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POLICIES AND PROCEDURES

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MEDICAID HOSPICE BENEFICIARY ENROLLMENT FLOW CHART 29

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PROGRAM DESCRIPTION

HOSPICE OVERVIEW

A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals, meets the Medicare conditions of participation for hospices, and has a valid provider contract. Hospice coverage for South Carolina Medicaid beneficiaries is available for an unspecified number of days, subdivided into election periods as follows: two periods of 90 days each, and an unlimited number of subsequent periods of 60 days each. Benefit periods can be used consecutively or at different times during the beneficiary's life span. At the beginning of each period, the beneficiary must be certified by a physician as terminally ill with a life expectancy of six months or less.

PROCEDURES

Election Procedures

In order for a Medicaid beneficiary to be eligible to elect hospice care under Medicaid, that beneficiary must be certified as being terminally ill. An individual is considered terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less if the disease runs its normal course.

Individuals who elect to receive hospice care must file a Medicaid Hospice Election Statement (DHHS Form 149) (See the Forms section) with a particular hospice. This required form includes the hospice provider identifying information. An election may also be filed by a family member or a patient representative. With respect to an individual granted the power of attorney for the patient, or acting as an agent of the patient under a Durable Power of Attorney for Health Care, state law determines the extent to which the individual may act on the patient's behalf.

An election to receive hospice care will be considered to continue through the initial election period and through any subsequent election periods without a break in care as long as the individual remains in the care of the hospice and does not revoke the election. An individual may designate an effective date for the election period that begins with the first day of the hospice care or any subsequent day of

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PROGRAM DESCRIPTION

Election Procedures (Cont'd.)

hospice care, but an individual may not designate an effective date that is earlier than the date the election is made.

For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. A beneficiary residing in such a setting may elect the hospice benefit.

When a beneficiary residing in a nursing facility begins to receive hospice services, the hospice agency that is providing services must notify the hospice program manager of the arrangement of services. If the hospice is placing a patient in a nursing facility utilizing a Medicaid-certified bed, the procedures for pre-admission screening by Community Long Term Care must be followed.

Revoking Hospice Election

An individual or legal representative may revoke the election of hospice care at any time. To do so, the individual must file a Medicaid Hospice Revocation Form (DHHS Form 153) (See the Forms section) with the hospice, along with a signed statement indicating all of the following:

1. That the individual revokes the election for Medicaid coverage for any remaining days in the election period
2. That the beneficiary is aware of the revocation
3. Why the beneficiary has chosen to revoke hospice services

An individual may not designate an effective date earlier than the date the revocation is made.

Upon revoking the election of Medicaid coverage of hospice care for a particular election period, an individual resumes Medicaid coverage of the benefits waived when hospice care was elected, effective on the date of revocation. An individual may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

When a beneficiary is noncompliant, the hospice may advise the beneficiary of the option to revoke the benefit and any advantages and disadvantages related to the decision. A beneficiary is considered to be noncompliant if any of the following occur:

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PROGRAM DESCRIPTION

Revoking Hospice Election (Cont'd.)

- The beneficiary seeks aggressive treatment for the terminal illness.
- The beneficiary receives treatment in a facility that does not have a contract with the hospice.
- The beneficiary receives treatments that are not in the hospice plan of care or are not pre-authorized by the hospice.

Discharge

A hospice can discharge (not revoke) a beneficiary for the following reasons:

- The beneficiary dies.
- The beneficiary is noncompliant.
- The beneficiary is determined to have a prognosis greater than six months.
- The beneficiary moves out of the hospice's geographically defined service area.
- The safety of the patient or of the hospice staff is compromised.

The hospice must make every effort to resolve these problems satisfactorily before it considers discharge an option. All efforts by the hospice to resolve the problem must be documented in detail in the beneficiary's clinical record. The hospice must notify the DHHS hospice program manager and the state survey agency of the circumstances surrounding controversial impending discharges where noncompliance or safety issues are the cause or the causes for discharge. Whatever the reason for discharge, the hospice must clearly document why the patient was discharged from the hospice benefit.

When discharging a beneficiary, the Medicaid provider must submit a Medicaid Hospice Discharge Statement (DHHS Form 154) (See the Forms section) to the DHHS program manager within five working days of the discharge. When discharging for reasons other than death, the hospice must send a copy of the Medicaid Hospice Discharge Statement to the beneficiary or responsible party upon discharge. The reverse side of the Medicaid Hospice Discharge Statement contains the appeals procedures provided for each Medicaid beneficiary when adverse action is taken against that beneficiary. When forwarding a

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PROGRAM DESCRIPTION

Discharge (Cont'd.)

copy of this completed form, the provider must ensure that the reverse side of the form is included.

A hospice provider may not discharge a beneficiary who has revoked the Medicaid hospice benefit. Therefore, a Medicaid Hospice Discharge Statement should not be completed when a revocation is made.

Appeals

When a Medicaid beneficiary is discharged from a hospice program for one of the reasons listed under “Discharge,” the beneficiary has the right to a fair hearing regarding the decision. Beneficiaries and their legal representatives have the right to appeal the hospice discharge within 30 days of the receipt of the Medicaid Hospice Discharge Statement by submitting a written request to the following address:

Department of Health and Human Services
Director, Division of Appeals and Fair Hearings
Post Office Box 8206
Columbia, SC 29202-8206

The request must state specifically which issues are being appealed and must be accompanied by a copy of the Medicaid Hospice Discharge Statement.

A request for a fair hearing is considered filed if postmarked by the 30th calendar day following receipt of the Medicaid Hospice Discharge Statement. Both the Medicaid beneficiary and the provider will be notified of the date, time, and place the fair hearing will take place.

Changing Hospice Providers

An individual may change the designation of the particular hospice from which he or she elects to receive hospice care **once** in each election period. The change of the designated hospice is not considered a revocation of election.

To change the designation of hospice providers, individuals must notify their current hospice provider that they wish to change hospices. The sending hospice provider must file a signed Medicaid Hospice Provider Change Request (DHHS Form 152) (See the Forms section) that includes all of the following information:

1. Appropriate beneficiary identification information
2. Name of the hospice from which the beneficiary plans to receive care

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PROGRAM DESCRIPTION

Changing Hospice Providers (Cont'd.)

3. Date the change is to be effective as indicated in the top section of the change request form

A change of ownership of a hospice is not considered a change in the patient's designation of hospice and requires no action on the patient's part.

The hospice provider that is releasing the beneficiary must complete the appropriate portions of the Medicaid Hospice Provider Change Request, including the last day of service to be included for billing. The provider must then forward a copy to the DHHS hospice program manager within five working days. The receiving hospice provider must receive a copy of the Medicaid Hospice Provider Change Request within two working days of the effective date of the change.

The receiving hospice provider must complete the Medicaid Hospice Provider Change Request and forward a completed copy to the DHHS hospice program manager within five working days of the effective date of the receiving hospice's first day of service to be included for billing.

All elections, provider changes, revocation statements, and discharge summaries must be submitted to the DHHS hospice program manager within the designated amount of time from the effective date. Forms received outside the time frames specified will result in a change in the effective date of the action and may therefore result in additional liabilities on the part of the hospice or claims that cannot be reimbursed to the hospice.

Dually Eligible Beneficiaries

If an individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected and revoked simultaneously under both programs. In other words, if a Medicaid beneficiary elects the hospice Medicaid benefit and is also eligible for Medicare, then the beneficiary must also elect the Medicare hospice benefit. If a Medicare beneficiary elects the hospice Medicare benefit and is also eligible for Medicaid, then the beneficiary must also elect the Medicaid hospice benefit.

For dually eligible beneficiaries, Medicare is the primary payer for the hospice benefit, though the Medicaid hospice election process must also be completed. Revocation, discharge, and change of provider procedures must be

SECTION 2 POLICIES AND PROCEDURES

PROGRAM DESCRIPTION

Dually Eligible Beneficiaries (Cont'd.)

followed and designated forms completed as specified in this section. A flowchart of the documentation submission process can be found at the end of this section.

Retroactive Eligibility

Effective July 1, 2005, individuals who have applied for Medicaid eligibility can elect the hospice benefit while their applications are pending approval. If an individual is determined eligible, DHHS may pay the hospice for services delivered while the eligibility determination was pending. Eligibility can be retroactive for a maximum of three months.

If an individual has not been determined Medicaid eligible but meets all other criteria to elect the Medicaid hospice benefit, he or she may elect the hospice benefit by completing the DHHS Form 149, the Medicaid Hospice Election Statement, including the effective date (date of election).

A Physician Certification/Recertification, DHHS Form 151, must be completed within 10 days of the date of election.

Once the individual is notified of his or her Medicaid eligibility, the beneficiary identification number must be entered on the signed and dated election form and physician certification form (DHHS 149 and 151). At this time, both forms must be submitted to the DHHS Hospice Program Manager for entry into the Recipient Special Program (RSP).

The hospice agency may continue to verify the beneficiary's eligibility status by using the Web Tool. See Sections 1 and 3 for more information.

A hospice agency cannot submit a claim form for payment until after the beneficiary has been determined Medicaid eligible, and at no time can reimbursement be requested for dates of service prior to the actual date of election or prior to July 1, 2005.

A hospice agency that elects an individual whose Medicaid eligibility has not been determined assumes all liability for services the individual may receive, whether or not that individual is determined to be eligible. All liability rules are effective as though the individual has already been determined to be eligible (*e.g.*, hospitalizations related to

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PROGRAM DESCRIPTION

Retroactive Eligibility (Cont'd.)

the terminal illness). A hospice agency cannot solicit payment from the individual for services that may be provided after the Medicaid hospice benefit has been elected.

General information regarding retroactive eligibility claim submission can be found in Sections 1 and 3 of this manual.

Waiver of Medicaid Services

An individual must waive all rights to other Medicaid benefits for the duration of the election of hospice care for the services below:

1. Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice)
2. Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected or a related condition, or services that are equivalent to hospice care, except for the following types of services:
 - a) Services provided (either directly or under arrangement) by the designated hospice
 - b) Services provided by another hospice under arrangements made by the designated hospice
 - c) Services 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 the services

After the hospice benefit expires, the patient's waiver of these other Medicaid benefits expires and coverage of certain services provided through the hospice may be possible. For example, if the patient requires a covered Medicaid service such as acute inpatient care, home health, durable medical equipment, or pharmaceutical services, and the hospice benefit expires and has not been renewed, the providers of those services may bill S.C. Medicaid directly if they are authorized Medicaid providers.

The hospice must determine whether the beneficiary is receiving other Medicaid waiver services, such as Community Long Term Care (CLTC). If other services are being provided, the hospice and CLTC need to work

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PROGRAM DESCRIPTION

Waiver of Medicaid Services (Cont'd.)

together to ensure that the beneficiary is getting the best care possible.

For eligible individuals who are enrolled in the Elderly/Disabled waiver, services that may be routinely authorized by Community Long Term Care (CLTC), if appropriate, include Case Management, Companion, PERS, Personal Care I (HM), and Home Delivered Meals.

If the eligible beneficiary is enrolled in the HIV or Vent waivers, he or she may be authorized to have up to two additional prescriptions, but not authorized to have Companion services.

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PROGRAM REQUIREMENTS

PROVIDER QUALIFICATIONS

In addition to conditions of participation in the Medicaid program outlined in Section 1 of this manual, the following also apply to hospices in order to participate in the Medicaid program:

1. The hospice must be currently licensed under the provisions of South Carolina state law.
2. The hospice must meet Title XVIII standards for Medicare participation and be certified as eligible for participation in the Medicare program.
3. The hospice must develop written policies and procedures on advance directives in compliance with Section 1902(a)(57) of the Social Security Act.
4. The hospice must attend provider orientation conducted by the South Carolina Department of Health and Human Services. Provider orientation will be held at a minimum one time a year. To attend a session, a written request to become a Medicaid hospice provider must be mailed to:

Department of Health and Human Services
Hospice Program Area
Post Office Box 8206
Columbia South Carolina 29202-8206.

The Provider Enrollment Form and SCDHHS Provider Contract will be supplied upon completion of the session.

In addition to completing a Provider Enrollment Form and a SCDHHS Provider Contract, a hospice must also submit all of the following information to the hospice program manager:

1. A copy of the letter from the South Carolina Department of Health and Environmental Control, Division of Health Licensing, showing the license number and the effective date of the license or a copy of the current license
2. A copy of the letter from the South Carolina

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PROGRAM REQUIREMENTS

PROVIDER QUALIFICATIONS (CONT'D.)

Department of Health and Environmental Control, Division of Survey and Certification, showing that the hospice has been recommended for certification or meets the requirements for the Medicare program

3. A copy of the written notification to the hospice from the Medicare fiscal intermediary showing the approved reimbursement rate, the fiscal year end, and Medicare Provider ID number

In compliance with Section 1902(a)(57) of the Social Security Act, a hospice must do all of the following:

- Provide written information to patients regarding their rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives
- Provide written information to individuals regarding the institution's or program's written policies respecting the implementation of the right to formulate advance directives
- Document in the patient's medical record whether or not an advance directive has been executed
- Comply with all requirements of state law respecting advance directives
- Provide (individually or with others) education for staff and the community on issues concerning advance directives
- Not condition the provision of care or otherwise discriminate against an individual who has executed an advance directive

DOCUMENTATION REQUIREMENTS

Prior Approval of Services

Services provided by certain Medicaid providers for care not related to the terminal illness must be pre-approved by the hospice provider. The Medicaid provider will contact the hospice provider indicated by the South Carolina Medicaid Web-based Claims Submission Tool (Web Tool) to obtain confirmation that the service does not relate to the terminal illness, as well as a prior authorization number to

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PROGRAM REQUIREMENTS

Prior Approval of Services (Cont'd.)

be included on that provider's claim form. The hospice prior authorization number on the claim certifies that the services provided are not related to the terminal illness or are not included in the hospice plan of care. If the prior authorization number is not included on the claim form, the form will be rejected and returned to the provider. Services that require prior authorization are:

- Hospital
- Emergency Room
- Pharmacy
- Mental Health
- Drug, Alcohol, and Substance Abuse Services
- Audiology
- Psychologist Services
- Speech Therapy
- Occupational Therapy
- Ambulatory Surgery Clinics
- Medical Rehabilitation Services
- School-Based Services
- Physical Therapy
- Private Duty Nursing
- Podiatry
- Health Clinics
- County Health Departments
- Home Health
- Home- and Community-Based Services
- Durable Medical Equipment

Non-hospice-related claims for these services will not be reimbursed without the prior authorization number. For example, if a hospice patient is admitted to the hospital for treatment not related to terminal illness, DHHS will reimburse the hospital for services directly only if the prior authorization number appears on the claim. The hospice will continue receiving reimbursement from DHHS and will be responsible for all other care and services required

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Prior Approval of Services (Cont'd.)

by the patient during the hospitalization.

All services delivered to hospice patients, regardless of provider, will be subject to post-payment review. A hospice that authorizes Medicaid payment for a service that is related to the terminal illness and that should thus be provided by the hospice is subject to recoupment of the Medicaid funds expended for the service.

A hospice provider must pre-approve all services that are not related to the terminal illness by reviewing a request from other Medicaid providers. In each situation where the hospice provider is authorizing that the service to be performed is not related to the terminal illness, the prior authorization number will be the same number as the hospice provider number issued upon contracting with the DHHS. It is necessary for each hospice to maintain a documentation log of each pre-authorization action and to make this documentation available to the staff of DHHS upon request. Documentation must include the service that is pre-approved, the service provision date, the Medicaid provider, the approving hospice authority, and the date approval was issued. If a dispute arises regarding whether a prior authorization was obtained, the documentation log will serve as the primary basis in resolving the disagreement.

When a patient leaves a hospital and enrolls in hospice on the same day, the hospice provider must give a prior authorization to the hospital so that the claim for the last day of hospital services can be paid. Conversely, when a patient is discharged or revoked by a hospice program and is admitted to the hospital on the same day, the hospice provider must give a prior authorization to the hospital so that the claim for that day of hospital services can be paid.

The hospice provider must determine which, if any, of the prescription drugs taken by a hospice patient are not related to the terminal illness. The hospice patient's pharmacy must be given a prior authorization number each time the drugs that are not related to the terminal illness are dispensed.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Physician Certification

The hospice must obtain certification that an individual is terminally ill in accordance with the procedures below, using the Medicaid Hospice Physician Certification/Recertification (DHHS Form 151) (See the Forms section).

No certification or recertification forms are required if the beneficiary has also elected the Medicare hospice benefit. In other words, the certification or recertification notification for dual eligibility, when Medicare is primary, is not required.

The hospice must ensure that all of the following conditions are met:

1. The attending physician must be a doctor of medicine or osteopathy and be identified by the individual at the time of hospice election as having the most significant role in the determination and delivery of the individual's medical care. A nurse practitioner's signature may be substituted for the physician's.
2. For the first election of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification statements 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 individual has an attending physician).
3. If the hospice does not obtain a written certification within two days after the initiation of hospice care, a verbal certification may be obtained within these two days, and a written certification must be obtained no later than eight days after care is initiated. If these requirements are not met, no payment can be made for days prior to the certification.
4. For any subsequent period, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement using DHHS Form 151, prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the physician's signature

SECTION 2 POLICIES AND PROCEDURES

PROGRAM REQUIREMENTS

Physician Certification (Cont'd.)

and a statement that the individual's medical prognosis is of a life expectancy of six months or less if the terminal illness runs its normal course.

The hospice must retain the certification statements in accordance with South Carolina statute of limitations requirements. For beneficiaries that are eligible for Medicaid only, a copy of the initial physician certification statement must be submitted to the hospice program manager with the election form within 10 days after the effective date of certification. Recertification statements must be submitted to the hospice program manager within 10 days after the effective date of recertification.

Direct all program-related forms to the following address:

Department of Health and Human Services
Hospice Program Manager
Division of Community Services
Post Office Box 8206
Columbia, SC 29202-8206

Plan of Care (POC)

Providers must design a plan of care (POC) for each beneficiary before rendering hospice services. This plan must be established on the same day as the assessment if the day of assessment is to be a covered day of hospice care.

In establishing the initial POC, the member of the basic interdisciplinary group who assesses the patient's needs must meet with or call at least one other group member (nurse, physician, medical social worker, or counselor) before writing the initial POC. At least one of the persons involved in developing the initial plan must be a nurse or physician. The other two members of the basic interdisciplinary group must review the initial POC and provide their input to the process of establishing the POC within two calendar days following the day of assessment. A physician must sign the established plan of care.

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PROGRAM SERVICES

In order for hospice services to be covered, they must be deemed reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care in accordance with the provisions described under “Election Procedures.” A certification that the individual is terminally ill must be completed as set forth under “Physician Certification.” A plan of care (POC) must be established before services are provided; services rendered must be consistent with the POC.

COVERED SERVICES

All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The services below are covered hospice services:

1. Nursing care provided by or under the supervision of a registered nurse
2. Medical social services provided by a social worker who has at least a bachelor’s degree and is working under the direction of a physician
3. Physicians’ services provided by the hospice medical director or physician member of the interdisciplinary group. Such services must be performed by a doctor of medicine or osteopathy. The following services performed by hospice physicians are included in the hospice rates and may not be billed as a physician’s service:
 - a) General supervisory services performed by the medical director
 - b) Participation in the establishment of plans of care, supervision of care and services, periodic review and updating of care plans, and establishment of governing policies by the physician member of the interdisciplinary group

See “Payment for Physician Services” for additional information regarding the payment of physician services not related to the above.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

COVERED SERVICES (CONT'D.)

4. 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 individual's family or other caregiver 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.
5. Short-term inpatient care provided in either a participating hospice inpatient unit or a participating hospital or nursing home that additionally meets the special hospice standards regarding staffing and patient areas. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home. Respite care is the only type of inpatient care that may be provided in a nursing home.
6. Medical appliances and supplies, including drugs and biologicals. Only drugs 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 patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written POC.
7. Home health aide services furnished by qualified aides. Home health aides may provide personal care services. Aides also may perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse.

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PROGRAM SERVICES

COVERED SERVICES (CONT'D.)

8. Homemaker services, including assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care
9. Physical therapy, occupational therapy, and speech-language pathology services provided for purpose of symptom control or to enable the individual to maintain activities of daily living and basic functional skills

NON-COVERED SERVICES

Respite care and continuous care are only reimbursed within certain limits. These are discussed in detail under Levels of Care.

Bereavement counseling consists of counseling services provided to the individual's family after the individual's death. Bereavement counseling is a required hospice service but is not reimbursable.

SPECIAL COVERAGE ISSUES

With the exception of payment for physician services, Medicaid reimbursement for hospice care will be made at one of four predetermined rates for each day on which an individual is under the care of the hospice. The four rates are prospective rates established by the Centers for Medicare and Medicaid Services (CMS) for the Medicare hospice program. There will be no retroactive adjustments other than the limitation on payments for inpatient care. The rate paid for any particular day will vary depending on the level of care furnished to the individual. The limitations on payment for inpatient care are described below.

DHHS will not provide payment for Medicaid hospice services where retroactive eligibility has been determined. Please refer to Section 1 for information on Medicaid eligibility.

Levels of Care

There are four levels of care into which each day of care is classified:

- Routine Home Care
- Continuous Home Care
- Inpatient Respite Care
- General Inpatient Care

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PROGRAM SERVICES

Levels of Care (Cont'd.)

For each day that an individual 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 individual for that 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. A description of each level of care follows:

Routine Home Care — The hospice will be paid the routine home care rate for each day the patient is at home under the care of the hospice. This includes patients residing in a nursing home. This rate is paid without regard to the volume or intensity of routine home care services on any given day; however, the frequency and intensity of services delivered must be consistent with the patient's Plan of Care (POC). The patient's record should include any updates to the POC and changes in the patient's condition between the updates. Also, the patient's record should include all disciplines' daily/weekly/monthly progress notes that record the types and frequencies of the services being provided to the patient.

Continuous Home Care — The hospice will be paid the continuous home care rate when continuous home care is provided.

Continuous home care is to be provided only during a period of crisis. This is defined as a period during which a patient requires continuous care to achieve palliation or management of acute medical symptoms. Continuous home care is primarily nursing care — a nurse must provide the care for more than half of the period of crisis. Nursing care must be provided by either a registered nurse or a licensed practical nurse. A minimum of eight hours of care must be provided during a 24-hour day that begins and ends at midnight. This care need not be continuous; *i.e.*, four hours could be provided in the morning and another four hours in the evening of the same day. Homemaker and aide services may also be provided to supplement the nursing care.

Continuous home care is covered when it is provided to maintain an individual at home during a medical crisis. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

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PROGRAM SERVICES

Levels of Care (Cont'd.)

Documentation should clearly report the reason for continuous home care, list the dates of service, and illustrate hour by hour and day by day what services were provided, the patient's condition, and the type of personnel providing the continuous home care.

Inpatient Respite Care — The hospice will be paid at the inpatient respite care rate for each day that the beneficiary is in an approved inpatient facility and is receiving respite care.

Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the hospice patient is residing in a nursing home on a permanent basis.

Services provided in the facility must conform to the hospice's POC. Payment for respite care may be made for a maximum of five consecutive days at a time including the date of admission, but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. Documentation in the beneficiary's record should reflect why the respite care was necessary. If there is more than one respite care admission in a short amount of time, documentation should indicate why multiple admissions were necessary.

General Inpatient Care — Payment at the inpatient rate will be made when general inpatient care is provided for services related to the terminal illness. No other fixed payment rate (*i.e.*, routine home care) will be applicable for a day that the patient receives hospice inpatient care. Services provided in the inpatient setting must conform to the hospice's POC. The hospice must have a contract with the inpatient facility delineating the roles of each provider in the hospice's POC; however, the hospice is the professional manager of the patient's care, despite the physical setting of that care or the level of care. General inpatient care is a short-term level of care and is not intended to be a permanent solution to a negligent or absent caregiver. Documentation in the beneficiary's record should clearly explain the reason for the admission and the

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Levels of Care (Cont'd.)	beneficiary's condition during the stay in the facility at this level of care. The key to general inpatient level of care is the patient's medical condition.
Date of Discharge	The appropriate routine home care rate is to be paid for the day of discharge from an inpatient unit. If the patient dies in the inpatient unit, the appropriate rate (general or respite) is to be paid for the discharge date.
Hospice Payment Rates	The federal hospice rates are issued each year, effective October 1, by CMS and adjusted for local wage indices. The DHHS Division of Ancillary Reimbursement, in conjunction with the hospice program manager, will notify each hospice of the approved Medicaid hospice reimbursement rates.
Limitation of Payments for Inpatient Care	<p>Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. 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 beneficiaries during that same period. Effective for services on and after July 1, 1988, this calculation will exclude days for beneficiaries afflicted with Acquired Immune Deficiency Syndrome (AIDS).</p> <p>This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 – October 31). For purposes of this computation, if it is determined that the inpatient rate should not be paid, any days for which the hospice receives payment at a routine home care rate will not be counted as inpatient days. The limitation is calculated as follows:</p> <ol style="list-style-type: none">1. The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.2. If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

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Limitation of Payments for Inpatient Care (Cont'd.)

3. If the total number of days of inpatient care exceeds the maximum allowable number, the limitation will be determined by calculating the ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement that was made for inpatient care (general inpatient and inpatient respite reimbursement).
 - a) Multiply excess inpatient care days by the routine home care rate.
 - b) Add together the amounts calculated in 1 and 2 above.
 - c) Compare the amount in 3 above with interim payments made to the hospice for inpatient care during the “cap period”.

Any excess reimbursement will be recouped from the hospice by DHHS.

Payment for Physician Services

DHHS will pay the physician in accordance with the usual S.C. Medicaid reimbursement methodology for physician services regardless of whether services are provided by a hospice employee, a physician under agreement with the hospice, or the patient’s attending physician for related or non-related services. Services furnished voluntarily by physicians are not reimbursable.

Physicians’ administrative services provided by the hospice medical director or physician member of the interdisciplinary group, such as general supervisory services or participation in the establishment of plans of care, supervision of care and services, periodic review and updating of care plans, and establishment of governing policies, are included in the daily hospice reimbursement rate and not eligible for the physician’s fee-for-service reimbursement.

The hospice must notify the Medicaid hospice program manager of the name of the physician who has been designated as the attending physician by the beneficiary. This information is included on the Medicaid Hospice Election Statement.

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Payment for Physician Services (Cont'd.)

A physician who wishes to enroll as a S.C. Medicaid provider of services may obtain information and enrollment forms by contacting:

Department of Health and Human Services
 Department of Physician Services
 Post Office Box 8206
 Columbia, SC 29202-8206

HOSPICE SERVICES FOR RESIDENTS OF NURSING FACILITIES OR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

Participation with Skilled Nursing Facility, Nursing Facility, Intermediate Care Facility for the Mentally Retarded, or Non-Certified Facility

The term “home” is not to be limited for hospice beneficiaries. A beneficiary’s home is where he or she resides. A hospice may furnish routine or continuous home care to a beneficiary who resides in a Skilled Nursing Facility (SNF), Nursing Facility (NF) or Intermediate Care Facility for the Mentally Retarded (ICF/MR), or a facility not eligible for Medicare or Medicaid such as a Community Residential Care Facility (CRCF). The facility is considered to be the beneficiary’s place of residence (the same as a house or apartment), and the Medicaid facility resident may elect the hospice benefit if he or she also meets the hospice eligibility criteria.

The hospice then assumes full responsibility for professional management of the individual’s hospice care in accordance with the Hospice Conditions of Participation (42 CFR 418) and makes any arrangements necessary for inpatient care in a participating Medicare or Medicaid facility.

Notification of Nursing Facility Utilization

The Medicaid hospice program manager must be notified in writing by the hospice when either of the following occurs:

- A Medicaid beneficiary who is a nursing facility resident and is also Medicare eligible (referred to as dually eligible) chooses to elect the hospice benefit.

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Notification of Nursing Facility Utilization (Cont'd.)

- A Medicaid-sponsored nursing facility resident elects the hospice benefit under the Medicaid hospice program.

A Medicaid Hospice Election Form must be completed and forwarded to the hospice program manager as described under “Election Procedures” with the facility address in the appropriate section for the beneficiary’s address.

Compliance with SNF/NF and Intermediate Care Facilities for the Mentally Retarded: Conditions of Participation

A Medicaid hospice provider must have a written agreement with a facility specifying that the Skilled Nursing Facility/Nursing Facility (SNF/NF) Conditions of Participation (42 CFR 483) or the Conditions of Participation for an Intermediate Care Facility for the Mentally Retarded (ICF/MR) (42 CFR 483.400 Subpart I) are applicable to all residents in the facility. Hospice beneficiaries are no exception. This means that the resident must be assessed using the information contained in the appropriate assessment instrument; have a plan of care (POC) which, in this case, will be jointly developed and agreed upon by the hospice and facility; and be provided with all services contained in the POC.

When a resident of a facility elects the Medicaid hospice benefit, the hospice and the facility must communicate, establish, and agree upon one coordinated plan of care for both providers. The POC must also reflect the hospice philosophy and be based on an assessment of the individual’s needs and unique living situation in the nursing facility. The POC must include the individual’s current medical, physical, psychosocial, and spiritual needs. The hospice must designate a registered nurse from the hospice to coordinate the implementation of the POC.

An emergency plan, including telephone numbers that may be used in cases of beneficiary emergency, must also be left with the facility.

Professional Responsibility Coordination

The facility and the hospice are responsible for performing their respective functions agreed upon and included in the POC. The POC should reflect the participation of the hospice, facility, and the resident to the greatest extent possible. The hospice and facility must communicate with each other when any changes are indicated to the POC.

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PROGRAM SERVICES

Professional Responsibility Coordination (Cont'd.)

The hospice retains overall professional management responsibility for directing the implementation of the POC.

All covered hospice services must be available as necessary to meet the needs of the patient. All core services must be routinely provided directly by hospice employees and cannot be delegated to the facility. Nursing care, physicians' services, medical social services, and counseling are considered to be core hospice services.

The facility nursing personnel may assist with the administration of prescribed therapies included in the POC only to the extent that the hospice would routinely rely on the services of a hospice patient's family or caregiver in implementing the POC.

Drugs and medical supplies must be routinely provided as needed for the palliation and management of the terminal illness and related conditions. Drugs must be furnished in accordance with accepted professional standards of practice.

Evidence of this coordinated POC must be present in the clinical records of both providers. All aspects of the POC should reflect the hospice philosophy.

The hospice beneficiary residing in a facility should not experience any lack of facility services or personal care because of his or her status as a hospice beneficiary. The facility 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 hospice beneficiary has the right to refuse any services.

Non-Core Services

The hospice may arrange to have non-core hospice services provided by the facility if the hospice assumes professional management responsibility for these services and ensures that these services are performed in accordance with the policies of the hospice and the patient's POC. Non-core services are considered to be the provision of medical appliances and supplies, including drugs and biologicals, home health aide services, physical therapy, occupational therapy, and speech language pathology services.

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Payment For Facility Residents

When a Medicaid beneficiary who is a nursing facility or ICF/MR resident and is also Medicare eligible (referred to as dually eligible) chooses to elect the hospice benefit, Medicare becomes the primary payer for the hospice benefit. For either a Medicaid only or a dually eligible resident, the state Medicaid agency must pay the hospice agency for the facility room and board payment.

For dates of service July 11, 2011 and forward, when presented with a reimbursement claim, DHHS will directly reimburse the hospice agency an amount no less than 95% of the daily Medicaid rate of reimbursement for the room and board of the patient receiving hospice. The hospice must reimburse the facility according to the terms specified in their contract arrangements.

This rate is designed to cover room and board, which includes the following:

- Performance of personal care services
- Assistance in the activities of daily living
- Administration of medication
- Maintaining the cleanliness of the patient's environment
- Supervision and assistance in the use of durable medical equipment and prescribed therapies

Along with this reimbursement, DHHS will reimburse the hospice provider the daily rate for hospice care provided and billed on the CMS-1500.

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

Payment/Sponsorship Guidelines for Hospice in a Nursing Facility or Intermediate Care Facility for the Mentally Retarded

Eligibility Status	Nursing Facility Sponsorship	Hospice Sponsorship	Comments
Dual	Medicare	Medicare	Rare — In NF for a diagnosis code related to the terminal illness. NF can bill Medicare for room and board using modifier 07.
Dual	Medicare	Private	No Medicaid Payment for Hospice
Dual	Medicaid	Medicare	Medicare becomes the primary hospice payer.
Medicaid Only	Medicaid	Medicaid	DHHS reimburses the hospice agency for the Medicaid room and board rate.

Note: Medicaid is always the payer of last resort.

Hospice Beneficiaries Entering a Nursing Facility from the Community or a Hospital

When a Medicaid beneficiary who has elected the hospice benefit in the community subsequently requires placement in a nursing facility for long-term care, additional eligibility determinations must be completed before the beneficiary can receive Medicaid CLTC sponsorship. The authorization of medical necessity, or pre-admission review, is a function of Community Long-Term Care (CLTC). A PASARR determination is also completed by CLTC or a nursing facility or a hospital by a signed memorandum of agreement (MOA). The financial eligibility portion is determined by Medicaid eligibility staff.

Level of Care Certification

The Community Long-Term Care nurse consultant must be contacted and a pre-admission review completed in order for a beneficiary to be determined medically eligible. Medicaid vendor payment is authorized by the issuance of the Level of Care Certification letter, DHHS Form 185, which certifies medical necessity.

If a beneficiary receives a Medicare-qualifying skilled service for a condition unrelated to the terminal diagnosis, Medicare will pay the nursing facility and hospice benefit.

SECTION 2 POLICIES AND PROCEDURES

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Level of Care Certification (Cont'd.)

If a beneficiary receives a Medicare-qualifying skilled service for a condition related to the terminal diagnosis, Medicare will only pay for the hospice benefit. In this situation, CLTC will certify for Medicaid sponsorship if all criteria are met.

If the beneficiary is not Medicare eligible, CLTC will certify the beneficiary following its usual procedures.

PASARR

The Preadmission Screening and Annual Resident Review (PASARR) screening is a federally mandated program that requires each state to screen individuals for any indication of mental illness or mental retardation. CLTC will refer to the appropriate agency if the screenings reveal indicators of mental illness or mental retardation. A referral must be made to the appropriate CLTC office for this screening. Most nursing facilities and hospitals have a Memorandum of Agreement with CLTC to perform this screening.

Financial Eligibility

The beneficiary must meet additional financial eligibility requirements before Medicaid will sponsor a stay in a long-term care facility. Once the DHHS eligibility worker determines financial eligibility, a signed DHHS 181 form is sent to the nursing facility.

The nursing facility attaches a copy of the DHHS 181 to the billing invoice for the resident at the end of the billing period and forwards that invoice to the hospice agency for reimbursement. The DHHS 181 form verifies the resident's applicable recurring income.

If the hospice beneficiary decides to revoke his or her hospice election, the hospice provider must notify the nursing facility of the revocation in writing, indicating the effective date. The nursing facility would then initiate billing procedures as usual.

Medicaid Bed Hold Days

If a Medicaid nursing facility resident should require a short-term hospitalization with the expectation of returning to the nursing facility, the nursing facility will reserve the bed for up to 10 days. Reimbursement for the bed hold will be the responsibility of the hospice agency. Medicaid will reimburse the hospice agency for up to 10 consecutive bed hold days if both criteria, short-term stay and expectation of returning to the facility, are met.

SECTION 2 POLICIES AND PROCEDURES

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Therapeutic Care Deinstitutionalization Program

A Medicaid nursing facility resident may leave the facility for up to eighteen days each fiscal year with expectation of Medicaid sponsorship for the absence. Each period of leave may be for a maximum of nine days, and periods may not be consecutive. The plan of care must include the attending physician's authorization for home leave.

Chart entries should include:

1. The length of time for which the leave was approved
2. The goal of the leave
3. On the resident's return, the results of the leave in relation to the goal

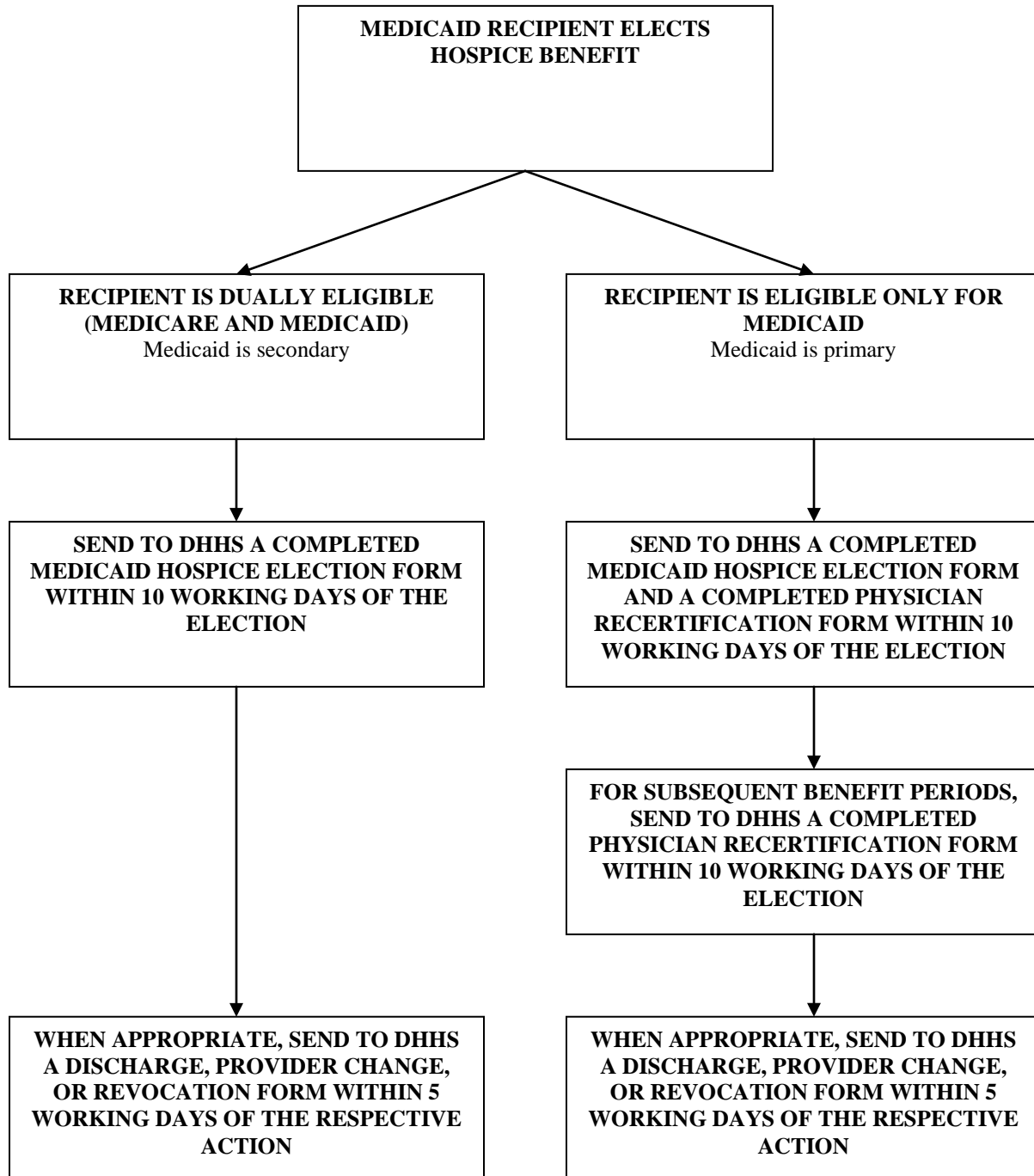
The hospice agency then submits a claim to the Medicaid agency for reimbursement for these days and subsequently reimburses the nursing facility. The hospice agency is expected to continue with routine home care should the resident leave the facility.

Notification of Death

The hospice agency is required to notify the nursing facility and the DHHS eligibility worker of the date of death, using the DHHS form 154, Medicaid Hospice Discharge Form. After notification, the nursing facility will submit a final invoice to the hospice agency. This invoice will not include the date of death for reimbursement.

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MEDICAID HOSPICE BENEFICIARY ENROLLMENT FLOW CHART



FAXED FORMS ARE NOT ACCEPTABLE

QUESTIONS?

CALL: 803-898-2590

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