MEDICAID SERVICES MANUAL
TRANSMITTAL LETTER

February 22, 2017

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: LYNNE FOSTER, CHIEF OF DIVISION COMPLIANCE /Lynne Foster/

SUBJECT: MEDICAID SERVICES MANUAL CHANGES,
CHAPTER 3200 – HOSPICE

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 3200 – Hospice are being proposed to better coincide with the Code of Federal Regulation (CFR) Title 42 Part 418, Conditions of Participation (COP) updates and to coincide with the Medicare Guidelines Criteria for Non-Cancer Terminal Illnesses. The chapter was also updated to clarify the criteria for pediatric hospice recipients.

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

Entities Financially Affected: Provider Type (PT) 64 – Hospice and PT 65 – Hospice, Long Term Care.

Financial Impact on Local Government: None.

These changes are effective February 23, 2017.

MATERIAL TRANSMITTED	MATERIAL SUPERSEDED
MTL 05/17 HOSPICE	MTL 02/14, 29/11, 41/10 HOSPICE

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3203.1	**HOSPICE SERVICES**	The second sentence was made in to its own paragraph. New language was added in the first paragraph for clarification.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
		The second paragraph was moved to a new section, Section 3203.1A, “Pediatric Recipients.” The new third and fifth paragraph were moved here from Section 3203.1B, Provider Responsibility. The fourth paragraph is new language. The word "condition" in the sixth paragraph was changed to "illness."
3203.1e	**HOSPICE SERVICES**	This sentence was deleted.
3203.1h	**HOSPICE SERVICES**	The second sentence was deleted due to duplication.
3203.1A	**COVERAGE AND LIMITATIONS**	This section was deleted and renamed “Pediatric Recipients,” with new language.
3203.1B	**PROVIDER RESPONSIBILITY**	This section was deleted. The language from Section 3203.7, “Hospice Coverage and Waiver recipients” was moved here and renamed, “Waiver Recipients.” New language was added related to the pediatric waiver recipient.
3203.1C	**RECIPIENT RESPONSIBILITY**	This section was deleted. The language from Section 3203.8, “Managed Care and Hospice Recipients” was moved here and renamed, “Managed Care Recipients.”
3203.1A.3	**HOSPICE CARE SERVICES**	This was renumbered as Section 3203.2, “Covered Services.” All the language from Section 3203.1A3 was moved to this new section, with the last sentence in item number 3 being deleted for clarification, and item number 4 being deleted for clarification.
3203.1A.4	**LEVEL OF CARE**	This section renumbered as Section 3203.3 and renamed, “Hospice Categories” per CFR language. All language from Section 3203.1A4 was moved and inserted here.
3203.1A.4	**LEVEL OF CARE**	The last paragraph became its own Section 3203.4.
3203.1B	**PROVIDER RESPONSIBILITY**	This section was deleted.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3203.1.C	**RECIPIENT RESPONSIBILITY**	This section was moved to a new Section 3211, "Recipient Responsibility."
3203.2	**NON-HOSPICE SERVICES**	This section was moved and renumbered as Section 3204.
3203.2A	**COVERAGE AND LIMITATIONS**	This section was deleted and the language was moved to Section 3204 for better flow.
3203.2B	**PROVIDER RESPONSIBILITY**	This section was deleted. The language was moved to new Section, 3207, "Election of Hospice Care."
3203.2C	**RECIPIENT RESPONSIBILITY**	This section was deleted and the language was moved to Section 3204 for better flow.
3203.3	**CHANGING THE DESIGNATED HOSPICE**	This section was deleted. The language was moved to new Section 3212, "Changing the Designated Hospice." New language added due to new forms.
3203.4	**REVOKING THE ELECTION OF HOSPICE CARE**	This section was deleted. The language was moved to new Section 3213, "Revoking the Election of Hospice Care." New language added due to new forms.
3203.5	**DISCHARGE OF A RECIPIENT FROM HOSPICE**	The language was moved to new Section 3214, "Discharge of a Recipient from Hospice." New language added due to new forms. This section was renamed, "Hospice Recipients Residing in a Nursing Facility."
3203.6	**HOSPICE RECIPIENTS RESIDING IN A NURSING FACILITY**	This section was deleted. The language was moved to a new Section 3203.5, "Hospice Recipients Residing in a Nursing Facility." The first sentence was removed for redundancy. New language was added for clarification.
3203.6A	**COVERAGE AND LIMITATIONS**	This section deleted and language moved to Section 3203.5, "Hospice Recipients Residing in a Nursing Facility."
3203.6B	**PROVIDER RESPONSIBILITIES**	This section deleted and language moved to Section 3203.5B, "Coordination of Services."
3203.6B.2	**NURSING FACILITY SCREENINGS**	This section deleted except for the first sentence which was moved to Section 3203.5, "Hospice Recipients Residing in a Nursing Facility."

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3203.7-3203.7B	**HOSPICE COVERAGE AND WAIVER RECIPIENTS**	This section moved to new Section 3203.1B, "Waiver Recipients."
3203.8	**MANAGED CARE AND HOSPICE RECIPIENTS**	This section moved to new Section 3203.1C, "Managed Care Recipients."
3203.9	**CLINICAL RECORDS**	This section was deleted.
3203.10	**DHCFP REVIEW**	This section was moved to new Section 3203.6, "DHCFP Review." New language was added for clarification.
3203.10A	**PROVIDER RESPONSIBILITY**	This section was moved to new Section 3203.6, "DHCFP Review" for better flow.
3204	**HEARINGS**	This section was moved to new Section 3215, "Hearings" for better flow.
3203.5A	**HOSPICE PLAN OF CARE**	New section.
3203.5B	**COORDINATION OF SERVICES**	New section with new language and retained language.
3203.6	**DHCFP REVIEW**	New section with new language and retained language .
3204	**NON-HOSPICE SERVICES**	New section with new language and retained language.
3205	**CURATIVE SERVICES**	New section with retained language.
3206	**INITIATION OF SERVICES**	New section.
3206.1	**ELIGIBILITY REQUIREMENTS**	New section with new language and retained language.
3206.1A	**CERTIFICATION OF TERMINAL ILLNESS**	New section with retained language and new language.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3206.1B	**HOSPICE PLAN OF CARE (POC)**	New section with retained language and new language.
3207	**ELECTION OF HOSPICE CARE**	New section with retained language and new language.
3207.1	**DURATION OF HOSPICE CARE PERIODS**	New section with retained language and new language.
3208	**COORDINATION OF SERVICES**	New section with retained language and new language.
3209	**DETERMINING TERMINAL STATUS-LOCAL COVERAGE DETERMINATIONS (LCD) - ADULTS**	New section.
3209.1	**NON-CANCER TERMINAL ILLNESSES**	New section.
3209.2	**HOSPICE CRITERIA FOR ADULT CANCER**	New section.
3210	**REASONS FOR DENIAL OF ANY OF THE ABOVE**	New section.
3211	**RECIPIENT RESPONSIBILITY**	New section with retained language.
3212	**CHANGING THE DESIGNATED HOSPICE**	New section with retained language and new language.
3213	**REVOKING THE ELECTION OF HOSPICE CARE**	New section with retained language and new language.

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
3214	**DISCHARGE OF A RECIPIENT FROM HOSPICE**	New section with retained language and new language.
3215	**HEARINGS**	New section with retained language.

DIVISION OF HEALTH CARE FINANCING AND POLICY

MEDICAID SERVICES MANUAL
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HOSPICE

3200 INTRODUCTION

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

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

3201 AUTHORITY

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

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

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

Health Care and Education Affordability Reconciliation Act of 2010.

3202 RESERVED

3203 POLICY

3203.1 HOSPICE SERVICES

Hospice services must be identified in the established plan of care; maintain a high standard of quality and be reasonable and necessary to palliate or manage the terminal illness and related illnesses. Hospice must include a comprehensive set of services identified and coordinated by an Interdisciplinary Group (IDG) to provide for the physical, psychosocial, spiritual and emotional needs of a terminally ill recipient and/or family members, as delineated in a specific recipient plan of care.

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

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

Nevada Medicaid shall be available to assist hospice providers in coordinating the services and shall require that the other service providers cooperate in these coordination efforts and understand that the hospice provider is the lead case coordinator.

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

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

1. Provided (either directly or under arrangement) by the designated hospice;

2. Provided by the individual’s attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services;

3. Provided as room and board by a Nursing Facility (NF) if the individual is a resident, or

4. Provided by a Home and Community-Based Waiver (HCBW) whose services do not duplicate hospice services.

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

1. Continuity of Care: The hospice program assures the continuity of recipient/family care in home, outpatient, and inpatient settings;

2. Written Agreement: The hospice has a legally binding written agreement for the provision of arranged services. The agreement includes at least the following:

   a. Identification of the services to be provided;

   b. A stipulation that services may be provided only with the express authorization of the hospice;

   c. The manner in which the contracted services are coordinated, supervised, and evaluated by the hospice;

   d. The delineation of the role(s) of the hospice and the contractor in the admission process, recipient/family assessment, and the interdisciplinary group care conferences;

   e. Requirements for documenting services are furnished in accordance with the agreement; and

   f. The qualification of the personnel providing the services.

Professional Management Responsibility:

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

3203.1A PEDIATRIC RECIPIENTS

Recipients under the age of 21 are entitled to concurrent care under the Affordable Care Act (ACA); that is curative care and palliative care at the same time while an eligible recipient of the Medicaid Hospice Program, and shall not constitute a waiver of any rights of the child to be provided with, or to have payment made for services that are related to the treatment of the child's terminal illness. Upon turning 21 years of age, the recipient will no longer have concurrent care benefits and will be

subject to the rules governing adults who have elected Medicaid hospice care. Upon turning 21 years of age, the recipient must sign a Nevada Medicaid Hospice Program Election Notice-Adult (FA-93), continuing in the certification period currently in place.

Pediatric hospice care is both a philosophy and an organized method for delivering competent, compassionate and consistent care to children with terminal illnesses and their families. This care focuses on enhancing quality of life, minimizing suffering, optimizing function and providing opportunities for personal and spiritual growth, planned and delivered through the collaborative efforts of an interdisciplinary team with the child, family and caregivers as its center.

3203.1B WAIVER RECIPIENTS

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

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

Pediatric waiver recipients are entitled to continue to receive Waiver services that are related to their terminal illness, but are not covered by the hospice benefit because they are curative not palliative in nature. Close coordination between the hospice agency and the waiver case manager is required to avoid any unnecessary duplication of services.

This also includes all HCBW recipients who have Medicare as their primary insurance and Medicare is paying for the hospice services. The hospice agency must immediately notify the QIO-like vendor of any new hospice admissions who are receiving services through a Medicaid HCBW.

3203.1C MANAGED CARE RECIPIENTS

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

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

2. The recipient electing the hospice benefit will then return to Fee-for-Service (FFS) Medicaid.

3. There should be no delay in enrolling managed care recipients in hospice services.

3203.2 COVERED SERVICES

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

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

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

1. Nursing Services: Nursing services must comply with the following: The hospice must provide nursing care and services by or under the supervision of a qualified RN; a qualified RN is one who is authorized to practice as an RN by the Nevada State Board of Nursing or the licensing board in the state in which the RN is employed. Recipient care responsibilities of nursing personnel must be specified.

2. Medical Social Services: Medical Social Services (MSS) must be provided by a qualified social worker, under the direction of a physician. A qualified social worker is a person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education and is licensed to practice social work in the State of Nevada or the state in which the social worker is employed.

3. Physician Services: In addition to palliative care and management of the terminal illness and related conditions, physician employees of the hospice, including the physician member(s) of the interdisciplinary group, must also meet the general medical needs of the recipients to the extent these needs are not met by the attending physician.

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

    b. Costs for administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care. These activities include participation in the establishment of POCs and services, periodic review and updating of POCs, and contribute to establishment of governing policies.

c. Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians, and are not considered hospice services, therefore are not included in the amount subject to the hospice payment limit.

4. Counseling Services: Counseling services are available to both the individual and the family. Counseling includes bereavement counseling, dietary, spiritual and any other counseling services for the individual and family provided while the individual is enrolled in the hospice. Bereavement counseling for the client's family and significant others, as identified in the POC, must be provided for up to one year after the recipient's death and is not reimbursable per 42 CFR 418.204.(c).

5. Medical Appliances, Supplies and Pharmaceuticals:

a. Medical supplies include those that are part of the written POC. Only drugs which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the client's terminal illness. Equipment is provided by the hospice for use in the recipient's home while he or she is under hospice care and the reimbursement for this is included in the rates calculated for all levels of hospice care.

b. Drugs, supplies and durable medical equipment prescribed for conditions other than for the palliative care and management of the terminal illness are not covered benefits under the Nevada Medicaid hospice program and are to be billed in accordance with the appropriate Medicaid Services Manual (MSM) chapter for those services.

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

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

3203.3 HOSPICE CATEGORIES

1. Routine Home Care: The reimbursement rate for routine home care is made without regard

to the intensity or volume of routine home care services on any specific day.

2. Continuous Home Care:

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

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

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

3. Inpatient Care (Respite or General):

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

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

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

   d. Time limited for reimbursement: In a 12-month period the inpatient reimbursement is subject to the following limitation. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20% of the aggregate total number of days of hospice care provided to all Medicaid

recipients during that same period. Refer to the 42 CFR 418.302 for further information on the calculation of the inpatient limitation.

3203.4 OPTIONAL CAP ON OVERALL HOSPICE REIMBURSEMENT

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

3203.5 HOSPICE RECIPIENTS RESIDING IN A NURSING FACILITY

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

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

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

A hospice that provides hospice care to residents of a SNF/NF or ICF/IID must abide by the following additional standards:

1. Resident eligibility, election and duration of benefits. Recipients receiving hospice services and residing in a SNF, NF or ICF/IID are subject to the Medicaid/Medicare hospice eligibility criteria set out at Title 42 CFR 418.20 through CFR 418.30.

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

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

    b. A provision that the SNF/NF or ICF/IID immediately notifies the hospice when:

        (1) A significant change in a recipient's physical, mental, social or emotional status occurs;

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

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

(4) A recipient dies.

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

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

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

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

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

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

i. A delineation of the responsibilities of the hospice and the SNF/NF or ICF/IID to

provide bereavement services to SNF/NF or ICF/IID staff.

3203.5A HOSPICE PLAN OF CARE

In accordance with Title 42 CFR 418.56, a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/IID representatives. All hospice care provided must be in accordance with this hospice plan of care.

3203.5B COORDINATION OF SERVICES

The hospice must:

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

   a. Providing overall coordination of the hospice care of the SNF/NF or ICF/IID resident with SNF/NF or ICF/IID representatives; and

   b. Communicating with SNF/NF or ICF/IID representatives and other health care providers participating in the provision of care for the terminal illness and related illnesses and other illnesses to ensure quality of care for the recipient and family.

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

3. Provide the SNF/NF or ICF/IID with the following information:

   a. The most recent hospice plan of care specific to each recipient;

   b. Hospice election form and any advance directives specific to each recipient;

   c. Physician certification and recertification of the terminal illness specific to each recipient;

   d. Names and contact information for hospice personnel involved in hospice care of each recipient

   e. Instructions on how to access the hospice's 24-hour on-call system;

   f. Hospice medication information specific to each recipient; and

g. Hospice physician and attending physician (if any) orders specific to each recipient.

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

a. Room and board includes:

(1) Performance of personal care services;

(2) Assistance in the ADLs;

(3) Socializing activities;

(4) Administration of medication;

(5) Maintaining the cleanliness of a resident's room; and

(6) Supervising and assisting in the use of Durable Medical Equipment (DME) and prescribed therapies.

3203.6 DHCFP REVIEW

The DHCFP may conduct a review of a hospice provider to ensure appropriateness of care and accuracy of claims. The hospice provider being reviewed must comply with the DHCFP staff on providing all information requested in a timely manner.

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

1. On-site visits with recipients and family at their residence;

2. Chart reviews at the hospice agency;

3. Post-payment review of claims data;

4. The DHCFP desk review;

5. On-site review in facilities; and

6. Independent Physician Review for Extended Care.

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

When an adult recipient (21 years of age or older) reaches 12 months in hospice care, an independent face-to-face physician review is required. Independent reviews are subsequently required every 12 months thereafter if the recipient continues to receive extended hospice care. Hospice agencies should advise recipients of this requirement and provide The Nevada Medicaid Independent Physician Review for Extended Care form (FA-96) to take with them to each independent review.

Prior authorization requests for extended hospice care will be denied if this form is not submitted along with the PA request or if this form indicates the recipient does not continue to meet program eligibility requirements.

The following medical professionals may conduct the Independent Physician Review:

1. Physician (MD)

2. Doctor of Osteopathic Medicine (D.O.)

3. Physician's Assistant (PA)

4. Advanced Practice Registered Nurse (APRN)

The Independent Physician Review can occur at a physician's office or at the recipient’s place of residence, whether it be a private home or a nursing facility. The review must be completed no sooner than 30 days before the end of the recipient's 12-month certification period. In cases when the independent physician reviewer claims the recipient should no longer be appropriate for hospice services, the hospice provider will be notified. The hospice physician has seven days to submit a narrative update on the recipient to staff at LTSS for further review. The Independent Physician review is not required for dual-eligible recipients. Due to concurrent care allowed for the pediatric recipient of hospice services, the Independent Physician Review is required for the pediatric hospice recipient who has elected not to pursue curative treatment.

3204 NON-HOSPICE SERVICES

1. Nevada Medicaid recipients continue to be eligible for applicable state benefits for services unrelated to the terminal illness and related conditions for which hospice was elected. Pediatric recipients continue to be eligible for the applicable State benefits for services that are curative in nature and related to the terminal illness for which hospice was elected. The hospice provider is expected to be the lead case coordinator and maintain communication with other services including those listed below:

   a. Personal Care Services (PCS) for Recipients Enrolled in Hospice:

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

   b. Home Health Agency (HHA) Services for Recipients Enrolled in Hospice:

      HHA Services may be provided for recipients enrolled in hospice when the need for HHA Services is unrelated to the terminal illness and related conditions. The HHA Services provided to a recipient for needs unrelated to the terminal illness may not exceed State Plan program limitations. Refer to MSM Chapter 1400 for HHA Services policy.

   c. Private Duty Nursing (PDN) for Recipients Enrolled in Hospice:

      PDN may be provided for recipients enrolled in hospice when the need for PDN is unrelated to the terminal illness and related conditions. PDN provided to a recipient for needs unrelated to the terminal illness may not exceed State Plan program limitations. Refer to MSM Chapter 900 for PDN policy.

2. Typical services available that are not covered by the hospice benefit but payable by the DHCFP may include, but are not limited to:

   a. Attending physician care (e.g., office visits, hospital visits, etc.);

b. Optometric services;

c. Any services, drugs, equipment or supplies for an illness other than the recipient's terminal illness.

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

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3205 CURATIVE SERVICES

Neither the hospice nor Nevada Medicaid is responsible for payment for curative services related to an adult's terminal illness.

3206 INITIATION OF SERVICES

3206.1 ELIGIBILITY REQUIREMENTS

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

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

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

1. Nevada Medicaid Hospice Program Election Notice for Adults or a Nevada Medicaid Hospice Program Election Notice for Pediatrics.

2. Nevada Medicaid Hospice Program Physician Certification of Terminal Illness.

3. A face-to-face visit with the recipient within 15 days of admission to Hospice.

4. The hospice Plan of Care.

3206.1A CERTIFICATION OF TERMINAL ILLNESS:

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

The certification of terminal illness must meet the following requirements:

1. The recipient must have a face-to-face encounter with any of the following within 15 business days from date of planned admission to Hospice Services. This face-to-face is not for certification of hospice services, but to ensure that recipient has been seen, examined and deemed appropriate for admission to Hospice. This encounter can occur in any setting

prior to Hospice admission:

a. Acute Care hospital

b. Nursing Facility

c. Private residence

d. Medical professional's office

e. Long Term Acute Care (LTACH)

The medical professional will make a note in their progress notes or discharge summaries when in the acute care setting:

The face-to-face may be performed by the following:

a. Physician

b. Doctor of Osteopathic Medicine (DO)

c. Physician Assistant

d. Advanced Practice Registered Nurse (APRN)

2. The Certification of Terminal Illness (CTI) must specify that the recipient's prognosis is terminal and life expectancy is six months or less if the illness runs its normal course.

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

4. The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of six months or less as part of the certification and re-certification. The content of the narrative must support the terminal illness diagnosis by adhering to the Local Coverage Determination for Hospice (LCD) Guidelines and the Medicare Non-Cancer and Cancer Diagnosis Determination Guidelines for Hospice (see Section 3209, Determining Terminal Status).

5. Pediatric patients may not meet LCD criteria given that the criteria is largely geared toward adult prognosis and diseases. Hospices providing services to pediatric recipients must

submit clinical narratives describing the signs and symptoms that support the terminal illness and life expectancy prediction of six month or less without taking into account whether the patient is receiving concurrent care services.

3206.1B HOSPICE PLAN OF CARE (POC)

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

3207 ELECTION OF HOSPICE CARE

An individual who is a designated Nevada Medicaid recipient, and has been certified as terminally ill, may file a Nevada Medicaid Hospice Election form (FA-92 for adults and FA-93 for pediatrics) with a licensed hospice provider who is contracted with the DHCFP. If the recipient is physically or mentally incapacitated, his or her representative may file a signed hospice election statement which must include the following:

1. Identification of the particular hospice and of the attending physician that will provide care to the individual. The individual or representative must acknowledge that the identified attending physician was his or her choice;

2. The recipient's or representative's acknowledgment he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as related to the individual's terminal illness;

3. Acknowledgment that certain otherwise covered Medicaid services are waived by the election, except for children under the age of 21;

4. The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date the election statement was executed and the date certification was made; and

5. The signature of the recipient or representative. In cases where a recipient signs the Hospice Election Statement 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 daytime phone numbers. Hospice provider representatives, employees or subcontractors cannot sign as witnesses. Verbal elections are prohibited.

The hospice agency will not be reimbursed for hospice services unless all signed paperwork has been submitted to the QIO-like vendor and prior authorization has been obtained. It is the responsibility of the hospice provider to ensure that prior authorization is obtained for services unrelated to the hospice benefit. Authorization requests for admission to Hospice Services must be submitted as soon as possible, but not more than eight business days following admission. Please note: if the authorization request is submitted after admission, the Hospice Provider is assuming responsibility for program costs if the authorization request is denied. Prior Authorization only approves the existence of medical necessity, not recipient eligibility.

3207.1 DURATION OF HOSPICE CARE PERIODS

1. An eligible recipient may elect to receive hospice care during one or more of the following election periods:

a. An initial 90-day period;

b. A subsequent 90-day period;

c. An unlimited number of subsequent 60-day periods.

2. An eligible recipient may receive an unlimited number of subsequent 60 day periods without a break in care as long as:

a. The recipient is re-certified by the hospice physician;

b. A hospice physician or Nurse Practitioner (NP) has a face-to-face encounter with the recipient to determine continued eligibility prior to the 180th day recertification, and prior to each subsequent recertification. The face-to-face encounter must occur no more than 30 calendar days prior to the 180th day benefit period recertification and no more than 30 calendar days prior to every subsequent recertification thereafter. These face-to-face encounters are used to gather clinical findings to determine continued eligibility for hospice services.

c. The practitioner certifies that the recipient has a life expectancy of six months or less if the illness runs its normal course;

d. The recipient does not revoke the election of hospice; and

e. The recipient in the care of a hospice remains appropriate for hospice care.

3208 COORDINATION OF SERVICES

The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to:

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

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

3. Ensure that the care and services provided are based on all assessments of the recipient and family needs.

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

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

3209 DETERMINING TERMINAL STATUS – Local Coverage Determinations (LCD) - Adults

Pediatric recipients may not meet LCD criteria given that the criteria is geared toward adult prognosis and diseases. Hospices providing services to pediatric recipients need to ensure all narratives and clinical documentation address all body systems, showing clinical data supporting the recipient's terminally ill status and decline in condition if curative care were no longer being pursued.

3209.1 NON-CANCER TERMINAL ILLNESSES:

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

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

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

4. All recipients must have a terminal illness with a life expectancy of six months or less if the illness runs its normal course.

    a. Hospice Criteria for Adult Failure to Thrive Syndrome:

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

        (2) Criteria for initial certification or recertification: Criteria below must be present at the time of initial certification or re-certification for hospice. An individual is considered to be terminally ill if the individual has a medical

prognosis that his or her life expectancy is six months or less if the terminal illness runs its normal course. Recipients must meet a) and b) below:

a) The nutritional impairment associated with the adult failure to thrive syndrome must be severe enough to impact a beneficiary's weight. The Body Mass Index (BMI) of beneficiaries electing the Medicaid Hospice Benefit for the adult failure to thrive syndrome must be below 22 kg/m^2 and the recipient must be either declining enteral/parenteral nutritional support or has not responded to such nutritional support.

b) The disability associated with the adult failure to thrive syndrome should be such that the individual is significantly disabled. Significant disability must be demonstrated by a Karnofsky or Palliative Performance Scale value less than or equal to 40%. Both the recipient's BMI and level of disability should be determined using measurements/observations made within six months (180 days) of the most recent certification/recertification date. If enteral nutritional support has been instituted prior to the hospice election and will be continued, the BMI and level of disability should be determined using measurements/observations made at the time of the initial certification and at each subsequent recertification. At the time of recertification recumbent measurement(s) - (anthropometry) such as mid-arm circumference in cm may be substituted for BMI with documentation as to why a BMI could not be measured. This information will be subject to review on a case by case basis.

b. Hospice Criteria for Adult HIV Disease:

(1) Criteria for initial certification: Criteria below must be present at the time of initial certification for hospice. Recipients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet the following criteria: HIV Disease a) and b) must be present; factors from (3) will add supporting documentation.

a) CD4+ Count less than 25 cells/mcL or persistent viral load greater than 100,000 copies/ml, plus one of the following:

1) CNS lymphoma.

2) Untreated, or not responsive to treatment, wasting (loss of 33% lean body mass).

3) Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment or treatment refused.

4) Progressive multifocal leukoencephalopathy.

5) Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy.

6) Visceral Kaposi's sarcoma unresponsive to therapy.

7) Renal failure in the absence of dialysis.

8) Cryptosporidium infection.

9) Toxoplasmosis, unresponsive to therapy.

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

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

1) Chronic persistent diarrhea for one year

2) Persistent serum albumin less than 2.5 gm/dl

3) Age greater than 50 years

4) Absence of antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease

5) Advanced AIDS dementia complex

6) Toxoplasmosis

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

c. Hospice Criteria for Adult Pulmonary Disease

(1) Criteria for initial certification: Criteria below must be present at the time of initial certification for hospice. Recipients will be considered to be in the terminal stage of pulmonary disease (life expectancy of six months or less)

if they meet the following criteria. The criteria refer to recipients with various forms of advanced pulmonary disease who eventually follow a final common pathway for end stage pulmonary disease: a) and b) must be present; documentation of c), d) and/or e) will lend supporting documentation:

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

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

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

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

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

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

e) Resting tachycardia greater than 100/min.

d. Hospice Criteria for Adult Alzheimer's Disease, Dementia & Related Disorders:

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

Criteria below must be present at the time of initial certification and recertification for hospice. Alzheimer's disease and related disorders may support a prognosis of six months or less under many clinical scenarios. The structural and functional impairments associated with a primary diagnosis of Alzheimer's disease are often complicated by co-morbid and/or secondary illnesses. Co-morbid illnesses affecting recipients with Alzheimer's disease are by definition distinct from the Alzheimer's disease itself - examples include coronary heart disease (CHD) and chronic obstructive pulmonary disease (COPD). Secondary illnesses on the other hand are directly related to a primary illness - in the case of Alzheimer's disease examples include delirium and pressure ulcers.

(2) The presence of secondary illnesses is thus considered separately by this policy. Recipients must meet a) and b) below:

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

FAST Scale Items:

Stage #1: No difficulty, either subjectively or objectively.

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

Stage #3: Decreased job functioning evident to coworkers; difficulty in traveling to new locations.

Stage #4: Decreased ability to perform complex tasks (e.g., planning dinner for guests; handling finances).

Stage #5: Requires assistance in choosing proper clothing.

Stage #6: Decreased ability to dress, bathe, and toilet independently:

Sub-stage 6a: Difficulty putting clothing on properly.

Sub-stage 6b: Unable to bathe properly; may develop fear of bathing.

Sub-stage 6c: Inability to handle mechanics of toileting (e.g., forgets to flush the toilet, does not wipe properly).

Sub-stage 6d: Urinary incontinence.

Sub-stage 6e: Fecal incontinence.

Stage #7: Loss of speech, locomotion and consciousness:

Sub-stage 7a: Ability to speak limited to approximately a half dozen intelligible different words or fewer, in the course of an average day or in the course of an intensive interview.

Sub-stage 7b: All intelligible vocabulary lost (Speech ability limited to the use of a single intelligible word in an average day or in the course of an intensive interview – the person may repeat the word over and over).

Sub-stage 7c: Non-ambulatory (Ambulatory ability lost – cannot walk without personal assistance).

Sub-stage 7d: Unable to sit up independently (Cannot sit up without assistance - e.g., the individual will fall over if there are not lateral rests [arms] on the chair).

Sub-stage 7e: Loss of ability to smile.

Sub-stage 7f: Loss of ability to hold head up independently.

b) Documentation of specific secondary illness(es) related to Alzheimer's Disease must be present, including but not limited to, Contractures, Pressure Ulcers, recurrent UTI, Dysphagia, Aspiration Pneumonia.

e. Hospice Criteria for Adult Stroke and/or Coma

(1) Criteria below must be present at the time of initial certification and recertification for hospice. The medical criteria listed below would support

a terminal prognosis for individuals with a diagnosis of stroke. Recipients must meet a) and b) below:

a) A Palliative Performance Scale (PPS) of less than or equal to 40:

1) Degree of ambulation - Mainly in bed.

2) Activity/extent of disease - not able to do work; extensive disease.

3) Ability to do self-care - Mainly Assistance.

4) Food/fluid intake - Normal to reduced.

5) State of consciousness - Either fully conscious or drowsy/confused.

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

1) Weight loss greater than 10% during previous three months.

2) Weight loss greater than 7.5% in previous six weeks.

3) Serum albumin less than 2.5 gm/dl.

4) Current history of pulmonary aspiration without effective response to speech language pathology interventions to improve dysphagia and decrease aspiration events.

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

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

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

Comatose recipients with any three of the following on day three or after of coma:

1) Abnormal brain stem response.

2) Absent verbal response.

3) Absent withdrawal response to pain.

4) Increase in serum creatinine greater than 1.5 mg/dl.

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

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

a) The recipient must demonstrate critically impaired breathing capacity.

Critically impaired breathing capacity as demonstrated by all the following characteristics occurring within the 12 months preceding initial hospice certification:

1) Vital capacity (VC) less than 30% of normal.

2) Continuous dyspnea at rest.

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

4) Recipient declines artificial ventilation.

b) Recipient must demonstrate both rapid progression of ALS and critical nutritional impairment.

1) Rapid progression of ALS as demonstrated by all the following characteristics occurring within the 12 months preceding initial hospice certification:

(a) Progression from independent ambulation to wheelchair or bed bound status.

(b) Progression from normal to barely intelligible or unintelligible speech.

(c) Progression from normal to pureed diet.

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

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

(a) Oral intake of nutrients and fluids insufficient to sustain life.

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

c) Recipient must demonstrate both rapid progression of ALS and life-threatening complications.

1) Rapid progression of ALS, see b) 1) above.

2) Life-threatening complications as demonstrated by one of the following characteristics occurring within the 12 months

preceding initial hospice certification: Upper urinary tract infection (pyelonephritis) and Sepsis.

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

g. Hospice Criteria for Adult Heart Disease

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

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

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

1) Unable to carry on any physical activity without symptoms.

2) Symptoms are present even at rest.

3) If any physical activity is undertaken, symptoms are increased.

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

1) Treatment resistant symptomatic supraventricular or ventricular arrhythmias.

2) History of cardiac arrest or resuscitation.

3) History of unexplained syncope.

4) Brain embolism of cardiac origin.

5) Concomitant HIV disease.

6) Documentation of ejection fraction of 20% or less.

7) Angina pectoris, at rest.

h. Hospice Criteria for Adult Liver Disease

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(1) Criteria for initial certification and recertification: Criteria below must be present at the time of initial certification/recertification for hospice. Recipients will be considered to be in the terminal stage of liver disease (life expectancy of six months or less) if they meet the following criteria:

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

1) Clinical Status

(a) Recurrent or intractable infections such as pneumonia, sepsis or upper urinary tract.

2) Documented progressive inanition (II) Symptoms

(a) Dyspnea with increasing respiratory rate.

(b) Nausea/vomiting poorly responsive to treatment.

(c) Diarrhea, intractable.

(d) Pain requiring increasing doses of major analgesics more than briefly.

3) Signs

(a) Ascites.

(b) Edema.

(c) Weakness.

(d) Increasing pCO2 or decreasing pO2 or decreasing SaO2.

(e) Increasing liver function studies.

(f) Progressively decreasing or increasing serum sodium.

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

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

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

b) End stage liver disease is present and the recipient shows at least one of the following:

1) Change in level of consciousness.

2) Ascites, refractory to treatment or recipient non-complaint.

3) Spontaneous bacterial peritonitis.

4) Hepatorenal syndrome (elevated serum creatinine and BUN with oliguria (<400 ml/day) and urine sodium concentration less than 10 mEq/l.

5) Hepatic encephalopathy, refractory to treatment or recipient non-compliant.

6) Recurrent variceal bleeding, despite intensive therapy.

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

1) Progressive malnutrition.

2) Muscle wasting with reduced strength and endurance.

3) Continued active alcoholism (>80 gm ethanol/day).

4) Hepatocellular carcinoma.

5) HBsAg (Hepatitis B) positivity.

6) Hepatitis C refractory to interferon treatment.

i. Hospice Criteria for Adult Renal Disease

When an individual elects Hospice care for end stage renal disease or for a condition to which the need for dialysis is related, the Hospice agency is financially responsible for the dialysis. In such cases, there is no additional reimbursement beyond the per diem rate. The only situation in which a recipient may access both the hospice benefit and ESRD benefit is when the need for dialysis is not related to the patient's terminal illness, or if the pediatric recipient is pursuing concurrent care.

(1) Criteria for initial certification: Criteria below must be present at the time of initial certification for hospice. Recipients will be considered to be in the terminal stage of renal disease (life expectancy of six months or less) if they meet the following criteria:

a) Acute renal failure 1) and 2) must be present:

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

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

b) Chronic renal failure 1), 2) and 3) must be present:

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

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

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

3209.2 HOSPICE CRITERIA FOR ADULT CANCER

1. Criteria for initial certification or recertification: Criteria below must be present at the time of initial certification or re-certification for hospice. Recipients will be considered to be in the terminal stage of cancer (life expectancy of six months or less) if (a) or (b) below are present:

   a. Documentation of metastasis or final disease stage is required with evidence of progression as documented by worsening clinical status, symptoms, signs and/or laboratory results.

   b. Progression from an earlier stage of disease to metastatic disease with either:

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

      (2) Recipient declines further disease directed therapy.

3210 REASONS FOR DENIAL OF ANY OF THE ABOVE

1. Recipients not meeting the specific medical criteria in this policy.

2. Absence of supporting documentation of progression or rapid decline.

3. Failure to document terminal status of six months or less if the illness runs its normal course.

4. Recipient is not eligible for full Medicaid benefits.

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

3211 RECIPIENT RESPONSIBILITY

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

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

3212 CHANGING THE DESIGNATED HOSPICE

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

1. The change of the designated hospice is not a revocation of the hospice election for the period in which it was made.

2. To change the designation of hospice agencies, the individual or representative must file, with the hospice agency from which care has been received and with the newly designated hospice, a Nevada Medicaid Hospice Action Form that includes the following:

   a. The name of the hospice from which the individual has received care;

   b. The name of the hospice from which he or she plans to receive care;

   c. The effective date of the transfer of hospice care.

3. The transferring hospice agency files the notice in the medical record and faxes one copy to the receiving hospice and faxes one copy to the QIO-like vendor along with a Hospice Medicaid Information form.

4. The receiving hospice agency must fax an updated Hospice Medicaid Information form, Hospice Ancillary Information form, a signed election statement and a signed copy of the physician's certification of terminal illness to the QIO-like vendor.

5. If a hospice recipient is residing in an NF, the transferring hospice agency is required to submit a copy of the transfer statement to the NF for their records.

3213 REVOKING THE ELECTION OF HOSPICE CARE

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

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

   a. Signed statement that the recipient or representative revokes the recipient's election for coverage of hospice care for the remainder of that election period with the date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made);

   b. The hospice agency is required to fax the QIO-like vendor the signed copy of the revocation notice and a Medicaid Hospice Information form/Notice of Revocation within 72 hours, once the revocation notice has been signed.

2. If the hospice recipient is residing in an NF, the hospice agency is required to immediately submit to the NF a signed copy of the notice of revocation for their medical records.

3. An individual, upon revocation of the benefit election of hospice care for a particular election period:

   a. Is no longer covered for hospice care for that election period;

   b. Resumes eligibility for all Medicaid covered services as before the election to hospice; and

   c. May at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible to receive.

3214 DISCHARGE OF A RECIPIENT FROM HOSPICE

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

1. Reasons for discharge may include:

   a. Noncompliance with hospice POC;

   b. Moves out of the hospice's service area or transfers to another hospice;

   c. No longer meets the criteria for hospice;

   d. No longer eligible for Medicaid; or

   e. Request of recipient, or representative.

2. The hospice must have policies in place to address disruptive, abusive or uncooperative behavior, on the part of the recipient or other individuals in the home, to the extent that delivery to the recipient or the ability of the hospice to operate is seriously impaired. The hospice must do the following prior to discharge for cause:

   Advise the recipient that a discharge for cause is being considered.

   a. Make a serious effort to resolve the problem(s) presented by the recipient's behavior or situation;

   b. Ascertain that the recipient's proposed discharge is not due to the recipient's use of necessary services; and

   c. Document the problem(s) and efforts made to resolve the problems(s) and enter this documentation into its medical records.

3. Prior to discharge, the hospice must obtain a written discharge order from the hospice medical director. If a recipient has an attending physician, the physician must be consulted and his/her recommendation or decision must be included in the discharge note.

4. A copy of the signed discharge notice, physician's discharge order and the Nevada Medicaid Hospice Action Form are required to be faxed to the QIO-like vendor within 72 hours of the discharge. A copy is retained in the client's record at the hospice.

5. If the hospice recipient is residing in an NF, the hospice is required to immediately submit a copy of the signed discharge notice to the facility for their records the day the discharge notice has been signed. The hospice agency is required to also verbally inform the NF staff

of the discharge.

3215 HEARINGS

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