for appropriate personnel has not changed significantly since the initial waiver was granted if this is the case. No additional evidence is required with this certification.

**Levels of Care**

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

- Routine Home Care;
- Continuous Home Care;
- Inpatient Respite Care; and
- General Inpatient Care.

**NOTE:** Refer to Section 24.9 - Reimbursement for an explanation of the four levels of care.

**SERVICE LIMITATIONS**

**Services Unrelated to Terminal Illness**

Once a recipient 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 recipient’s terminal illness and related conditions. Although a recipient 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

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.3: COVERED SERVICES****PAGE(S) 9**

---

diagnosis and not another. A recipient must be enrolled in hospice for a terminal illness. If the recipient elects hospice, he/she has given up the option for therapeutic care for any and all of the related conditions. For example, if the recipient 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. Recipients (and more particularly providers) cannot pick and choose among their diagnoses for hospice election; it is the life expectancy related to the recipient's overall terminal condition that is the controlling factor. Recipients under 21 years of age who are approved for hospice may continue to receive curative treatments for their terminal illness; however, the hospice provider is responsible for coordinating all curative treatments related to the terminal illness. Refer to Section 24.2 – Election of Hospice Care of this manual chapter for recipients under 21 years of age.

“Clinical condition” is defined as a diagnosis or a patient state (physical and/or mental) that may be associated with more than one diagnosis or that may be as yet undiagnosed. Therefore, any claim for services submitted by a provider other than the elected hospice provider will be denied if the claim does not have attached justification that the service was medically necessary and was not related to the terminal condition for which hospice care was elected. However, claims for prescription drugs and home and community based waiver services will not deny but will be subject to post-payment review. If documentation is attached to the claim, then the claim will be pending review.

**NOTE:** Service logs and progress notes will not suffice alone. They may be provided in addition; however, DXC will follow the written policy which states that the documentation must include the physician statement, documentation of procedure/diagnosis, admission and discharge information.

**Determining Hospice Liability**

Hospice providers are held liable for payments to non-hospice providers in the following situations:

- The medical consultant with the fiscal intermediary (FI) determines which services rendered are actually hospice related;
- Services rendered to a recipient on the same day an election for hospice is made; and
- Charges incurred by recipients who receive services while in an inpatient facility (hospital, long term care acute care facility, etc.) or other services (transportation) if the services are/were rendered on the same day a recipient elects/elected hospice. The time of day is not factored in when recipient information is processed and

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.3: COVERED SERVICES**

claims are submitted for payment. Hospice providers bill Medicaid for the whole day and not a partial day. **Providers are reimbursed for date(s) of service.**

**Required Documentation**

Any information necessary to justify that the service was medically necessary and was not related to the terminal condition must be attached to the claim. Such documentation must include all of the following:

- A statement/letter from the physician confirming that the services were not related to the recipient's terminal illness;
- Documentation of the procedure and diagnosis which illustrates why the service was not related to the recipient's terminal illness; and
- Hospital admission and discharge documentation information, where applicable.

**Review of Documentation**

The claim will deny if the information does not justify that the service was medically necessary and not related to the terminal condition for which hospice care was elected.

The provider must resubmit the claim with attached justification if a claim is denied and is for a covered service not related to the terminal condition for which hospice care was elected.

**NOTE:** This information must be submitted as a hard copy. **Do not submit electronically.**

If review of the claim and attachments justify that the claim is for a covered service not related to the terminal condition for which hospice care was elected, the claim will be released for payment. If prior authorization is required for any covered Medicaid services not related to the treatment of the terminal condition, the prior authorization must be obtained just as in any other case.

Final determination of non-hospice related charges does not rest with the hospice provider. Hospice providers cannot deny payments to non-hospice providers based on not knowing the recipient received services from a non-hospice provider, services were not authorized or merely stating the services were not related to the hospice diagnosis.

Claims submitted by the non-hospice provider will go through a physician review at the fiscal intermediary, and a final determination will be made at that time. The claim may still be denied as being hospice related. If denied, the non-hospice provider must then submit charges to the

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.3: COVERED SERVICES****PAGE(S) 9**

---

hospice provider. The hospice provider is responsible for payment of services rendered. Refusing to pay for these charges or any charges submitted from a non-hospice provider puts the hospice provider out of compliance with the provider agreement. Non-compliance with the provider agreement could place the provider in a position of sanctions being imposed which include, but are not limited to, denial or revocation of enrollment, withholding of payments, exclusion from the program, recovery of overpayments and administrative fines. For additional information, please refer to Section 24.5 – *Provider Requirements*.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.4: RESERVED**

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.5: PROVIDER REQUIREMENTS**

---

**PROVIDER REQUIREMENTS**

A hospice provider must be Medicare-certified in order to qualify for enrollment as a Louisiana Medicaid hospice provider. The hospice provider must be enrolled prior to billing for any services provided to Medicaid recipients.

**Licensure**

Except to the extent required by the licensing standards for hospice as defined in LAC 48:I.Chapter 82, §8205.A.1, it shall be unlawful to operate or maintain a hospice program without first obtaining a license from the Louisiana Department of Health (LDH). LDH is the only licensing authority for hospice providers in the state of Louisiana.

**Provider Responsibilities**

The hospice provider must ensure employees providing hospice services have all licensure, certification or registration requirements in accordance to applicable federal and/or state laws.

**Interdisciplinary Group**

Additionally, the hospice provider must designate an interdisciplinary group (IDG) composed of qualified medical professionals and social support staff from all core services, with expertise in meeting the special needs of hospice recipients and their families. The IDG must consist of the following individuals:

- Physician;
- Registered Nurse;
- Social Worker; and
- Pastoral or other counsel.

**NOTE:** Nurse practitioners (NPs) may not serve as medical director or as the physician member of the interdisciplinary group.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.5: PROVIDER REQUIREMENTS****PAGE(S) 7**

---

**Plan of Care**

A written plan of care (POC) must be established before services are provided and must be maintained for each recipient admitted to a hospice program in accordance with the provisions set forth in the Licensing Standards for Hospices (LAC 48:I.Chapter 82). The initial plan of care must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice. The date of the POC should be the date it is first established. The care provided to a recipient must be consistent with the plan and be reasonable and necessary for the palliation or management of the terminal illness as well as all related conditions. In establishing the initial POC, the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member (nurse, physician, or medical social worker or counselor) before writing the initial plan of care. At least one of the persons involved in developing the initial POC must be a nurse or physician. The POC is signed by the attending physician or an appropriate member of the interdisciplinary group.

The POC must encompass plans on access to emergency care and address the condition of the recipient as a whole. All co-morbidities must be included even those not related to the terminal illness. In addition, the POC must meet general medical needs of recipients to the extent that these needs are not being met by the attending physician. This information is being required to assess the recipient for complications and risk factors that would affect care planning (i.e., access to emergency care). Providers may not be responsible for providing care for the unrelated co-morbidities.

There is no official hospice POC form. Each hospice provider should develop a form which includes the required information and best meets its needs.

**Physician Certification and Narrative**

The hospice provider must obtain written certification of terminal illness via BHSF Form Hospice-CTI (Certification of Terminal Illness). The certification must specify that the recipient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. The certification must be based on the physician's clinical judgment regarding the normal course of the individual's illness and must include the signatures of the physicians. A copy of this certification must be on file in the recipient's clinical record.

Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with a written certification. In addition, the attending physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of six months or less. This may be done as an addendum to the

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.5: PROVIDER REQUIREMENTS****PAGE(S) 7**

---

certification and recertification forms if additional space is needed. The physician must also sign and date immediately following the narrative in the addendum. The physician must print and sign his/her name. The narrative must include a statement under the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the recipient's medical record or, if applicable, his or her examination of the patient. The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients. Submit this narrative along with the signed CTI form to the Hospice PA Unit. A copy of this certification must also be on file in the recipient's clinical record.

The narrative associated with the third benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of six months or less.

### **Nurse Practitioners as Attending Physician**

A nurse practitioner (NP) is defined as a registered nurse who is permitted to perform such services as legally authorized to perform (in the state in which the services are performed) in accordance with state law (or state regulatory mechanism provided by state law) and who meets training, education and experience requirements described in 42CFR 410.75.

If a recipient does not have an attending physician or a nurse practitioner who has provided primary care prior to or at the time of the terminal diagnosis, the recipient may choose to be served by either a physician or a nurse practitioner who is employed by the hospice provider. The recipient must be provided with a choice of a physician or a nurse practitioner. The attending physician or nurse practitioner must be identified on the NOE, or on an addendum to the NOE, during the election of hospice services. (See Section 24.2 – *Election of Hospice Care* of this manual chapter.)

Services provided by a nurse practitioner that are medical in nature must be reasonable and necessary, be included in the plan of care and must be services that, in the absence of a nurse practitioner, would be performed by a physician. If the services performed by a nurse practitioner are such that a registered nurse could perform them in the absence of a physician, they are not considered attending physician services and are not separately billable. Services that are duplicative of what the hospice nurse would provide are not separately billable.

Nurse practitioners cannot certify a terminal diagnosis or the prognosis of six months or less, if the illness or disease runs its normal course, or re-certify terminal diagnosis or prognosis. In the event that a beneficiary'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 nurse

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.5: PROVIDER REQUIREMENTS**

practitioner 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.

**Certification of Terminal Illness**

The hospice provider must obtain written certification of terminal illness (BHSF Form Hospice-Certification of Terminal Illness (CTI)) 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. See Appendix B for detailed information on completing the BHSF Form Hospice-CTI.

**Certification of Initial Period**

The hospice provider must obtain BHSF Form Hospice CTI no later than two calendar days after hospice care is initiated. If written certification is not obtained within two calendar days, verbal verification from the physician must be received by an interdisciplinary group (IDG) member and the verbal verification section on the form must be completed and submitted to BHSF within two calendar days following the initiation of hospice care. The clinical information may be provided verbally, and must be documented in the medical record and included as part of the hospice provider's eligibility assessment. Written certification must be obtained no later than eight calendar days after care is initiated. If the NOE (see Appendix A) physician's narrative and Certification of Terminal Illness Forms are not received within 10 calendar days of the initiation of hospice care, the date of admission (election) will be the date that BHSF receives the proper documentation.

**NOTE: The 10 calendar day requirement is the same for Medicaid only recipients as well as dual eligible (Medicaid/Medicare) recipients.**

**Verbal Certification**

If verbal certification is made, the referral from the physician must be received by a member of the hospice IDG. The entry of the verbal certification in the recipient's clinical record must include at a minimum the recipient's name, attending physician's name, terminal diagnosis, prognosis, and the name, date and signature of the IDG member taking the referral. The diagnosis code on the NOE and the diagnosis description on the CTI must match. The diagnosis description must be notated on the CTI.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.5: PROVIDER REQUIREMENTS****PAGE(S) 7**

---

Hospice staff must make an appropriate entry in the recipient's clinical record as soon as a verbal certification is received and file written certifications in the clinical record.

**Sources of Certification**

For the initial 90 calendar day period, the hospice provider must obtain a completed certification form from:

- The recipient's attending physician. The attending physician must be a doctor of medicine or osteopathy and must be identified by the recipient, at the time of election for hospice care, as having the most significant role in the determination and delivery of the individual's medical care;

The hospice's medical director or a physician member of the hospice IDG.

The recipient shall not be required to relinquish his/her attending physician in order to receive hospice benefits. If the attending physician wishes to relinquish care of the recipient to the hospice's medical director, the attending physician must:

- Sign the BHSF Form Hospice-CTI; and
- Submit a narrative statement indicating relinquishment of the care of the patient to the hospice physician.

For all subsequent periods, the hospice provider must submit the completed CTI form to the PA Unit within 10 calendar days prior to the last day of the current benefit period. The form must be signed and dated by either the medical director or a physician member of the IDG.

**Face-to-Face Encounters**

Section 3131(b) of the Affordable Care Act of 2010 requires a hospice physician or nurse practitioner (NP) to have a face-to-face encounter with every hospice recipient to determine the continued eligibility of that recipient prior to the recipient's 180th day recertification and each subsequent recertification. These required encounters are due no more than 30 calendar days prior to the recertification date. LDH will align with the Centers for Medicare and Medicaid Services (CMS) regarding the face-to-face requirement.

The regulation requires that the hospice physician or nurse practitioner attest that the encounter occurred, and the recertifying physician must include a narrative which describes how the clinical

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.5: PROVIDER REQUIREMENTS**

findings of the encounter support the recipient’s terminal prognosis of six months or less. The attestation language must be located directly above the physician or nurse practitioner attestation signature and date line. The physician or nurse practitioner must sign and date the form. The statement must include the date of visit, the requested period, signature of the physician or nurse practitioner who made the visit along with his date of signature. The physician must print and then sign his/her name. Visit notes are not a substitute for a physician narrative, which is a brief explanation of the clinical findings that supports continuing eligibility for the hospice benefit. Outside attending physicians are not allowed to perform the face-to-face encounter. The hospice provider is responsible for either providing the encounter itself or for arranging for the encounter. Please note volunteer physicians are considered hospice employees. Hospice providers are supposed to provide physician services to their recipients when needed during a time of crisis.

If a recipient improves or stabilizes sufficiently over time while in hospice, such that he/she no longer has a prognosis of six months or less from the most recent recertification evaluation or definitive interim evaluation, that recipient should be considered for discharge from Medicaid hospice services.

**NOTE:** In the event that a recipient is in the hospital or emergency room, and a referral is made to hospice, the physician attending to the recipient in the hospital or emergency room or the physician referring the recipient to hospice services must sign the BHSF Form Hospice-CTI, if the recipient does not have an attending physician.

**BHSF Written Notice of Hospice Decision**

The Hospice PAU notifies the hospice provider and the hospice recipient (or legal representative) of the recipient’s approval or denial of hospice services in writing. **It is the Hospice provider’s responsibility to notify the nursing facility.** The approval letter contains the election date and the prior authorization requirements (if applicable). The denial letter gives the reason(s) for the denial.

**Disaster Operations**

The provisions set forth in the Licensing Standards for Hospices (LAC 48:1, Chapter 82) state, “The hospice provider shall have policy and procedures and a written plan for emergency operations in case of disaster.” To ensure compliance, all providers should adhere to the following procedure in the event a state emergency occurs where evacuations are required:

- Transportation during an emergency evacuation of a nursing facility recipient receiving hospice services is the responsibility of the nursing facility;

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.5: PROVIDER REQUIREMENTS**

- Hospice recipients who receive hospice services in their home and are without accessible transportation during an emergency evacuation will be directed to a parish pick-up point; and
- Transportation during an emergency evacuation of an inpatient hospice facility recipient is the responsibility of the inpatient hospice facility.

**It is the responsibility of the hospice provider to know the location of recipients under their care at all times.**

**PROGRAM INTEGRITY**

To maintain the programmatic and fiscal integrity of the Medicaid Program, the federal and state governments have enacted laws, promulgated rules and regulations and policies concerning fraud and abuse, and the Louisiana Department of Health (LDH) has established policies concerning those laws, rules, regulations and procedures. It is the responsibility of the provider to become familiar with these laws and regulations.

Non-compliance with the provider agreement may place the provider in a position of sanctions being imposed which include, but are not limited to, denial or revocation of enrollment, withholding of payments, exclusion from the program, recovery of overpayments and administrative fines.

Providers, recipients and others may also be subject to criminal prosecution, civil action and/or administrative actions if they violate laws, rules, regulations or policies applicable to the Medicaid Program.

Providers should refer to the *Medicaid Services Manual*, Chapter 1 *General Information and Administration* for a full description of administrative sanctions.

**NOTE:** The provider should also refer to the laws and regulations related to sanctions for each program of enrollment and should review the *Louisiana Administrative Code (LAC)*, Subpart E and LAC 50:I.Chapters 41 and 42.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.6: PRIOR AUTHORIZATION PROCESS**

**PRIOR AUTHORIZATION PROCESS**

Prior authorization (PA) is required upon the initial request for hospice coverage. PA requests must be submitted within 10 calendar days of the hospice election date. If the 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. Reimbursement will be effective the date the Prior Authorization Unit (PAU) receives the proper documentation if approved.

The completed PA (see *Required Documentation* in this section,) which includes the updated and signed “Hospice Certification of Terminal Illness” (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 PAU 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 recipient eligibility. (See Appendix B for detailed information regarding BHSF Form Hospice CTI.)

All requests for hospice PA must be submitted to DXC Technologies through their electronic prior authorization (e-PA) system. No other form or substitute will be accepted.

**Electronic Prior Authorization**

Electronic prior authorization (e-PA) is a web application that provides a secure web-based tool for providers to submit prior authorization requests and to view the status of previously submitted requests. For more information regarding e-PA, visit the Louisiana Medicaid web site or call the PAU.

**NOTE:** PA is not required for dual eligible recipients (Medicare primary) during the two 90-day election periods and the subsequent 60-day election periods. However, they must send in a copy of the Medicare Common Working File screen showing the hospice segment through the e-PA system and the signed Certificate of Terminal Illness (CTI) and Notice of Election (NOE) forms.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.6: PRIOR AUTHORIZATION PROCESS****PAGE(S) 5**

---

**Required Documentation**

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

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

**First Benefit Period (90 days)**

- Hospice Election Form (primary diagnosis code(s) using the International Classification of Disease, Tenth Revision (ICD-10) or its successor; other codes);
- Hospice Certification of Terminal Illness form (BHSF Form Hospice – CTI);
- Clinical/medical information;
- Hospice provider plan of care:
  - Progress notes (hospital, home health, physician's office, etc.);
  - Physician orders for plan of care; and
  - Include Minimum Data Set (MDS) form (original and current) if recipient is in a facility; weight chart; laboratory tests; physician and nursing progress notes. **The MDS form (original and current) is not required if the recipient has been in a long-term care facility less than 30 days. The MDS form must be provided upon the subsequent request for continuation of hospice services; and**
- Documentation to support recipient's hospice appropriateness:
  - Paint picture of recipient's condition;
  - Illustrate why recipient is considered terminal and not chronic;

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.6: PRIOR AUTHORIZATION PROCESS****PAGE(S) 5**

---

- Explain why his/her diagnosis has created a terminal prognosis; and
- Show how the body systems are in a terminal condition.

**Second and Subsequent Periods**

Providers requesting PA for the second period, and each subsequent period, must send the following packet to the PAU at (see Appendix D for Contact/Referral Information):

- MDS forms (original and current) are required; weight chart; laboratory tests; physician and nursing progress notes if the recipient resides in a nursing facility;
- An **updated** Hospice Certification of Terminal Illness 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;
- An updated plan of care;
- Updated physician's orders;
- List of current medications (within last 60 days);
- Current laboratory/test results (within last 60 days if available);
- Description of hospice diagnosis;
- Description of changes in diagnoses;
- Progress notes for all services rendered (daily/weekly physician, nursing, social worker, aide, volunteer and chaplain);
- A social evaluation;
- An updated scale such as: Karnofsky Performance Status Scale, Palliative Performance Scale or the Functional Assessment Tool (FAST);

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.6: PRIOR AUTHORIZATION PROCESS****PAGE(S) 5**

---

- The recipient's current weight, vital sign ranges, lab tests and any other documentation supporting the continuation of hospice services. Documentation must illustrate the recipient's decline in detail. Compare last month's status to this month's status; and
- Original MDS; current MDS form if recipient is a resident in a facility.

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

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

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

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

**Example:** A recipient receives hospice care during an initial 90-day period and is discharged or revokes his/her election of hospice care during a subsequent 90-day period, thus losing any remaining days in that election period. If this recipient chooses to elect a subsequent period of hospice care, even after an extended period without hospice care, prior authorization will be required. The Notice of Election (NOE), Hospice Certification of Terminal Illness 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 PAU if receipt is past 10 days.

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

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.6: PRIOR AUTHORIZATION PROCESS**

**Written Notice of Prior Authorization Decision**

PA requests will be reviewed using the Medicare criteria found in local coverage determination hospice determining terminal status (L34538) and approved or denied within five working days. Once the review process has been completed and a decision has been made, the hospice provider will receive a written notification of the decision. A denial does not represent a determination that further hospice care would not be appropriate, but that based on the documentation provided, the recipient does not appear to be in the terminal stage of illness. Providers are encouraged to submit prior authorization packets for the next subsequent period within the set time frame when there is evidence of a decline in health if a prior period had been denied.

**NOTE:** It is the hospice provider’s responsibility to inform the nursing facility of approval or denial.

**Reconsideration**

If a recipient does not agree with the denial of a period or subsequent period, reconsideration may be requested. Documentation must be recent and not for dates that were previously omitted or previously submitted. All reconsideration requests will be reviewed within five working days from the receipt of the written request.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.7: HOSPICE REVOCATION AND DISCHARGE PAGE(S) 4**

---

**HOSPICE REVOCATION AND DISCHARGE**

When a recipient revokes or is discharged alive during an election period, the recipient loses any remaining days in the election period. The recipient may at any future time elect to receive hospice coverage for any other hospice periods for which he/she is eligible.

This requirement will affect both Medicaid-only and dual eligibles. The Centers for Medicare and Medicaid Services (CMS) requires the election and revocation/discharge to be simultaneous for both payer sources. If a recipient is eligible for Medicare as well as Medicaid (dual eligible) and revokes hospice care, the revocation forms must be submitted to the appropriate agency in compliance with the agency's requirements simultaneously.

The date of discharge (except discharge due to death) is not reimbursed by Medicaid.

**Revocations**

A recipient 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 recipient or legal representative.

At no time is the hospice provider to demand a revocation. In addition, the hospice recipient or legal representative must not be asked to sign a blank form to be completed by the hospice provider prior to submission to the Prior Authorization Unit (PAU) through an electronic prior authorization (e-PA). 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 recipient or legal representative is in agreement, the revocation will not be honored.

**Required Statement of Revocation**

When a recipient revokes or is discharged alive during an election period, the recipient 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 recipient or legal representative and include the recipient's contact information.

The statement must be submitted to the hospice PAU for verification and follow up.

A signed statement must include the date the revocation is to be effective. A recipient or his/her legal representative cannot designate an effective date earlier than the date that the revocation is

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.7: HOSPICE REVOCATION AND DISCHARGE PAGE(S) 4**

---

made. The date of signature and proper written statement must also be included. This revocation shall be received by the hospice PAU 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.

The requirements for revocation and time limits also apply to recipients who have both Medicare and Medicaid eligibility (dual eligible).

**Discharges**

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

**Reasons for Discharge**

Recipients must be discharged **only** in the following circumstances:

- Change in terminal status;
- Recipient relocates from the hospice's geographically defined service area;
- Safety of the recipient 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 recipient's clinical record;
- Medicaid-only recipients who enter a non-contracted nursing home or hospital and all options have been exhausted (a contract is not attainable, the recipient 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 recipient without due cause; and
- The hospice provider determines that the recipient's (or other persons in the recipient's home) behavior is disruptive, abusive or uncooperative to the extent that delivery of care to the recipient, or the ability of the hospice staff to operate effectively, is seriously impaired.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.7: HOSPICE REVOCATION AND DISCHARGE PAGE(S) 4**

---

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

- Advise the recipient that a discharge for cause is being considered;
- Make a serious effort to resolve the problem(s) presented by the recipient's behavior or situation;
- Ascertain that the recipient's proposed discharge is not due to the recipient's use of necessary hospice services;
- Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into the recipient's clinical record; and
- Obtain a written physician's discharge order from the hospice medical director prior to discharging a recipient for any reason.

**NOTE:** If a recipient 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 PAU 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 recipient.

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 e-PA so the files may be updated in a timely manner.

### **Discharge/Revocation Due to Hospital Admit**

It is against Medicaid hospice policy to encourage recipients 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 hospice PAU for referral to Program Integrity.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.7: HOSPICE REVOCATION AND DISCHARGE PAGE(S) 4**

---

**Service Availability upon Revocation or Discharge**

A recipient is no longer covered for hospice care under Medicaid upon discharge or revocation. All previously waived benefits will resume.

**NOTE:** This does not apply to waiver services received prior to hospice election.

**Notice of Transfer**

A Notice of Transfer is sent when the recipient is in the middle of an election period and wants to change hospice providers. A recipient may change hospice providers once each election period. The date of discharge from the current hospice provider must be only one day before the date of admission to the newly designated hospice provider.

Within five calendar days after discharge, the transferring hospice provider must submit the signed a type bill 81C via BHSF Form-Hospice through e-PA so the files may be updated in a timely manner. The new hospice provider receiving the recipient must also submit a completed notice of transfer (81C) to the hospice PAU within five days of receipt of transfer. Refer to Appendix A of this chapter.

**Late Notifications**

Failure to submit Notices of Revocation, Discharge or Transfer in a timely manner can result the inability for other providers to bill for services. Late submissions will be monitored by the department and PAU, and may be subject to monetary penalties.

Revocations received through e-PA that are more than five days old can be submitted with any proof of prior attempts to submit timely. For example, a fax confirmation sheet reflecting the appropriate discharge/revocation form with explanation (81B) is acceptable as proof as long as there is a successful fax transmission with a date on the confirmation sheet. A blank or failed fax confirmation sheet is not acceptable.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.8: RECORD KEEPING****PAGE(S) 4**

---

**RECORD KEEPING**

The hospice provider must have sufficient space, facilities and supplies to ensure effective record keeping.

A hospice provider must maintain and retain the business and professional records sufficient to document fully and accurately the nature, scope and details of the health care provided. The hospice provider must provide reports and keep records as the Louisiana Department of Health (LDH) determines necessary to administer the program. Failure to comply may result in one or more of the following:

- Recoupment;
- Sanction;
- Loss of enrollment; or
- Referral to Surveillance and Utilization Review Systems (SURS).

**Contract Services**

If services are provided on a contractual basis, the hospice provider must have a legally binding written agreement for the provision of arranged services that includes requirements as detailed in LAC 48:I.Chapter 82-*Licensing Standards for Hospices*, Section 8237.

**Review by State and Federal Agencies**

When requested, a provider must furnish access to all administrative, personnel and recipient records to authorized state and federal personnel, at all reasonable times. Providers' records are subject to audit by LDH, the State Attorney General's Office, the Office of Inspector General, and the Centers for Medicare and Medicaid Services (CMS) or other appropriate state or federal agencies.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.8: RECORD KEEPING****PAGE(S) 4**

---

### **Administrative Files**

The hospice provider must disclose all financial, beneficial ownership, equity, surety or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services to recipients of medical assistance.

The provider's administrative files must include, at a minimum:

- Documentation identifying the governing body;
- A list of members and officers of the governing body, their addresses and terms of membership;
- An organizational chart which delineates lines of authority and responsibility for all hospice personnel;
- Documentation of the provider's administrative policies and procedures as detailed in LAC 48:I.Chapter 82-*Licensing Standards for Hospices*, Section 8235; and
- Documentation of quality assurance as detailed in LAC 48:I.Chapter 82-*Licensing Standards for Hospices*, Section 8239.

### **Personnel Records**

The provider must have written employment and personnel policies which detail:

- Job descriptions for all positions, including volunteers and students, that include the duties, qualifications and competencies;
- A description of hiring practices that includes a policy against discrimination based on race, color, religion, sex, age, national origin, disability, political beliefs, disabled veteran, veteran status or any other non-merit factor;
- A description of procedures for employee evaluation, promotion, disciplinary action, termination and hearing of employee grievances; and

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.8: RECORD KEEPING****PAGE(S) 4**

---

- A written record on each employee that includes:
  - An application for employment and/or resume;
  - References;
  - Verification of professional credentials;
  - Performance evaluations;
  - Employee's starting and termination date; and
  - Time sheets for all times on duty.

**Recipient Clinical Records**

In accordance with LAC 48:I.Chapter 82-*Licensing Standards for Hospices*, Section 8233, the hospice provider must establish and maintain a clinical record for every recipient receiving care and services. The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval. The clinical records must substantiate the services billed to Medicaid by the hospice provider. Services not specifically documented in the recipient's clinical record as having been rendered will be deemed not to have been rendered and no reimbursement will be provided. Entries are to be made for all services provided. Entries are to be signed and dated by the person providing the services. The record includes all services whether furnished directly or under arrangements made by the hospice provider. Each recipient's record must contain the following:

- The initial and subsequent assessments;
- The plan of care (updated and original);
- Identification data;
- Authorization forms;
- Pertinent medical history, recipient's primary hospice diagnosis, other diagnoses and prognosis;
- Physician's orders, including, if respite, continuous care or general inpatient care, orders for these services, including number of days and justification;

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.8: RECORD KEEPING**

**PAGE(S) 4**

---

- Complete documentation of all services and events (including evaluations, treatments, progress notes for all services rendered, etc.);
- Certification statements and physician narratives of the terminal illness for each benefit period;
- Election statements; and
- Discharge/revocation/transfer forms and notes, if applicable.

**Confidentiality and Protection of Records**

The hospice provider must safeguard the clinical record against loss, destruction and unauthorized use in accordance with Medicaid policies, federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA). All medical assistance information regarding recipients must be held confidential and used for authorized Medicaid purposes only. A provider shall disclose information in his/her possession only when the information is to be used in conjunction with a claim for health benefits or when the data is necessary for the functioning of the Medicaid Program.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.9: REIMBURSEMENT**

**REIMBURSEMENT**

With the exception of payment for physician services, Medicaid reimbursement for hospice care is made at one of four predetermined per diem rates for each day a Medicaid recipient is under the care of the hospice regardless of the amount of services furnished on any given day. The four rates are prospective rates; there are no retroactive adjustments other than the limitation on payments for inpatient care. The rates are calculated on a yearly basis and based on information provided by the Centers for Medicare and Medicaid Services (CMS) and in line with the provider requirements as set forth in 42 CFR Part 418.

The payment rates for each level of care are those used under Part A of Title XVIII (Medicare) of the Social Security Act, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. These rates are adjusted for regional wage differences. The hospice shall submit claims, for payment for hospice care only, on the basis of the geographic location (Metropolitan Statistical Area) where the services are furnished.

The rates are effective from October 1 through September 30 of each federal fiscal year. The provider should split bills if they span the effective date of the annual updates to the payment rates.

**Claim Form**

Bills are submitted on a Form UB-04. Claims-related information can be found in Section 24.10 of this Chapter.

**Levels of Care**

Payment rates are determined for the following four categories of hospice care into which each day of care is classified:

- Routine Home Care;
- Continuous Home Care;
- Inpatient Respite Care; and
- General Inpatient Care.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.9: REIMBURSEMENT****PAGE(S) 12**

---

**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 recipient 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.

Routine home care is also paid when the recipient is receiving hospital care for a condition **unrelated** to the terminal condition. This rate is also paid in the following situations:

- If the recipient is in a hospital that is not contracted with the hospice;
- If the recipient is receiving outpatient services in the hospital; or
- For the day of discharge from general inpatient care or respite level of care.

Reimbursement is based upon a two-tier payment system. Reimbursement begins at a higher rate and then decreases to a lower rate. The higher rate is payable for the first 60 days of an initial election of hospice services. If the member remains in hospice, on day 61, payment drops to the lower rate.

**Examples:**

A member that is discharged or voluntarily revokes hospice elections and readmits to hospice in less than 60 days will have no disruption for the purpose of counting days.

A member that is discharged or voluntarily revokes hospice elections and readmits to hospice in 61 or more days constitutes a new hospice election and the higher rate of pay starts again.

A member who transfers to another hospice, in either a managed care organization (MCO) or fee-for-service (FFS) Medicaid, continues the count of days from the original hospice provider.

An additional add-on rate may apply. (See Service Intensity Add-on in this section.)

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.9: REIMBURSEMENT****PAGE(S) 12**

---

**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 recipient at home. Routine home care code must be billed if less skilled care is needed on a continuous basis to enable the recipient to remain at home. Services should reflect direct recipient 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:

- A period of medical crisis is when a recipient 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
- 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

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.9: REIMBURSEMENT**

**PAGE(S) 12**

---

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 recipient 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 recipient is a resident in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

Criteria for Inpatient Respite Care:

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

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.9: REIMBURSEMENT**

**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 recipient'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 recipient's permanent or temporary residence. Routine home care shall be billed.

Criteria for general inpatient care:

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

The hospice is the professional manager of the recipient's care despite the physical setting of the care or the level of care.

**Payment for Physician Services**

In addition to the four basic payment rates for hospice care, hospices can also bill Medicaid for certain physician services. For purposes of Medicaid hospice, these physicians' services can be divided into the following three categories:

- Professional services, or those actual procedures performed by the physician, are designated by the appropriate CPT-4 code. (Direct care services furnished to individual recipients by hospice employees and for physician services furnished under arrangements made by the hospice unless furnished on a volunteer basis.);
- Administrative services include administrative and general supervisory activities generally performed by the physician serving as the medical director and the

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.9: REIMBURSEMENT**

**PAGE(S) 12**

---

physician member of the hospice interdisciplinary group (IDG). Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care and establishment of governing policies;

- The four basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the recipient's terminal illness and related conditions. This includes the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice; and
- Technical services include lab, x-ray and other non-professional services performed by the physician or other health care professionals.

**NOTE:** It should be noted that administrative and technical services are included in the four basic payment rates for hospice when the services are related to the terminal illness and related conditions.

### **Provision of Physician services**

For purposes of Medicaid hospice, physicians providing these services are divided into two categories: Attending Physician and Consulting Physician.

Only professional services are reimbursable outside of the four payment rates for hospice care.

The medical director of the hospice is to assume overall responsibility for the medical component of the hospice's recipient care program.

#### **Attending Physician**

During the election process, the patient designates the physician primarily responsible for his/her care while receiving hospice. This physician is the attending physician. The attending physician is not required to be an employee of the hospice.

---

CHAPTER 24: HOSPICE

---

SECTION 24.9: REIMBURSEMENT

PAGE(S) 12

---

**Non-Employee**

If the attending physician is not an employee of the hospice, the attending physician's professional services will be billed to Medicaid by the physician.

An independent attending physician is reimbursed in accordance with the usual Medicaid reimbursement methodology for physician services. Any other technical or administrative services are covered under the daily reimbursement rates paid to the hospice and are reimbursed by the hospice to the physician according to their agreement.

The attending physician can choose to bill Medicaid for physician care plan oversight if the coverage and documentation requirements are met.

**Employee**

If the attending physician is an employee of the hospice or a volunteer (such as medical director or physician member of the IDG), the physician's professional services are billed to Medicaid by the hospice. The hospice is responsible for reimbursing the physician.

**The hospice must ensure that the services were professional and not technical or administrative.**

The hospice is reimbursed in accordance with the usual payment rules for Medicaid physician services. The hospice must reimburse the physician for the technical component of the service out of the per diem rate as agreed upon in the physician's arrangement with the hospice.

Physicians who are designated by recipients as the attending physician and who also volunteer services to the hospice are, as a result of their volunteer status, considered employees of the hospice. **Physician services furnished on a volunteer basis are excluded from Medicaid reimbursement.** The hospice may be reimbursed on behalf of a volunteer physician for specific services rendered which are not furnished on a volunteer basis (a physician may seek reimbursement for some services while furnishing other services on a volunteer basis). Liability rests with the provider to reimburse the physician for those physician services rendered.

In determining which services are furnished on a volunteer basis and which services are not, a physician must treat recipients on the same basis as other recipients in the hospice. For instance, **a physician may not designate all physician services rendered to non-Medicaid recipients as volunteered and at the same time seek payment from the hospice for all physician services rendered to Medicaid recipients.**

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.9: REIMBURSEMENT****PAGE(S) 12**

---

**Example:** Dr. Jones has an agreement with a hospice to serve as its medical director on a volunteer basis. Mrs. Smith, a Medicaid recipient, enters this hospice and designates Dr. Jones as her attending physician. Dr. Jones, who does not furnish direct recipient care services on a volunteer basis, renders a direct recipient care service to Mrs. Smith. Dr. Jones seeks reimbursement from the hospice for this service. The hospice is then paid by Medicaid in accordance with the usual payment rules for Medicaid physician services for the service that Dr. Jones rendered to Mrs. Smith. The hospice then reimburses Dr. Jones for that service.

**Consulting Physician**

Any physician services other than those rendered by the attending physician are classified as consulting physician services. The procedure for billing for consultant physicians is the same as for employee attending physicians. The hospice must have a contractual agreement with the physician.

The hospice is responsible for billing Medicaid for the physician's professional services and is to reimburse the physician for the services as indicated in their contractual agreement. The hospice can contract with a group of physicians as long as all the physicians in the group are listed in the contract.

**Payment for Long-Term Care Facility Residents**

The hospice provider will be paid an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility for a recipient who meets the following criteria:

- Resides in a nursing facility or ICF/ IID;
- Is eligible under the Medicaid State Plan for nursing facility services or services in an ICF/IID if he/she had not elected to receive hospice care;
- Elects to receive hospice care; and
- For whom the hospice provider and the nursing facility or ICF/IID have entered into a written agreement in accordance with the provisions set forth in the Licensing Standards for Hospices (LAC 48:I.Chapter 82), under which the hospice provider

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.9: REIMBURSEMENT****PAGE(S) 12**

---

takes full responsibility for the professional management of the individual's hospice care, and the facility agrees to provide room and board to the individual.

Payment to the facility is to be discontinued and effective as of the date of the resident's hospice election. Payment will be made to the hospice to take into account the room and board furnished by the facility for a Medicaid recipient. The hospice must then reimburse the facility for room and board. Dual eligible recipients in a skilled nursing facility (bed) are ineligible for reimbursement for room and board by Medicaid. Hospice must submit claims to Medicare.

The amount to be paid is determined in accordance with the rates established under the Social Security Act, Section 1902(a) (13) (B). The rate of reimbursement is 95 percent of the per diem rate that would have been paid to the facility for that recipient in that facility under the Medicaid State Plan, except that any patient liability income (PLI) determined by the Medicaid Program will be deducted from the payment amount. It is the responsibility of the nursing facility or ICF/IID to collect the recipient's PLI.

This rate is designed to cover "room and board" which includes performance of personal care services, including assistance in the activities of daily living, administration of medication, maintaining the cleanliness of the recipient's environment, and supervision and assistance in the use of durable medical equipment (DME) and prescribed therapies. Certain DME is included in the "room and board" rate. A list of DME supplies can be found at the Louisiana Medicaid website at [www.lamedicaid.com](http://www.lamedicaid.com), under the fee schedules link (see Appendix D).

Nursing facilities are currently reimbursed on a case-mix methodology in which the rates can be adjusted from time to time. Hospice providers are subject to the same per diem rate adjustments as the nursing facilities, as deemed necessary. This may result in an overpayment or underpayment, and the claims will be reprocessed accordingly.

**NOTE:** See Section 24.10 - *Claims Related Information* of this manual chapter for additional claims related information regarding payment for nursing and ICF/IID residents.

**Provider of First Choice**

The nursing facility retains the right to decide if it wishes to offer the option of hospice. If the nursing facility chooses not to offer hospice care and a resident requests this service, the resident is to be informed that hospice is not available in the facility. The nursing facility is to assist with arrangements for transfer to another facility that offers the service, if the resident so chooses.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.9: REIMBURSEMENT**

**Non-Emergency Transportation for Non-Hospice Related Medical Appointments**

It is the responsibility of the nursing facility to arrange for or provide transportation to all non-hospice related medical appointments. This includes wheelchair bound residents and those residents going to therapies. Transportation shall be provided to the nearest available qualified provider of routine or specialty care within reasonable proximity to the facility. Residents can utilize medical providers of their choice in the community in which the facility is located when they are in need of transportation services.

In cases where residents are bed bound and cannot be transported other than by stretcher, and the nursing facility is unable to provide transportation, an ambulance may be used. The nursing facility will reimburse the provider at the non-emergency transportation rate.

**Emergency Transportation for Non-Hospice/Hospice Related Medical Conditions**

It is the responsibility of the nursing facility to contact the hospice provider for any and all emergencies. **The hospice agency has full responsibility for the professional management of the individual's care.**

**Medicare Coinsurance**

For dual eligible recipients (Medicare and Medicaid coverage) for whom Medicare is the primary payer for hospice services, Medicaid will also provide for payment of any coinsurance amounts imposed under §1813(a)(4) of the Social Security Act.

Additionally, hospice services should not be billed to Medicaid for dual eligible recipients. These services are covered in the hospice Medicare reimbursement. Room and board for skilled nursing is billed to Medicare.

After providing a service to a dual eligible recipient, the provider sends a claim to its Medicare carrier or the intermediary. After Medicare processes the claim, it sends the provider an explanation of Medicare benefits. If Medicare has approved the claim, Medicaid will pay the deductible and/or coinsurance through its established Medicare crossover process.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.9: REIMBURSEMENT****PAGE(S) 12**

---

**Drugs and Biologicals Coinsurance (Dual Eligibles)**

The amount of coinsurance for each prescription approximates five percent of the cost of the drug or biological to the hospice, determined in accordance with the drug co-payment schedule established by the hospice, except that the amount of coinsurance for each prescription may not exceed five dollars. The cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances.

To ensure the correct billing of drug services, it is imperative that the hospice provider communicate with the pharmacist to verify which drugs are related to the terminal illness (billed to the hospice) and which drugs are not related to the terminal illness (billed to Medicaid).

**NOTE:** Refer to the pharmacy provider manual, Chapter 37 for more information on prescription services and associated co-payments. The manual can be accessed on the Louisiana Medicaid website at [www.lamedicaid.com](http://www.lamedicaid.com).

**Respite Care Coinsurance (Dual Eligibles)**

The amount of coinsurance for each respite care day is equal to five percent of the payment made under Medicare for a respite care day. The amount of the individual's coinsurance liability for respite care during a hospice coinsurance period may not exceed the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began.

**NOTE:** Federal law mandates that Medicaid is the payer of last resort. Refer to Chapter 1 of the Louisiana Medicaid provider manual, *General Information and Administration*. The manual can be accessed on the internet at [www.lamedicaid.com](http://www.lamedicaid.com).

**Telephone Calls and Consultations**

Hospices may report some social worker calls as a visit. Hospices may not report any other types of phone calls.

**Non-covered Days**

Hospice providers are reimbursed for date of death only. Providers are not reimbursed for dates of discharge nor revocation.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.9: REIMBURSEMENT**

**PAGE(S) 12**

---

**Hospice Services to Medicaid/Medicare/Veteran's Eligible Beneficiaries**

Medicaid recipients that are dual eligible veterans and reside at home in their community may elect hospice services and have the services paid under the Medicare hospice benefits.

If a dual eligible veteran who had been receiving Medicare hospice services in his/her home is admitted to a Veterans Administration owned and operated inpatient facility, the recipient must revoke the Medicare hospice benefits. The same applies for a Medicaid-only recipient. Medicare and Medicaid are not allowed to pay for those services for which another federal entity is primary payer.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.10: CLAIMS RELATED INFORMATION**

**CLAIMS RELATED INFORMATION**

Reimbursement requires compliance with all Medicaid requirements. Hospice providers bill for room and board using the standard 837 Institutional (837I) electronic claim transaction or the hardcopy UB-04 Form, regardless of the date of service. All supplemental billing must also be submitted electronically using the 837I format or on the UB-04 hard copy claim form. The 837I is the preferred method of claim submission.

**Medicaid Requirements for Enrolling Ordering, Prescribing and Referring Providers**

The Affordable Care Act (ACA) requires physicians or other practitioners who order, prescribe, or refer items or services to Medicaid recipients to enroll in the Medicaid Program, even when they do not submit claims to Medicaid. ACA requirements are designed to ensure items or services for Medicaid recipients originate from appropriately licensed providers who have not been excluded from Medicare or Medicaid.

Individuals who order, prescribe, or refer items or services for Medicaid recipients, but choose not to submit claims to Medicaid, are referred to throughout this notice as “OPR providers.”

**Professional and Institutional Billing Providers should begin notifying any individuals who you report on fee-for-service claims as an ordering, prescribing or referring provider that they must enroll with Louisiana Medicaid.**

OPR providers must understand the implications of failing to enroll in Medicaid. If you are an OPR provider, then the individuals and facilities who bill services for Medicaid recipients based on your order, prescription or referral, will not be paid for those items or services unless you enroll in Medicaid. Timely filing claim requirements may be impacted while waiting for providers to be enrolled; therefore, applications should be submitted as quickly as possible.

**Effective with claims using dates of service on or after September 1, 2016, the Louisiana Medicaid Program will deny fee-for-service claims that use referring providers who are not enrolled as of the date of service. Providers should monitor the Louisiana Medicaid website for future information specific to ordering providers.**

Louisiana Medicaid has established edits for issues with prescribing providers.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.10: CLAIMS RELATED INFORMATION**

**Enrollment**

Practitioners currently enrolled as participating providers in fee-for-service Medicaid Program are not required to enroll separately as an OPR provider.

**Diagnosis Codes**

All billers should use the correct diagnosis codes (ICD-10-CM or its successor) that supports medical necessity, and are appropriate for use with hospice related conditions.

**Revenue Codes**

Bill for hospice services provided according to the level of care and location of the recipient for each day of the hospice election period.

**Frequency of Billing**

The UB-04 form should be submitted each month after the month for which services were provided. Providers do not have to split a claim for a month's dates of services around the recipient's election period dates. However, a claim cannot span more than two election periods. The provider should split bills if they span the effective date of the annual increase in the payment rates for hospice care services.

**Claims Submission for Recipients Residing In the Home**

Hospice providers only bill for direct hospice services when a recipient resides in the home. If the recipient is dual eligible with Medicare Part A, a bill should not be submitted to Medicaid since Medicare Part A reimburses hospice services at 100 percent.

**Claims Submissions for Recipients Residing In a Long Term Care Facility**

Hospice providers bill for both direct hospice services and room and board when a recipient resides in a Nursing Facility unless the recipient is dual eligible with Medicare Part A, then Hospice providers will bill only for room and board. Because Medicare Part A reimburses hospice services at 100 percent, no bill for direct hospice services or room and board in a skilled nursing facility should be submitted to Medicaid.

The room and board rate of reimbursement is 95 percent of the per diem rate that would have been paid to the facility for that recipient in that facility under the Medicaid State Plan, except that any patient liability income (PLI) determined by the Bureau of Health Services Financing will be

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.10: CLAIMS RELATED INFORMATION** **PAGE(S) 7**

---

deducted from the payment amount. It is the responsibility of the nursing facility or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-ID) to collect the recipient's PLI.

Hospice providers may only bill Medicaid once per calendar month for nursing facility or ICF-ID room and board.

**Medicaid Only**

Providers should bill for routine or continuous home care and bill the rate to cover room and board as appropriate. The Medicaid parish office will advise the resident and nursing facility or ICF-ID of the resident's patient liability income (PLI). Medicaid will deduct the resident's PLI from the amount to be reimbursed to the hospice. The hospice provider is to pay the facility according to the contract agreement subject to adjusted claims the nursing facility may encounter as a result of case mix methodology.

**Medicaid and Medicare (dual eligible)**

Providers should bill for the room and board rate for each day the resident is in the facility. Providers should bill Medicare for routine or continuous home care, as appropriate. The hospice provider is to pay the facility according to the contract agreement subject to adjusted claims the nursing facility may encounter as a result of the case mix methodology.

**NOTE: General inpatient care and room and board cannot be reimbursed for the same recipient for the same covered day of service.**

**Claims Submissions for Schedule (Room and Board ONLY)**

Claims for room and board are processed according to a predetermined schedule set by the Louisiana Department of Health and is updated every calendar year. This schedule includes deadlines for initial monthly claim submissions as well as for monthly supplemental claim submissions.

**NOTE:** Providers who bill hardcopy claims should continue to submit the initial monthly UB-04 forms in one package.

CHAPTER 24: HOSPICE

SECTION 24.10: CLAIMS RELATED INFORMATION

Levels of Care Billing

Payment rates are determined at one of four levels for each day of a recipient’s hospice care. Providers should use the following chart to determine the appropriate level for billing.

Revenue Code	Units of Service	Level of Care	Required Documentation
651	24-Hours (1 day)	<p><b>Routine Home Care</b></p> <p>The routine home care rate is paid for each day the recipient 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. It is also paid when the recipient is receiving hospital care for a condition <b>unrelated</b> to the terminal condition.</p> <p>This rate is also paid in the following situations: The recipient is:</p> <ul style="list-style-type: none"> <li>• In a hospital that is not contracted with the hospice;</li> <li>• In a hospital for care unrelated to the terminal condition;</li> <li>• Is receiving outpatient services in the hospital; or</li> <li>• For the day of discharge from general inpatient care or respite level of care.</li> </ul>	<p>The hospice must develop and maintain a plan of care (POC) for the recipient.</p> <p>The recipient’s clinical record should include any updates to the POC and changes to the recipient’s condition between the updates.</p> <p>The recipient’s clinical record should include all disciplines’ progress notes (daily/weekly/monthly) that record the type and frequency of the services provided to the recipient.</p>
659	1 unit=15 minutes	<p><b>Service Intensity Add-On Rate (SIA)</b></p> <p>SIA will be reimbursed only when billed in conjunction with the Routine Home Care code. Services must be rendered by a registered nurse or a social worker only. Bill codes G0299 (registered nurse) or G0155 (social worker) for each day a visit is made within the last seven days of a person’s life. Claims must be submitted hardcopy with documentation and progress notes justifying the intensity and number of visits. Payment will be reimbursed in 15 minute increments (one unit). The maximum total billed per day cannot exceed four hours.</p>	<p>The date of date must have been previously submitted to Medicaid and/or the appropriate health plan and is already on file before payment can be made on the SIA rate.</p>

**CHAPTER 24: HOSPICE**

**SECTION 24.10: CLAIMS RELATED INFORMATION**

Revenue Code	Units of Service	Level of Care	Required Documentation
652	1 Hour	<p><b>Continuous Home Care</b></p> <p>A minimum of eight hours of care must be provided during a 24-hour day which begins and ends at midnight. 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. Homemaker and aide services may also be provided to supplement the nursing care. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate.</p>	<p><b>Documentation must:</b></p> <p>Clearly document reason for continuous care.</p> <p>List the dates of service that the recipient was under continuous home care.</p> <p>Record hour by hour and day by day what services were provided, the recipient's condition, and the type of personnel providing the continuous care.</p>
655	1 Day	<p><b>Inpatient Respite Care</b></p> <p>The payment for respite care may be made for a maximum of five consecutive days in an election period at a time including the date of admission but not counting the date of discharge alive.</p> <p>Payment for the sixth and any subsequent days is to be made at the routine home care rate.</p>	<p><b>Documentation must:</b></p> <p>Clearly indicate the facility in which the recipient is receiving the respite level of care, the dates the recipient was at respite level of care, and why the respite was necessary.</p>

CHAPTER 24: HOSPICE

SECTION 24.10: CLAIMS RELATED INFORMATION

Revenue Code	Units of Service	Level of Care	Required Documentation
656	1 Day	<p><b>General Inpatient Care</b></p> <p>For the date of admission to the contracted inpatient facility, the general inpatient rate is to be paid.</p> <p>For the day of discharge from the contracted inpatient unit, the appropriate routine home care rate is to be paid unless the recipient dies as an inpatient.</p> <p>Upon death, the general inpatient rate is to be paid for the discharge date for the recipient admitted to the contracted facility.</p> <p>The provider should <b>bill revenue code 656 for recipients admitted to a contracted facility.</b></p> <p><b>The hospice may not bill the general inpatient rate for days the recipient is in a non-contracted facility or in a facility for a reason unrelated to the terminal condition or an inpatient facility where the facility is considered the recipient's temporary or permanent residence/home. The hospice bills routine home care rate for these days.</b></p>	<p>The name of the facility in which the recipient is receiving the general inpatient level of care;</p> <p>The dates the recipient was at the general inpatient level of care;</p> <p>A clear explanation of the reason why the admission was necessary;</p> <p>The recipient's condition during the inpatient stay; and</p> <p>The physician's discharge summary and any hospice interdisciplinary notes during the recipient's inpatient stay.</p> <p>NOTE: General inpatient care days are subject to limitations. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings. Payment for this care is limited to 5 days in an election period. Once the symptoms are under control, routine home care must be billed.</p>
657	1 day	<p><b>Physician Services</b></p> <p>For use when physician professional services are being provided to hospice recipients; and the hospice is responsible for reimbursing the physician.</p> <p>The physician can be an employee of the hospice, a volunteer, or a consultant.</p>	<p>Document all recipient encounters.</p>

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.10: CLAIMS RELATED INFORMATION**

**Third Party Liability**

Medicaid, by law, is intended to be the payer of last resort. Therefore, other available third-party resources, including private insurance, must be used before Medicaid pays for the care of a Medicaid recipient.

If probable third-party liability (TPL) is established at the time the claim is filed, Medicaid will deny the claim and return it to the provider for determination of third-party liability for most Medicaid services. In these cases, the Bureau will then pay the balance of the claim to the extent that payment is allowed under Medicaid's fee schedule after the third party's payment. EPSDT diagnostic and screening services are exempt from this requirement. For these services, Medicaid will pay the claim up to the maximum allowable amount. However, these exceptions do not include treatment or therapy that must be billed to the recipient's third-party carrier (if applicable) prior to billing Medicaid. When Medicaid is billed, hard copy of the claim must be filed with the third-party carrier's Explanation of Benefits (EOB) attached to the claim form.

For recipients with private insurance, hospice providers should still submit requests for hospice services timely to the hospice PAU, in order for the appropriate reviews and future accurate reimbursement to take place.

**Exception:** The only time Medicaid is considered primary is when the recipient has health coverage through Indian Health Services. In these cases, claims should be billed to Medicaid first, then to Indian Health Services.

**Timely Filing Guidelines**

To be reimbursed for services rendered, all providers must comply with the filing limits set by the Medicaid Program. Refer to Chapter 1 of the Louisiana Medicaid provider manual, General Information and Administration. The manual can be accessed on the internet at [www.lamedicaid.com](http://www.lamedicaid.com).

## **PROGRAM MONITORING**

Federal regulations require continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services of providers and by recipients.

The Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF), which administers the Medicaid Program, routinely conducts program monitoring to ensure that Medicaid payments being made for services are for eligible recipients, that the services provided are medically necessary and appropriate, and that they are provided by the appropriate provider. Participating hospices are responsible for ensuring that requirements, such as record documentation for services rendered, are met in order to receive payment. Hospices agree to give access to records and facilities to BHSF, its authorized representatives, representatives of LDH or the State Attorney General's Medicaid Fraud Control Unit, and authorized federal personnel upon reasonable request.

Data on hospices, certifications and claims may be analyzed for the appropriateness or necessity of review. Providers and recipients, including new hospice certifications, are identified for review either from systems generated reporting using various sampling methodologies or by referrals and complaints. Computerized exception reports may be used to look at utilization patterns for providers and recipients. Appropriateness of review may also be indicated for claims which involve vague or unreliable diagnoses, and/or of individual hospice providers that have a high percentage of recipients enrolled with diagnoses that do not normally represent a terminal illness. Data regarding average length of stay and use of the continuous home care and the general inpatient care category of care may also be helpful in identifying providers and claims that may be appropriate for review.

### **Review of Medical Eligibility**

A review may be conducted of hospice certifications to focus on hospice medical eligibility. A recipient must have a terminal prognosis and not just certification of terminal illness. Claims may be denied on the basis that a recipient is not terminally ill as defined in federal regulation. These regulations require certification of the recipient's prognosis, rather than diagnosis, i.e. denial is to be based on objective clinical evidence contained in the clinical record regarding the recipient's condition and not on the recipient's diagnosis.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.11: PROGRAM MONITORING****PAGE(S) 4**

---

**Utilization Review Visits**

Desk reviews may be made periodically of each Medicaid participating hospice provider.

On-site visits may be made and can be unannounced. The utilization review will include an interdisciplinary professional review of the services provided by the hospice with respect to the following:

- Care being provided to the recipients;
- Adequacy of the services available to meet current health needs and to provide the maximum physical and emotional well-being of each recipient;
- Necessity and desirability of the continued participation in hospice services by the recipient;
- Feasibility of meeting the recipient's health needs in alternate care arrangements; and
- Verification of the existence of all documentation required by Medicaid.

Services not documented in the recipient record will be determined not to have been performed and reimbursement will either be retracted or will not be made.

Other subsequent visits may be made for the purpose of the follow-up of deficiencies or problems, complaint investigation or technical assistance.

**Requests for Clinical Records**

When a new certification or claim is selected for review, a request will be made for the provider to submit the clinical records for a specific recipient's dates of service. The following documentation is required:

- Physician's certification;
- Plan of care;
- Lab results;

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.11: PROGRAM MONITORING****PAGE(S) 4**

---

- Medication lists;
- Progress notes for all services rendered;
- Physician's orders/updated physician orders to the plan of care; and
- Minimum Data Set (MDS) form.

A screening of the material received will be conducted before the claim is reviewed to ensure that the required documentation is included.

**NOTE:** The screening does not verify that the plan of care is valid, i.e., signed and dated; only that it has been received. It is the hospice's responsibility to ensure that all services rendered are appropriately documented and submitted to substantiate coverage.

In addition to the required documentation, any information that will support the recipient's hospice appropriateness should be included. Such documentation should:

- Describe in detail the recipient's condition;
- Describe the recipient's decline in detail. As an example, documentation should show last month's status compared to this month's status and should not merely summarize the recipient's condition for a month, but also show daily and weekly notes;
- Explain why the recipient is considered to be terminal and not chronic;
- Explain why his or her diagnosis has created a terminal prognosis;
- Show how the systems of the body are in a terminal condition;
- Show how the proposed services, specific to that individual, are reasonable and medically necessary; and
- Show that the cause of death was related to the hospice diagnosis, when the recipient has expired, if applicable.

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.11: PROGRAM MONITORING**

The hospice has 35 calendar days to submit the clinical records.

If the required documents are not submitted, an additional request will be sent to the hospice. Only one additional request will be made for this additional documentation.

If the physician's orders/updated physician orders to the plan of care are missing, an additional request will only be sent to the hospice for continuous care or general inpatient care categories.

Claims will be reviewed in 60 days from the date of receipt of the clinical records. To ensure a thorough and fair review, trained professionals will review all claims utilizing available resources, including appropriate consultants, and make on-site reviews as necessary. The prognosis of terminal illness will be reviewed and the reasonableness and medical necessity of the proposed services, specific to the recipient, for the palliation or management of the terminal illness, will be considered.

## **APPEALS**

### **Service Denial**

A hospice client who disagrees with the denial of hospice services has the right to request an appeal with the Division of Administrative Law. This request must be post marked no later than 30 days from the date of the denial notice. The request for appeal, stating the reason for the request and the denial letter, should be sent directly to the Division of Administrative Law (DAL). Information about the appeal process can be found by contacting the DAL (see Appendix D of this manual chapter) or refer to Chapter 1 - *General Information and Administration of the Medicaid Services Manual*. The manual can be accessed on the internet at [www.lamedicaid.com](http://www.lamedicaid.com).

### **Claims Payment Denial**

If a denial is upheld upon reconsideration and the hospice provider disagrees with a claims payment decision, the hospice provider has the right to request an appeal with the DAL within 30 days of the reconsideration decision date. The request for reconsideration and the denial letter should be submitted directly to the DAL. Information about the appeal process can be found by contacting the DAL (see Appendix D of this manual chapter) or refer to Chapter 1 - *General Information and Administration of the Medicaid Services Manual*. The manual can be accessed on the internet at [www.lamedicaid.com](http://www.lamedicaid.com).

---

**CHAPTER 24: HOSPICE**

---

**SECTION 24.13: RESERVED**

---

CHAPTER 24: HOSPICE

---

SECTION 24.14: ACRONYMS/DEFINITIONS/TERMS PAGE(S) 2

---

**ACRONYMS/DEFINITIONS/TERMS**

**Attending/Primary Physician** - A doctor of medicine or osteopathy, fully licensed to practice medicine in the State of Louisiana, who is designated by the recipient as the physician responsible for his/her medical care. The attending physician is the physician identified within the Medicaid system as the provider to which claims have been paid for services prior to the time of the election of hospice.

**Bereavement Counseling** - Organized counseling provided under the supervision of a qualified professional to help the family cope with death related grief and loss issues. This is to be provided for at least one year following the death of the recipient.

**BHSF FORM HOSPICE-NOE (Notice of Election/Revocation/Discharge/Transfer)** - This is the required form used to notify the hospice Prior Authorization Unit (PAU) of a recipient's election or cancellation of the hospice program as provided by Louisiana Medicaid. This form is also used to update changes in the Medicaid hospice recipient's condition and status.

**BHSF FORM HOSPICE-CTI (Certification of Terminal Illness)** - This is the required form to be used by the hospice agency for documentation of written and verbal certification of terminal illness for Medicaid recipients. **This form is not to be altered by the Hospice provider. In addition, this form may be utilized for dually eligible (Medicare/Medicaid) recipients.**

**Clinical Condition** – A diagnosis or recipient state that may be associated with more than one diagnosis, or may be as yet undiagnosed.

**Core Services** - Nursing services, physician services, medical social services and counseling services, including bereavement counseling, dietary counseling, spiritual counseling and any other counseling services provided to meet the needs of the individual and family.

**Curative Treatments** – Medical treatment and therapies provided to a recipient with the intent to improve symptoms and cure the patient's medical problem.

**Department/LDH** - Louisiana Department of Health

**Discharge** - The point at which the recipient's active involvement with the hospice services is ended and the hospice provider no longer has active responsibility for the care of the recipient.

**Geographic Area** - Area around location of licensed agency which is within a 50-mile radius of the agency premises.

---

CHAPTER 24: HOSPICE

---

SECTION 24.14: ACRONYMS/DEFINITIONS/TERMS PAGE(S) 2

---

**Hospice Employee** - An individual whom the hospice provider pays directly for services performed on an hourly or per visit basis and the hospice provider is required to issue a form W-2 on his/her behalf. If a contracting service or another agency pays the individual, and is required to issue a form W-2 on the individual's behalf, or if the individual is self-employed, the individual is not considered a hospice employee. An individual is also considered a hospice employee if the individual is a volunteer under the jurisdiction of the hospice.

**Interdisciplinary Group (IDG)** - an interdisciplinary group or groups designated by the hospice provider, composed of representatives from all the core services. The IDG must include at least a doctor of medicine or osteopathy, a registered nurse, a social worker and a pastoral or other counselor. The interdisciplinary group is responsible for: participation in the establishment of the plan of care; provision or supervision of hospice care and services; periodic review and updating of the plan of care for each individual receiving hospice care; and establishment of policies governing the day-to-day provision of hospice care and services.

**Level of Care** - Hospice care is divided into four categories of care rendered to the hospice recipient: (1) routine home care; (2) continuous home care; (3) inpatient respite care; and (4) general inpatient care.

**Non-Core Services** - Services provided directly by hospice employees or under arrangement. These services include, but are not limited to home health aide and homemaker, physical therapy services, occupational therapy services, speech-language pathology services, inpatient care for pain control and symptom management and respite purposes, and medical supplies and appliances, including drugs and biologicals.

**Plan of Care (POC)** - A written document established and maintained for each individual admitted to a hospice program. Care provided to an individual must be in accordance with the plan. The plan includes an assessment of the individual's needs and identification of the services, including the management of discomfort and symptom relief.

**Relative** - For the purpose of legal representation, a relative is all persons related to the recipient by virtue of blood, marriage, adoption or legal guardianship as court appointed.

**Service Intensity Add-On Rate (SIA)** – A rate for registered nurse and social worker visits provided to a patient within the last seven days of life,

**Terminal Illness** - A medical prognosis of limited expected survival, of approximately six months or less at the time of referral to a hospice program, of an individual who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone are no longer appropriate.

**CHAPTER 24: HOSPICE**

**APPENDIX A: RECIPIENT NOTICE OF ELECTION/REVOCAION/DISCHARGE/TRANSFER**

**RECIPIENT NOTICE OF ELECTION/REVOCAION/DISCHARGE/TRANSFER**

**Purpose of Form**

The BHSF Form Hospice–Notice of Election (NOE) is used to notify the Hospice Prior Authorization Unit (PAU) of a hospice recipient’s voluntary election or cancellation of the Hospice Program.

This form is also used to update changes in the recipient’s condition and status.

Upon completion, the form along with the CTI, physician narrative, and all related documentation must be sent to:

**DXC Technologies via the e-PA system  
@Lamedicaid.com**

**NOTE:** Electronic submissions are required due to the time-frames.

**Notifications and Type of Bill**

The alpha character for the third digit of the BHSF Form Hospice – Notice of Election’s field titled “Type of Bill” is used to indicate the type of notification that is being provided:

Notification	Type Bill	Description
Notice of Election (NOE)	81A/82A	When a recipient elects Medicaid hospice care, the recipient must sign and date the BHSF Form Hospice - Notice of Election. The hospice provider is required to submit this form as a Notice of Election (NOE) immediately after obtaining the receipt and receipt of the physician's completed BHSF Form Hospice – TI (Certification of Terminal Illness), including verbal certification where applicable. Both the forms, properly completed must be received by the Hospice Program within 10 calendar days following the initiation of hospice care. If this requirement is not met, reimbursement is not available for the days prior to receipt of the forms. Reimbursement will become effective the date the hospice PAU receives the proper documentation.

**CHAPTER 24: HOSPICE****APPENDIX A: RECIPIENT NOTICE OF  
ELECTION/REVOCATION/DISCHARGE/TRANSFER****PAGE(S) 9**

Notification	Type Bill	Description
Notice of Termination	81B/82B	This notice is used for a recipient who has revoked/discharged from a hospice election period. This must be sent to the Hospice PAU within five calendar of discharge or revocation. For revocation, a signed written statement by the recipient or legal representative must accompany the form with 81/B noted. In addition, the recipient's or legal representative's contact information must be provided.
Notice of Change (Transfer)	81C/82C	<p>A Notice of transfer is sent when the recipient is in the middle of an election period and wants to change hospice providers. <b>A recipient may change hospices once each election period.</b> The date of discharge from the current hospice must ideally be only one day before the date of admission to the newly designated hospice. These providers must communicate with each other to decide how the coordination of the recipient's hospice care will be handled. The first hospice should send the recipient's history and Plan of Care (POC) to the new hospice. The first hospice must submit the notice of transfer to the hospice PAU within five calendar days after receipt of the filed notice of change statement. The new hospice provider must submit the Notification of Transfer (81C/82C) to the Hospice PAU within five calendar days of transfer. The date of admission on the Notification of Transfer should be the date the recipient was admitted into the new hospice.</p> <p><b>NOTE:</b> An 81C/82C must also be sent to the Hospice PAU when a recipient is transferring to or from a nursing facility.</p>
Notice of Void (of a NOE)	81D/82D	<p>This notice is used to void an 81A/82A that was established in error, such as if the recipient changes his/her mind, or if the wrong Date of Admission was previously submitted. Please note: A notice of void will not be honored if submitted to avoid payments to non-hospice providers. Notice of Voids must be submitted within five calendar days.</p> <p><b>NOTE:</b> If claims have processed during the voided election period, claims must be voided before 81D/82D is submitted and a recoupment made to the intermediary.</p>

---

**CHAPTER 24: HOSPICE**

---

**APPENDIX A: RECIPIENT NOTICE OF  
ELECTION/REVOCAION/DISCHARGE/TRANSFER****PAGE(S) 9**

---

**Instructions for Completing the BHSF Form Hospice-Notice of Election****Completing the BHSF Form Hospice****PART I**

**The first section of the form (PART I) is to be completed by the recipient or legal representative only.** The signature of the recipient or legal representative is required. The recipient or legal representative may sign prior to the admission date or on the admission date, but not after the admission date. **The legal representative must show relationship to the recipient and provide contact information.**

**1. Election/Admission Date - REQUIRED**

The date of admission cannot precede the physician's certification by more than two calendar days, and is the same as the certification date if the certification is not completed on time. The date must be entered by the recipient or legal representative. Hospice providers are prohibited from entering information in this field.

**NOTE:** If the BHSF Form Hospice -Notice of Election form and the Certification of Terminal Illness are not received within ten calendar days of the initiation of hospice care, the date of admission (election) will be the date the Hospice PAU receives the proper documentation. This rule applies to recipients receiving Medicaid only, as well as Medicaid/Medicare (dual eligible) recipients.

**EXAMPLE:** The hospice election date (admission) is January 1, 2019. The physician's certification is dated January 3, 2019. The hospice date for coverage and billing is January 1, 2019. The first hospice benefit period ends 90 days from January 1, 2019. However, if the required forms and completed packet is not received within the ten calendar day timeframe, the benefit begin date will be the date the completed packet is received by the hospice PAU. For example, if the required forms and completed packet are received on January 11, 2019, the begin date would be January 11, 2019.

The admission date will change when the recipient re-elects hospice any time after a revocation or discharge.

---

**CHAPTER 24: HOSPICE**

---

**APPENDIX A: RECIPIENT NOTICE OF  
ELECTION/REVOCAION/DISCHARGE/TRANSFER**

---

**2. Signature of Patient/Legal Representative – REQUIRED**

The signature of the recipient or legal representative is required. The recipient or legal representative may sign prior to the admission date or on the admission date, but not after the admission date. The date of signature will become the LDH approval date if signed after the admission date.

In cases where a recipient signs the Notice of Election form with an “X”, there must be two witnesses to sign next to the recipient’s mark. The witnesses must also indicate relationship to the recipient and daytime phone number. One witness must be a relative or legal representative. Hospice representatives cannot sign as a witness.

**Definition of Relative**

A relative is defined as all persons related to the recipient by virtue of blood, marriage, adoption or legal guardians as court appointed.

**Non-Relatives**

Persons other than relatives signing the BHSF Form Hospice-Notice of Election must have legal rights, (a medical power of attorney) to make medical decisions for recipients who are physically or mentally incapacitated. Proof of these rights must be notarized or court issued documents and submitted at the time the election for hospice is made. Verbal elections are prohibited.

**3. Date of Signed - REQUIRED**

The recipient or legal representative must enter date at time of signature.

**4. Representative’s Daytime Phone Number - REQUIRED**

The legal representative must provide his/her contact information including the area code.

**5. Printed Name of Above Signee – REQUIRED**

The person who signed acknowledgement of Patient’s Declaration must also print name. This could be the recipient or the authorized representative, whichever has signed.

---

**CHAPTER 24: HOSPICE**

---

**APPENDIX A: RECIPIENT NOTICE OF  
ELECTION/REVOCATION/DISCHARGE/TRANSFER****PAGE(S) 9**

---

**6. Legal Representative's Relationship to Patient - REQUIRED**

The legal representative must show relationship to the recipient. If the legal representative is not related to the recipient, follow the instructions as outlined in number 2 above.

**PART II**

The second section of the form (**PART II**) is to be completed by the hospice provider.

**NOTE:** When revoking hospice services, the recipient or legal representative must, in their own handwriting, complete the reason for revocation.

**Patient Information****7. Patient Name - REQUIRED**

Enter the recipient's first name, middle initial and last name in this order as it is printed on the recipient's Medicaid card.

**8. Patient Address - REQUIRED**

Enter the recipient's complete mailing address, including zip code.

**9. Patient Medicaid ID Number - REQUIRED**

Enter the recipient's 13-digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid "swipe" card, e-MEVS, or REVS. Make certain that the last two digits are the correct individual suffix for your recipient. The number must match the recipient's name. If the patient is not eligible for Medicaid, reimbursement is not made by Medicaid.

**NOTE:** Providers enrolling patients with "Pending" ID numbers are assuming responsibility for those patients. **It is the provider's responsibility to notify the hospice PAU when recipients have been approved for Medicaid.**

**CHAPTER 24: HOSPICE****APPENDIX A: RECIPIENT NOTICE OF  
ELECTION/REVOCAION/DISCHARGE/TRANSFER****PAGE(S) 9****10. Patient Medicare ID Number – REQUIRED, IF APPLICABLE**

This field should only be used if the recipient has Medicare. Enter the recipient's Medicare health insurance number.

**11. Patient Date of Birth - REQUIRED**

Enter the month, day and year of birth (MM-DD-YYYY) of recipient. Example: 06-12-1903.

**12. Type Bill - REQUIRED**

Enter the three-digit numeric type of bill code, as appropriate. The first digit identifies the type of facility. The second classifies the type of care. The third is referred to as a "frequency" code and it indicates the sequence of this bill in this particular episode of care.

Code Structure:

1st Digit - Type of Facility

8 - Special facility (hospice)

2nd Digit - Classification

1 - Hospice (Non-hospital based)

2 - Hospice (Hospital based)

3rd Digit - Frequency

A - Hospice Admission Notice

B - Hospice Termination/ Revocation Notice

C - Hospice Change of Provider Notice

D - Hospice Election Void/Cancel

E - Hospice Change of Ownership

Definition

Use when the hospice is submitting form as an admission notice.

Use when the hospice is submitting form as a notice of termination/revocation for a previously posted hospice election.

Use when form is used as a notice of change in the hospice provider or nursing facility.

Use when form is used as a notice of a void/cancel of hospice election.

Use when form is used as a notice of change in ownership for the hospice.

---

**CHAPTER 24: HOSPICE**

---

**APPENDIX A: RECIPIENT NOTICE OF  
ELECTION/REVOCATION/DISCHARGE/TRANSFER****PAGE(S) 9**

---

**13. Statement Covers Period – REQUIRED, IF APPLICABLE**

This field is to be used when filing an 81B/82B document and upon the initial election of hospice only. The “From” date is the start date of the period from which the recipient is revoking. The “Through” date is the date of revocation. Dates must be entered numerically as MM-DD-YYYY. “From” date must match the date the recipient/legal representative elects the hospice service.

**14. Primary Diagnosis Code(s) - REQUIRED**

Use the most specific and accurate numeric ICD-10-CM diagnosis code(s) for the terminal illness that is current. The principal diagnosis is defined as the condition established after study to be chiefly responsible for the recipient's admission. CMS only accepts ICD-10-CM diagnostic and procedural codes using definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. CMS approves only changes issued by the Federal ICD-10-CM Coordination and Maintenance Committee. Use full ICD-10-CM or its successors' diagnoses codes including all five digits where applicable.

**15. List All Other Diagnosis Codes - REQUIRED**

Enter the full ICD-10 or its successors' codes, including all five digits where applicable, for any other terminal diagnosis and **or related condition. List ALL co-morbidities.**

**16. Discharge/Revocation Reason(s) - REQUIRED:**

Enter the reason(s) for the discharge or revocation. Recipient or legal representative must sign and date NOE form if the recipient is revoking hospice services.

The recipient or legal representative must also provide a statement for the reason of revoking services.

The hospice provider must sign and date if the recipient is discharging. The hospice provider must also provide the reason the recipient is being discharged.

Forms received after the specified time limits will become effective upon date of receipt.

**CHAPTER 24: HOSPICE**

**APPENDIX A: RECIPIENT NOTICE OF ELECTION/REVOCAION/DISCHARGE/TRANSFER**

**Provider Information**

**17. Hospice Provider Name - REQUIRED**

Enter the hospice provider name.

**18. Hospice Address - REQUIRED**

Enter the hospice provider address (street number and name, city, state, and zip code).

**19. Hospice Provider Number - REQUIRED**

Enter the seven-digit Medicaid provider identification number.

**20. Hospice Provider Telephone Number – REQUIRED**

Enter the hospice provider telephone number including area code. Fax number is optional.

**21. Name of Nursing Facility or ICF-ID – REQUIRED, IF APPLICABLE**

Enter the name of the facility in which the recipient resides or intends to reside. Medicaid field office staff determines long-term care eligibility.

**22. Attending Physician Printed Name - REQUIRED**

Print the name of the attending physician currently responsible for referring, certifying, and signing the individual's plan of care for medical care and treatment.

**NOTE:** The attending physician's name must be the same on the NOE and CTI.

**23. Attending Physician Provider Number - REQUIRED**

Enter the attending physician's seven digit Medicaid provider identification number.

**24. Hospice Relationship Status - REQUIRED**

Enter the word "employee" or "non-employee" here to describe the relationship the recipient's attending physician has with the hospice. "Employee" also refers to a volunteer under your jurisdiction.

---

**CHAPTER 24: HOSPICE**

---

**APPENDIX A: RECIPIENT NOTICE OF  
ELECTION/REVOCAION/DISCHARGE/TRANSFER**

---

**25. Hospice Provider's Representative's Signature – REQUIRED**

Signature required.

**26. Hospice Provider's Representative's Printed Name – REQUIRED**

Printed name required.

**27. Date – REQUIRED**

Hospice representative must enter date at time of signature.

CHAPTER 24: HOSPICE

APPENDIX A: RECIPIENT NOTICE OF ELECTION/REVOCAION/DISCHARGE/TRANSFER

**Department of Health and Hospitals  
Louisiana Medicaid Hospice Program  
RECIPIENT NOTICE OF ELECTION/REVOCAION/DISCHARGE/TRANSFER  
PART I: TO BE COMPLETED BY PATIENT OR LEGAL REPRESENTATIVE ONLY**

**1 Hospice is a program that gives help and support to patients during the final months of life. The program also helps loved ones cope. I choose to receive services from the Hospice provider named below starting**

**1**

Election/Admission Date (MM-DD-YYYY)

**NOTE:** To get hospice services, I must have Medicaid and my doctor must write that I am in my final months of life.

**PATIENT'S STATEMENT**

I understand and accept:

- I can get hospice for 3 months if approved for the service. If I need more days the hospice provider will ask for these days for me.
- If my illness is better. I will no longer get hospice services under the Medicaid Program. If I no longer receive hospice services, I can keep on using my Medicaid card for other services.
- By choosing hospice I understand that I will not be treated for my terminal sickness and any related condition.
- If I have Medicaid and Medicare, I must choose hospice with Medicaid and Medicare at the same time.
- I am signing this paper because I understand hospice services. The hospice provider explained the services to me/my legal representative and also explained to me that I can choose to not receive hospice care at any time.

**SIGNATURES**

Signature of Patient/Legal Representative	Date of Signed (MM-DD-YYYY)	Representative's Daytime Phone # (incl. area code)
<b>2</b>	<b>3</b>	<b>4</b>
Printed Name of Above Signee	Legal Representative's Relationship to Patient	
<b>5</b>	<b>6</b>	

**PART II: TO BE COMPLETED BY HOSPICE PROVIDER**

**PATIENT INFORMATION**

Patient Name ( First, Middle Initial, Last)	Patient's Address	City	State	Zip
<b>7</b>	<b>8</b>			
Patient Medicaid ID #	Patient Medicare ID #	Date of Birth (MM-DD-YYYY)		
<b>9</b>	<b>10</b>	<b>11</b>		
Type Bill	Statement Covers Period From (MM-DD-YY) Through (MM-DD-YYYY)	Primary Diagnosis Code (s)	List All Other Diagnosis Codes	
<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	
Discharge/Revocation Reason(s):				
<b>16</b>				

**PROVIDER INFORMATION**

Hospice Provider Name	Hospice Address	City	State	Zip
<b>17</b>	<b>18</b>			
Hospice Provider #	Hospice Provider Phone # (incl. area code & Fax)	Name of Nursing Facility or Intermediate Care Facility (ICF-DD)		
<b>19</b>	<b>20</b>	<b>21</b>		
Attending Physician Printed Name	Attending Physician Provider #s	Hospice Relationship Status		
<b>22</b>	<b>23</b>	<b>24</b>		

**SIGNATURES**

Hospice Provider Representative's Signature	Hospice Representative's Printed Name	Date (MM-DD-YYYY)
<b>25</b>	<b>26</b>	<b>27</b>

**Department of Health and Hospitals**

**Louisiana Medicaid Hospice Program**

**RECIPIENT NOTICE OF ELECTION/REVOCATION/DISCHARGE/TRANSFER**

**PART I: TO BE COMPLETED BY PATIENT OR LEGAL REPRESENTATIVE ONLY**

**1 Hospice is a program that gives help and support to patients during the final months of life. The program also helps loved ones cope. I choose to receive services from the Hospice provider named below starting**

\_\_\_\_\_ Election/Admission Date (MM-DD-YYYY)

**NOTE:** To get hospice services, I must have Medicaid and my doctor must write that I am in my final months of life.

**PATIENT'S STATEMENT**

I understand and accept:

- I can get hospice for 3 months if approved for the service. If I need more days the hospice provider will ask for these days for me.
- If my illness is better. I will no longer get hospice services under the Medicaid Program. If I no longer receive hospice services, I can keep on using my Medicaid card for other services.
- By choosing hospice I understand that I will not be treated for my terminal sickness and any related condition.
- If I have Medicaid and Medicare, I must choose hospice with Medicaid and Medicare at the same time.
- I am signing this paper because I understand hospice services. The hospice provider explained the services to me/my legal representative and also explained to me that I can choose to not receive hospice care at any time.

**SIGNATURES**

Signature of Patient/Legal Representative	Date of Signed (MM-DD-YYYY)	Representative's Daytime Phone # (incl. area code)
Printed Name of Above Signee	Legal Representative's Relationship to Patient	

**PART II: TO BE COMPLETED BY HOSPICE PROVIDER**

**PATIENT INFORMATION**

Patient Name ( First, Middle Initial, Last)	Patient's Address	City	State	Zip
Patient Medicaid ID #	Patient Medicare ID #	Date of Birth (MM-DD-YYYY)		
Type Bill	Statement Covers Period From (MM-DD-YYYY) Through (MM-DD-YYYY)	Primary Diagnosis Code (s)	List All Other Diagnosis Codes	
Discharge/Revocation Reason(s):				

**PROVIDER INFORMATION**

Hospice Provider Name	Hospice Address	City	State	Zip
Hospice Provider #	Hospice Provider Phone # (incl. area code & Fax)	Name of Nursing Facility or Intermediate Care Facility (ICF-DD)		
Attending Physician Printed Name	Attending Physician Provider #s	Hospice Relationship Status		

**SIGNATURES**

Hospice Provider Representative's Signature	Hospice Representative's Printed Name	Date (MM-DD-YYYY)
---	---------------------------------------	-------------------

## CERTIFICATION OF TERMINAL ILLNESS

### Instructions for Completing the BHSF Form Hospice-Certification of Terminal Illness

#### Purpose of BHSF Form Hospice-CTI

The purpose of the BHSF Form Hospice Certification of Terminal Illness (CTI) is to document written and verbal certification of terminal illness for Medicaid recipients. Additionally, this form may be utilized for dual eligible (Medicare/Medicaid) recipients.

**NOTE: This form is not to be altered by the Hospice provider.**

The CTI, BHSF Form Hospice-Notice of Election (NOE) and all related documents must be electronically submitted via electronic prior authorization (e-PA) system (See Appendix C for contact information.)

#### Completing the BHSF Form Hospice-CTI

For Medicaid-only recipients, there must be two different signatures on the CTI. For dual eligible (Medicare Part A) recipients, only one physician's signature is necessary.

Submission of the physician's CTI is required all election periods. However, additional copies of certification forms for all election periods must be made available to the Bureau upon request.

**NOTE:** A stamped physician's signature is not acceptable on the certification. The physician must date this form at time of his signature. No stamped dates are acceptable. Submitting forms incorrectly may delay the hospice segment being added to the system. If the physician forgets to date the certification; another signed and dated CTI can be obtained to verify when the certification was obtained. The hospice approval date will be the date the signed and dated CTI is received in the hospice program office if submitted beyond the ten-day time limit.

#### Patient Information

**1. Patient Name - REQUIRED**

Enter the recipient's first name, middle initial and last name in this order.

---

**CHAPTER 24: HOSPICE**

---

**APPENDIX B: CERTIFICATE OF TERMINAL ILLNESS PAGE(S) 5****2. Patient Medicaid ID Number - REQUIRED**

Enter the recipient's 13-digit Medicaid ID number exactly as it appears in the recipient's current Medicaid information using the plastic Medicaid "swipe" card, electronic Medicaid eligibility verification system (e-MEVS), or the recipient eligibility verification system (REVS). Make certain that the last two digits are the correct individual suffix for your recipient. The number must match the recipient's name. If the patient is not eligible for Medicaid, reimbursement is not made by Medicaid.

**3. Patient's Date of Birth - REQUIRED**

Enter the month, day and year of birth (MM-DD-YYYY) of patient.  
Example: 06-12-1903.

**Certification of Terminal Illness**

**For the first benefit period (90 days) both attending physician and the hospice medical director or the physician member of the interdisciplinary group (IDG) must certify terminal illness.**

Subsequent benefit periods (2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, etc.) require only the signature of the hospice medical director or the physician member of the IDG must certify terminal illness.

**First Benefit Period (90 days)****4. Signature of Attending Physician - REQUIRED**

This is the signature of the attending physician prior to electing hospice and currently responsible for referring, certifying and signing the individual's plan of care for medical care and treatment.

**5. Date Signed (MM-DD-YYYY) - REQUIRED**

The attending physician must enter the date at the time of signature.

**6. Printed Name of Above Attending Physician - REQUIRED**

Print the name of the attending physician currently responsible for certifying and signing the individual's plan of care for medical care and treatment.

**7. Signature of Hospice Medical Director or Physician Member of IDG - REQUIRED**

This is the signature of the hospice medical director or physician member of IDG.

**8. Date Signed (MM-DD-YYYY) - REQUIRED**

The hospice medical director or physician member of the IDG must enter date at time of signature.

---

**CHAPTER 24: HOSPICE**

---

**APPENDIX B: CERTIFICATE OF TERMINAL ILLNESS PAGE(S) 5**

**9. Printed Name of Hospice Medical Director or Physician Member of IDG Signee - REQUIRED**

Print the name of the hospice medical director or physician member of the IDG who signed in as per number 7.

**Second Benefit Period (90 Days)**

**10. Signature of Hospice Medical Director or Physician Member of IDG - REQUIRED**

This is the signature of the hospice medical director or physician member of the IDG.

**11. Date Signed (MM-DD-YYYY) - REQUIRED**

The hospice medical director or physician member of the IDG must enter the date at the time of signature.

**12. Printed Name of Hospice Medical Director or Physician Member of IDG Signee - REQUIRED**

Print the name of the hospice medical director or physician member of the IDG who signed in as per number 10.

**Third Benefit Period (60 Days)**

**13. Signature of Hospice Medical Director or Physician Member of IDG - REQUIRED**

This is the signature of the hospice medical director or physician member of the IDG.

**14. Date Signed (MM-DD-YYYY) - REQUIRED**

The hospice medical director or physician member of the IDG must enter the date at the time of signature.

**15. Printed Name of Hospice Medical Director or Physician Member of IDG Signee - REQUIRED**

Print the name of the hospice medical director or physician member of the IDG who signed in as per number 13.

**Referring Physician Narrative Statement**

**16. Narrative Statement - REQUIRED**

The attending/referring physician must complete a narrative in his handwriting providing the diagnosis, prognosis and the justification for hospice care. The narrative must be completed prior to the election of hospice care. The physician's signature is required.

---

CHAPTER 24: HOSPICE

---

APPENDIX B: CERTIFICATE OF TERMINAL ILLNESS PAGE(S) 5

- 17. **Signature of the Referring Physician - REQUIRED**  
This is the signature of the referring physician.
- 18. **Date Signed (MM-DD-YYYY) - REQUIRED**  
The referring physician must enter the date at the time of signature.
- 19. **Printed Name of the Referring Physician - REQUIRED**  
Print the name of the referring physician who signed in as per number 17.

**NOTE:** If additional periods are to be certified, use an additional form.

**Verbal Verification (within two days of election date)**

This section must be used to document that verbal verification was obtained from the physician as named in this section confirming the recipient’s prognosis of life expectancy of six months or less if the terminal illness runs its course. Either the verbal or written certification must be obtained within two days of the election date so hospice care can begin.

- 20. **Printed Name of Physician Who Gave Verbal Verification - REQUIRED**  
Print the name of the physician who gave verbal verification of the recipient’s terminal illness.
- 21. **Signature of the IDG Member Taking Referral - REQUIRED**  
This is the signature of the member of the IDG who obtained the physician’s verbal certification of terminal illness.
- 22. **Printed Name of IDG Member Signee Taking Referral - REQUIRED**  
Print the name of the IDG who signed in as per number 21.
- 23. **Date Signed (MM-DD-YYYY) - REQUIRED**  
The IDG member must enter date at time of signature.

CHAPTER 24: HOSPICE

APPENDIX B: CERTIFICATE OF TERMINAL ILLNESS PAGE(S) 5

Department of Health and Hospitals  
Louisiana Medicaid Program  
HOSPICE CERTIFICATION OF TERMINAL ILLNESS

<b>PATIENT INFORMATION</b>		
Patient's Name (First, Middle Initial, Last) <b>1</b>	Patient's Medicaid ID # (13-digits) <b>2</b>	Patient's Date of Birth (MM-DD-YYYY) <b>3</b>

**FIRST BENEFIT PERIOD (90 Days)**  
Having reviewed this patient's medical record and/or examination of the patient, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

**SIGNATURES (Physicians must date at time of signature)**

Signature of Attending Physician <b>4</b>	Date Signed (MM-DD-YYYY) <b>5</b>
Printed Name of Above Attending Physician <b>6</b>	
Signature of Hospice Medical Director or Physician Member of Interdisciplinary Group (IDG) <b>7</b>	Date Signed (MM-DD-YYYY) <b>8</b>
Printed Name of Above Hospice Medical Director or Physician Member of IDG <b>9</b>	

**SECOND BENEFIT PERIOD (90 Days)**  
Having reviewed this patient's medical record and/or examination of the patient, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

**SIGNATURES (Physicians must date at time of signature)**

Signature of Hospice Medical Director or Physician Member of Interdisciplinary Group (IDG) <b>10</b>	Date Signed (MM-DD-YYYY) <b>11</b>
Printed Name of Above Hospice Medical Director or Physician Member of IDG <b>12</b>	

**THIRD BENEFIT PERIOD (60 Days)**  
Having reviewed this patient's Medical record and/or Examination of the patient, I certify this patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course. This certification of terminal illness is based on my clinical judgment regarding the normal course of the individual's illness.

**SIGNATURES (Physicians must date at time of signature)**

Signature of Hospice Medical Director or Physician Member of Interdisciplinary Group (IDG) <b>13</b>	Date Signed (MM-DD-YYYY) <b>14</b>
Printed Name of Above Hospice Medical Director or Physician Member of IDG <b>15</b>	

**REFERRING PHYSICIAN NARRATIVE STATEMENT:**  
Review of the individual's clinical circumstances and medical information to provide clinical justification for admission to hospice services. Narrative must be written legible by the physician.

**16**

---



---



---

**SIGNATURES (Physicians must date at time of signature)**

Signature Referring Physician <b>17</b>	Date Signed (MM-DD-YYYY) <b>18</b>
Printed Name of Above Physician <b>19</b>	

**NOTE: If additional periods are to be certified, use an additional form**

**VERBAL VERIFICATION (within two days of election date)**  
I certify that on the date signed below a verbal verification was obtained from the physician named below; confirming that the recipient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.

**SIGNATURES**

Physician's Name (printed) <b>20</b>		
Signature of IDG Member Taking Referral <b>21</b>	Printed Name of IDG Member Taking Referral <b>22</b>	Date Signed (MM-DD-YYYY) <b>23</b>

## **HOSPICE DIAGNOSIS CODES**

Diagnosis code(s) are required when submitting a request for hospice services. Certain codes require criteria that must be met before the associated request can be approved. The specified codes are identified with an asterisk. Appropriate documentation is required for these codes. This list is not all inclusive. Additional codes may be added upon request with documentation and justification as to why the patient has a prognosis of six months or less with this diagnosis. Each code submitted will be considered on a case-by-case basis.

All claims/authorizations must use the applicable diagnosis codes that reflect the policy intent. The conversion link for ICD-9 and ICD-10 codes can be found in Appendix D of this manual chapter.

## **HOSPICE DIAGNOSIS CODES**

Diagnosis code(s) are required when submitting a request for hospice services. Certain codes require criteria that must be met before the associated request can be approved. The specified codes are identified with an asterisk. Appropriate documentation is required for these codes. This list is not all inclusive. Additional codes may be added upon request with documentation and justification as to why the patient has a prognosis of six months or less with this diagnosis. Each code submitted will be considered on a case-by-case basis.

All claims/authorizations must use the applicable diagnosis codes that reflect the policy intent.

**CHAPTER 24: HOSPICE SERVICES****APPENDIX D: CONTACT/REFERRAL INFORMATION****PAGE(S) 4****CONTACT/REFERRAL INFORMATION****DXC Technologies**

The Medicaid Program's fiscal intermediary, DXC Technologies, can be contacted for assistance with the following:

TYPE OF ASSISTANCE	CONTACT INFORMATION
<b>e-CDI technical support</b>	DXC Technologies (877) 598-8753 (Toll Free) (225) 216-6303
<b>Electronic Media Interchange (EDI)</b> Electronic Claims testing and assistance	P.O. Box 91025 Baton Rouge, LA 70898 Phone: (225) 216-6000 Fax: (225) 216-6335
<b>Hospice Prior Authorization Unit</b>	Phone: (800) 877-0666 Fax: (225) 216-6481
<b>Pharmacy Point of Sale (POS)</b>	P.O. Box 91019 Baton Rouge, LA 70821 Phone: (800) 648-0790 (Toll Free) Phone: (225) 216-6381 (Local) <i>*After hours, please call REVS</i>
<b>Prior Authorization Unit (PAU)</b>	DXC Technologies – Prior Authorization P.O. Box 14919 Baton Rouge, LA 70898-4919 (800) 488-6334
<b>Provider Enrollment Unit (PEU)</b>	DXC Technologies-Provider Enrollment P. O. Box 80159 Baton Rouge, LA 70898-0159 (225) 216-6370 (225) 216-6392 Fax
<b>Provider Relations Unit (PR)</b>	DXC Technologies – Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 Phone: (225) 924-5040 or (800) 473-2783 Fax: (225) 216-6334
<b>Recipient Eligibility Verification (REVS)</b>	Phone: (800) 766-6323 (Toll Free) Phone: (225) 216-7387 (Local)

**CHAPTER 24: HOSPICE SERVICES**

**APPENDIX D: CONTACT/REFERRAL INFORMATION PAGE(S) 4**

**Louisiana Department of Health**

TYPE OF ASSISTANCE	CONTACT INFORMATION
<b>General Medicaid Information</b>	General Hotline (888) 342-6207 (Toll Free) <a href="http://ldh.la.gov/index.cfm/subhome/1/n/10">http://ldh.la.gov/index.cfm/subhome/1/n/10</a> MedWeb@la.gov
General Medicaid Information for Providers	www.lamedicaid.com
<b>Health Standards Section (HHS)</b>	P.O. Box 3767 Baton Rouge, LA 70821 Phone: (225) 342-0138 Fax: (225) 342-5073 HSS.Mail@la.gov
<b>Long-Term Personal Services (LT-PCS)</b>	P.O. Box 2031 Baton Rouge, LA 70821 Phone: (877) 456-1146 Fax: (225) 219-0202 E-mail: <a href="mailto:MedWeb@la.gov">MedWeb@la.gov</a>  <a href="http://ldh.la.gov/index.cfm/subhome/12/n/327">http://ldh.la.gov/index.cfm/subhome/12/n/327</a>
<b>Louisiana Children’s Health Insurance Program (LaCHIP)</b>	(225) 342-0555 (Local) (877) 252-2447 (Toll Free)  <a href="http://ldh.la.gov/index.cfm/page/222">http://ldh.la.gov/index.cfm/page/222</a>
<b>Office of Aging and Adult Services (OAAS) State Office</b>	Office of Aging and Adult Services P. O. Box 2031 Baton Rouge, LA 70821-2031  Phone: (866) 758-5035 Fax: (225) 219-0202 OAAS.Inquiries@la.gov <a href="http://ldh.la.gov/index.cfm/subhome/12">http://ldh.la.gov/index.cfm/subhome/12</a>
<b>OAAS Regional Offices</b>	<a href="http://new.dhh.louisiana.gov/index.cfm/directory/category/141">http://new.dhh.louisiana.gov/index.cfm/directory/category/141</a>
<b>Office of Management and Finance (Bureau of Health Services Financing) - MEDICAID</b>	P.O. Box 91030 Baton Rouge, LA 70810-9030 <a href="http://ldh.la.gov/index.cfm/page/23">http://ldh.la.gov/index.cfm/page/23</a>
<b>Office for Citizens with Developmental Disabilities (OCDD)</b>	628 N. Fourth Street P.O. Box 3117 Baton Rouge, LA 70821-3117 Phone: (225) 342-0095 (Local) Phone: (866) 783-5553 (Toll-free) E-mail: <a href="mailto:ocddinfo@la.gov">ocddinfo@la.gov</a>

**CHAPTER 24: HOSPICE SERVICES**

**APPENDIX D: CONTACT/REFERRAL INFORMATION PAGE(S) 4**

<b>Pharmacy Program – Point of Sale</b>	P.O. Box 91019 Baton Rouge, LA 70821 Phone: (800) 648-0790 (Toll Free) Phone: (225) 216-6381 (Local) *After hours, please call REVS
<b>Rate Setting and Audit Hospital Services</b>	P.O. Box 91030 Baton Rouge, LA 70821 Phone: 225-342-0127 225-342-9462
<b>Recipient Assistance for Authorized Services</b>	Phone: (888) 342-6207 (Toll Free)
<b>Recovery and Premium Assistance Third Party Liability Unit TPL Recovery, Trauma</b>	P.O. Box 91030 Baton Rouge, LA 70821-9030 Phone: (225) 342-8662 Fax: (225) 342-1376

**Fraud hotline**

<b>TYPE OF ASSISTANCE</b>	<b>CONTACT INFORMATION</b>
To report fraud	Medicaid Program Integrity P.O. Box 91030 Baton Rouge, LA 70821-9030 Fraud and Abuse Hotline: (800) 488-2917 Fax: (225) 219-4155 <a href="http://dhh.louisiana.gov/index.cfm/page/219">http://dhh.louisiana.gov/index.cfm/page/219</a>

**Appeals**

<b>TYPE OF ASSISTANCE</b>	<b>CONTACT INFORMATION</b>
To file an appeal	Division of Administrative Law - Health and Hospitals Section Post Office Box 4189 Baton Rouge, LA 70821-4189 (225) 342-0443 (225) 219-9823 (Fax) Phone for oral appeals: (225) 342-5800

**CHAPTER 24: HOSPICE SERVICES**

**APPENDIX D: CONTACT/REFERRAL INFORMATION PAGE(S) 4**

**Other Helpful Contact Information:**

TYPE OF ASSISTANCE	CONTACT INFORMATION
<b>Adult/Elderly Protective Services</b>	Phone #: 800-898-4910
<b>Centers for Medicare and Medicaid Services</b> OASIS, CMS-485 Form	<a href="http://www.cms.gov">www.cms.gov</a>
<b>Governor’s Office of Homeland Security and Emergency Preparedness (GOSHEP)</b>	<a href="http://gohsep.la.gov/">http://gohsep.la.gov/</a>
<b>Southeastern Transportation Inc.</b> Transportation Call Center (Non-emergency transportation) <i>(All Medicaid recipients who are covered under a managed care plan should contact their respective plans to schedule a ride).</i>	To schedule transportation (855) 325-7576 NEMT Provider information (225) 342-2126 Medical Provider Line (855) 325-7576
<b>Federal Depository Library Program</b> <b>Superintendent of Documents</b>	<a href="http://www.fdlp.gov/about-the-fdlp/supdocs">http://www.fdlp.gov/about-the-fdlp/supdocs</a>
<b>International Classification of Disease (ICD) Conversion Link</b> Convert ICD-9-CM Codes to ICD-10-CM/PCS, or Convert ICD-10-CM/PCS Codes to ICD-9-CM	<a href="http://www.icd10data.com/Convert">http://www.icd10data.com/Convert</a>

---

**CHAPTER 24: HOSPICE**

---

**APPENDIX E: UB-04 FORM AND INSTRUCTIONS****PAGE(S) 1**

---

**UB-04 FORM AND INSTRUCTIONS**

The UB-04 claim form is required for billing Medicaid and is suitable for billing most third party payers (both government and private). Because it serves the needs of many payers, some data elements may not be needed by a particular payer. Detailed information is given only for items required for Medicaid hospice claims. Items not listed need not be completed, although you may complete them when billing multiple payees.

Claims for hospice services must be filed by electronic claims submission 837I or on the UB-04 claim form.

The most recent instructions for completing the UB-04 form along with samples of UB-04 claim forms for hospice services routine billing are located on the home page of the Louisiana Medicaid website. The billing instructions and examples may also be accessed by using the below hyperlink.

[http://www.lamedicaid.com/provweb1/billing\\_information/UB04\\_Hospice.pdf](http://www.lamedicaid.com/provweb1/billing_information/UB04_Hospice.pdf)