

**RHODE ISLAND EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
MEDICAL ASSISTANCE PROGRAM
HOSPICE SERVICES**

HOSPICE SERVICES COVERAGE POLICY

300-20

General Terms and Conditions

Provider Participation

Hospice providers must be a Medicare Certified Hospice Agency licensed by the Rhode Island Department of Health, located and performing services in the state of Rhode Island, and enrolled and approved for participation in the Medical Assistance Program by the Executive Office of Health and Human Services (EOHHS)

Provider Recertification

Hospice providers are annually recertified by the Department of Health (DOH). The license expiration date for Hospice providers is December 31. Providers obtain license renewal through DOH and then forward a copy of the renewal documentation to HP. HP must receive this information at least five business days prior to the expiration date of the license. Failure to do so will result in suspension from the program.

A provider may appeal to the DOH if they do not meet the recertification criteria. If the appeal to DOH is not successful, the provider may then appeal to the Centers for Medicare and Medicaid Services (CMS) formerly known as Health Care Financing Administration (HCFA).

Patient Certification

Documentation of all patient election and physician certification must be kept in the patient's medical record and signed copies sent to HP (the fiscal agent) for audit purposes by the EOHHS within 30 business days of election / certification. A beneficiary's terminal illness (life expectancy less than six months) must be certified by the beneficiary's attending physician **and** the medical director (or staff physician) of the hospice program providing the care.

This initial 90-day certification period must be made not later than two days after hospice care is initiated. If subsequent periods of hospice care are elected, the medical director (or staff physician) must recertify at the beginning of each of those periods that the individual is terminally ill. The Medicaid Hospice Benefit has a two 90-day periods and an unlimited number of 60 day periods.

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Written Care Plan

In addition to the physician certification and recertification requirements, a written plan for providing hospice care must be established before such care may be provided by, or under arrangements made by, a hospice program. The written plan of care must be established by the attending physician, medical director, or physician designee and interdisciplinary group. The written plan of care must be periodically reviewed by the beneficiary's attending physician (as well as by the medical director and the staff).

A copy of this care plan, and subsequent care plans at each new period of Hospice Care, along with the signed physician certification form, must be sent to HP, (the fiscal agent) for audit purposes by EOHHS within 30 business days after initiated. This care plan must include medical appliances and supplies, including drugs and biologicals, for pain and symptom control related to the individual's terminal illness. The care provided by the hospice provider must be provided pursuant to this established plan of care.

Certifying Physician

A physician is an attending physician for certification purposes if he/she is the physician (who may be employed by a hospice program) who the patient identifies as having the most significant role in the determination and delivery of medical care to the patient at the time the patient makes an election to receive hospice care. For a patient who does not have an attending physician, the medical director of the hospice program or a staff physician can perform an attending physician's certification functions.

**Medical Conditions
For Coverage**

Hospice care is covered by the Medical Assistance Program for beneficiaries who are terminally ill. A beneficiary will be considered to be terminally ill if there is a medical prognosis that life expectancy is six months or less. There must be a certification by the beneficiary's attending physician and the medical director (or staff physician) of the hospice program providing the care, that the beneficiary is terminally ill.

The beneficiary must elect to receive hospice care from a Medicare Certified hospice program. A spouse or legal

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Guardian may sign the election form, however, the relationship to the beneficiary must be documented on the Hospice Election form next to the signature. The beneficiary must also elect to give up their right to have the Medical Assistance Program pay for:

1. Hospice care provided by hospice programs other than the one the beneficiary has chosen (unless the chosen hospice program arranges for services to be provided by another program), and;
2. Any other Medical Assistance Program services furnished during the elected period that are determined to be related to the treatment of the beneficiary's condition for which diagnosis of terminal illness has been made or which are equivalent to or duplicative of hospice care.

However, item 2 above does not apply to physicians' services furnished by the patient's attending physician if the physician is not an employee of the hospice program or if the services provided by or under arrangements are made by the chosen hospice program.

A beneficiary may revoke hospice care election before the period has expired, thereby reinstating eligibility for other Medical Assistance Program benefits. A copy of this revocation form must be sent to EOHHS, Medicaid Program, Office of Long Term Services and Supports within 10 business days of revoking Hospice Care. A beneficiary may, at any time after such a revocation, make a new hospice care election.

If a beneficiary elects to receive hospice care, he/she must choose to receive his/her care from a hospice program and give up his/her right to receive curative treatment for the specified terminal illness. However, this election is revocable.

**Hospice Care Services
In Nursing Facilities**

The Provision of Hospice Care services is an enhancement of the existing scope of services already provided to nursing facility patients under the Medical Assistance Program.

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Hospice Care is available to patients already in residence or entering a nursing facility that has executed a written contract with a Hospice Care Provider.

Notification to EOHHS

For Medical Assistance Program beneficiaries residing in nursing facilities who elect Hospice Care, the Hospice Provider must notify the appropriate Long Term Care Regional Office that the patient was admitted to Hospice Care service as of a specified date. The Hospice Care Provider should use the Hospice election form for their notification and it must include the name and address of the Nursing Facility in which the beneficiary is residing.

Nursing Facility Providers also must notify the appropriate Long Term Care Regional Office that the patient was admitted to Hospice Care service as of a specified date.

**Billing Procedures for
Hospice Patients in Nursing Facilities**

The NF cannot bill RI Medical Assistance while the beneficiary is under the care of a Hospice agency. The DHS / LTC office will determine the amount of beneficiary income to be applied towards the cost of the institutional routine room and board and notify the appropriate Hospice provider of this amount.

The following procedures should be followed:

- The Nursing Facility (NF) will bill the Hospice Care provider for the patient's room and board by calculating the number of days covered times the NF current Medical Assistance Program per diem rate, times 95%, less applied income.
- The Hospice Care Provider will bill the RI Medical Assistance Program for the Hospice professional care services and for 95% of the current per diem rate for the patient's room and board while in the nursing facility.

DHS Responsibility

The Long Term Care Regional Offices are responsible for determinations and redeterminations of eligibility for Medical Assistance. The LTC offices are responsible for

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determining the patient's contribution towards the cost of their care in a nursing facility. The LTC offices are also responsible to notify the patient of the contribution due from the patient towards the cost of their care in a nursing facility. The Office of Medical Review (OMR) of EOHHS is responsible for a level of care and disability determinations, if required, for any Long Term Care service and for the oversight and monitoring of said services.

For cases already active with LTC in a Nursing Facility, a Discharge and Admission Notice must be received by the LTC office, from both the Hospice Provider and the Nursing Facility. When an individual is admitted to Hospice Care, the nursing home provider payment is ended.

Upon receipt of notification from the Nursing Facility that the individual is no longer receiving Hospice Care but is still in residence at the facility, the provider payment will be reinstated.

Basic Hospice Services Provided, Included and Covered within the Per Diem Rate

Medical Assistance Program beneficiaries who are terminally ill are eligible to receive hospice benefits in lieu of most other Medical Assistance Program benefits. Hospice care benefits, provided in the home or institutional settings include the following services and supplies.

Nursing Care

Nursing care provided by or under the supervision of a registered professional nurse.

Social Services

Medical social services provided by a social worker who has at least a bachelor's degree from an accredited school of social work, and who is working under the direction of a physician.

Physician Services

Physicians' services performed by a physician. The services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy.

Counseling Services

Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the

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individual's family or other care giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. Bereavement counseling, which consists of counseling services provided to the individual's family after the individual's death, is a required hospice service but it is not reimbursable.

Inpatient Care

In addition to basic Hospice Services, short-term inpatient care may be provided in a hospice inpatient unit, general inpatient hospital, or a nursing facility.

Two levels of inpatient care are covered and must conform to the written plan of care:

General Inpatient Care:

Medicaid Hospice General Inpatient care must meet Federal and State requirements for appropriate care level and document that the beneficiaries' need for pain and symptom management is beyond the routine care level. Beneficiaries should be evaluated on a case-by-case basis- but in general may be admitted for short-term General Inpatient Care when the physician and Hospice Interdisciplinary Team believes the beneficiary needs pain control or symptom management that cannot feasible be provided in other settings. Also the beneficiary must require an intensity of skilled nursing care by a Registered Nurse and frequent skilled nursing intervention on all three shifts directed toward pain control and symptom management.

All General Inpatient admissions and continued stays will require a prior authorization. All Fee-for-Service Medicaid inpatient Hospital stays will be authorized by Qualidigm. All others will require the current Prior Authorization process in place through HP, our fiscal agent.

Respite care may also be furnished to provide respite for the individual's family or other persons caring for the individual in their home.

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A hospice provider **may not** arrange to provide inpatient services to Medical Assistance Program recipients in a VA or military hospital because the Medical Assistance Program cannot pay for services that another government agency has paid or is obligated to pay.

DME, Supplies, Drugs

Medical appliances and supplies, including drugs and biologicals, are covered when included as part of the written plan of care or for symptom control related to the individual's terminal illness. 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 patient's terminal illness. Equipment is provided by the hospice provider for use in the patient's home or nursing facility while he or she is under hospice care.

Certified Nursing Assistants / Homemaker Services

Certified nursing assistants may provide personal care services. **CNAs** may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed, light cleaning and laundering essential to the comfort and cleanliness of the patient. **CNA** services must be provided under the general supervision of a registered nurse. **CNA** services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

Therapy Services

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

Continuous Care

Care and services to hospice patients may be provided on a 24-hour, continuous basis only during periods of crisis and only as necessary to maintain the terminally ill individual at home.

Reimbursement

All services under Medicaid Hospice are paid at the established Medicare / Medicaid All Inclusive Per Diem rates.

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**Physician
Reimbursement**

Physician's services furnished to hospice patients are reimbursed as "physician's services" under the FFS Medical Assistance Program if the physician is the patient's attending physician and he/she is not employed by the hospice provider.

**Four Levels Of Care
Reimbursed**

Each day of care is classified under four levels of care: **routine home care, continuous home care, inpatient respite care, and general inpatient care.**

For each day that a Medical Assistance beneficiary is under the care of a hospice, the hospice will be reimbursed an amount applicable to the type and intensity of the services furnished to the beneficiary for that day.

For all the levels, except continuous home care, only one rate is applicable for each day. For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the beneficiary on that day.

**Routine Home
Care**

The hospice provider will be paid the all-inclusive routine home care per diem rate for each day the patient is at home, under the care of the hospice, and receiving less than 8 hours of care per day. This is considered payment for the entire day and is paid without regard to the volume or intensity of routine home care services provided on any given day.

**Continuous Home
Care**

The hospice provider will be paid the continuous home care rate when they render a minimum of 8 hours of care during a 24-hour period that begins and ends at midnight. The hourly reimbursement rate will be paid for between 8 hours and 24 hours of care. The hourly rate will be reimbursed to the hospice up to 24 hours a day. Continuous home care is generally provided only during a period of crisis to achieve palliation or management of acute medical symptoms.

**Inpatient Respite
Care**

The hospice provider will be paid at the inpatient respite care rate for each day on which the recipient is in an approved inpatient facility and is receiving respite care. Respite care is short-term inpatient care provided to the patient only when necessary to relieve family members or primary care givers. Payment for respite care may be made for a maximum of 5 days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and

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any subsequent days is to be made at the routine home care rate.

General Inpatient Care

Payment at the inpatient rate will be made when general inpatient care is provided and meets the Federal and State requirements for appropriate care level and document that the beneficiaries' need for pain and symptom management is beyond the routine care level.

None of the other fixed payment rates (e.g., routine home care) will be applicable for a day on which the patient receives hospice inpatient care, except on the date of discharge. General inpatient care can be rendered in a hospice inpatient unit or participating SNF. This level of care is often needed for procedures required for pain control or acute symptom management, which is not feasible in other settings.

Claims Billing Guidelines Hospice services are billed on the UB-92 claim form. Instructions for completing the UB-92 claim form are located in Section 400 of the Provider Reference Manual.

Hospice Services Revenue Codes	
Rev. Code	Description
0650	Hospice
0651	Routine home care
0652	Continuous home care
0659	Other hospice