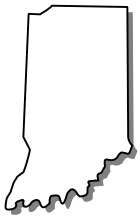
Indiana Health Coverage Programs



PROVIDER BULLETIN

BT200331 MAY 30, 2003

# To: All Hospice Providers

# Subject: Changes to the Hospice Benefit Rules

## Overview

This bulletin gives a detailed explanation of upcoming rule changes and the impact these changes will have on hospice providers for Indiana Health Coverage Programs (IHCP) hospice authorization, hospice provider enrollment, and hospice review.

> *Note: This bulletin should be used as an addendum to the* IHCP Hospice Manual, *dated August 2002.*

All changes to a rule are effective 30 days after filing with the Indiana Secretary of State. A future banner page article will notify hospice providers of the effective date of the hospice rule change. The Office of Medicaid Policy and Planning (OMPP) anticipates the hospice rule will become effective on or before July 12, 2003.

This bulletin provides information about the rule change, the policy implication, the procedure changes for hospice providers and the OMPP contractors, and the sections and page numbers of the *IHCP Hospice Manual* that are modified or superseded by this rule change.

## Amendments to the Rule

### 405 IAC 1-16-2 *is amended to specify the payment level for hospice services on the date that an individual is discharged from inpatient or respite hospice care.*

This rule change brings reimbursement payment levels in line with the current Medicare hospice reimbursement methodology for hospice services on the date an individual is discharged from inpatient or respite hospice care. Specifically, when a member is receiving general inpatient care or inpatient respite care, the applicable inpatient rate, general or respite, is paid for the date of the admission and all subsequent inpatient days, except on the day the patient is discharged. For the day of discharge, the appropriate home care rate, routine care or continuous care, is paid unless the patient dies as an inpatient. In the case where the member is discharged as deceased, the applicable inpatient rate, general or respite, is paid for the date of discharge.

**Language Modified or Superseded in the *IHCP Hospice Manual*, August 2002: This information is an addition to Section 6 of the *IHCP Hospice Manual*.**

### 405 IAC 1-16-4 *is amended to specify that to receive IHCP reimbursement for room and board for nursing home residents receiving hospice services, the hospice must have a written agreement with the nursing facility.*

This rule change makes the IHCP hospice rule consistent with federal regulations in *42 CFR Section 418.56 Condition of Participation-Professional Management, State Operations Manual Section 2082 (Revision 265)* and *CMS Publication 21, Section 204.2* that specifies the hospice is the manager of the member's hospice care and that the hospice has the responsibility to establish a written agreement or contract for the provision of arranged services, such as room and board for nursing home residents electing the hospice benefit.

**Language Modified or Superseded in the *IHCP Hospice Manual*, August 2002: This rule change supplements the following language in the *IHCP Hospice Manual*:**

- *Section 5: Hospice Authorization,* page 5-12, Hospice Provider's Contractual Responsibilities as the Professional Manager of the Member's Hospice Care
- *Section 6: Reimbursement,* page 6-2, Room and Board

### 405 IAC 5-34-1 *is amended to specify that the hospice provider must provide all services in compliance with the IHCP provider agreement, the appropriate provider manual and all other IHCP policy documents issued to the provider at the time services are rendered, and any applicable state or federal statute or regulation.*

This rule change holds the provider accountable to the same conditions listed in the IHCP provider agreement. If, at any time, the provider appeals a hospice authorization determination or a hospice review finding, the provider will be held accountable for complying with the provider agreement, appropriate IHCP provider manual, appropriate *IHCP Hospice Provider Manual,* and all other IHCP policy documents such as provider bulletins and banner pages. The provider must also render all services in compliance with state or federal statutes or regulations as an IHCP and Medicare-enrolled hospice provider.

An example of noncompliance includes failure by the hospice provider to check Medicaid eligibility on a regular basis which would result in the hospice provider mailing the hospice authorization for an IHCP-only member enrolled in the primary care case management (PCCM) managed care program instead of faxing the information to the HCE Prior Authorization Unit so HCE can disenroll the individual from PCCM as outlined in Section 3 of the *IHCP Hospice Manual*. The IHCP would start reimbursing for hospice the day after the member was disenrolled from PCCM instead of reimbursing the hospice provider retroactively through an expenditure payout as outlined in the IHCP provider bulletin, *BT199905*, dated January 26, 1999.

**Language Modified or Superseded in the *IHCP Hospice Manual*, August 2002: This rule change supplements the following sections in the *IHCP Hospice Manual.***

- *Section 1*: *Introduction*, page 1-1, Overview
- *Section 2*: *Provider Enrollment*, page 2-1, Provider Enrollment Application and Agreement

### 405 IAC 5-34-2 *amends provider enrollment to specify licensure and certification requirements for IHCP hospice providers.*

When the Indiana General Assembly enacted the IHCP hospice benefit effective July 1, 1997, the State statute required the hospice provider to be Medicare-certified before the IHCP would enroll the

hospice in the IHCP Hospice Program. This means the hospice provider must submit a copy of the Centers for Medicare and Medicaid Services (CMS) letter specifying that the hospice provider is Medicare-certified to participate in Medicare in the state of Indiana. This requirement remains in effect. In addition, this rule change specifies that a hospice agency must be licensed or approved by the Indiana State Department of Health (ISDH) to comply with mandatory State hospice licensure as outlined in *IC 16-25-1.1 et.seq.*, effective July 12, 1999.

**Before October 15, 2003**, to enroll as an IHCP hospice provider, all IHCP hospice providers need to be licensed or approved by the ISDH and have a current Medicare hospice certification letter from the CMS for each hospice office location where hospice staff are taking Medicare and IHCP hospice patients residing in the state of Indiana. The IHCP has conducted a review of all IHCP-enrolled hospice provider files to determine if there is any missing documentation that each hospice provider must resubmit to the Provider Enrollment Unit by October 15, 2003, to be in compliance with this rule. The Provider Enrollment Unit will issue a letter the last week in July 2003 that will specify the required documentation for the respective hospice provider enrollment files. **If the Provider Enrollment Unit does not receive the requested documentation by the October 15, 2003, deadline, program eligibility for that hospice provider will expire with a November 1, 2003, end date.**

Since the implementation of the IHCP hospice benefit and the passage of mandatory State hospice licensure, the IHCP has been working very closely with the Acute Care Division of the ISDH to ensure that IHCP hospice rules and policy directives are consistent with State hospice certification requirements as outlined in the CMS *State Operations Manual (SOM), Section 2080: Certification* and State hospice licensure as published in *IC 16-25-1.1 et. seq*. The ISDH has informed the OMPP that Indiana law does not permit the ISDH to enter into reciprocal agreements with other state agencies concerning State hospice licensure. Therefore, the ISDH cannot accept any other state hospice license (Ohio, Illinois, Michigan, or Kentucky) as satisfying Indiana licensing requirements. The following information expands on each one of these issues.

- *Medicare Certification for Each Hospice Location: SOM, Section 2081* specifies that a hospice must notify the CMS regional office (RO) through its agent, the state survey agency, or any new office location so that the state survey agency can conduct a survey of that office location to ensure the hospice meets the *Medicare Conditions of Participation for Hospice Care*. The state survey agency then makes a formal recommendation to the CMS RO about whether the hospice office location meets the Medicare conditions of participation to become Medicare-certified as a hospice provider. The IHCP and the ISDH have noted that hospice providers within the state of Indiana may open new office locations but fail to notify the ISDH so that the ISDH can conduct the survey to determine Medicare certification. It is important to note that the federal government expects hospice corporations or agencies to contact the appropriate state survey agency so each new office location can be Medicare-certified either as a satellite office of the parent hospice location or as a stand-alone hospice before billing Medicare for services rendered to Medicare hospice patients. The parent hospice agency A should not be billing Medicare for services rendered to Medicare patients at a new office location B**,** if office location B has not been Medicare-certified by the RO. If parent hospice agency A is billing for services rendered to hospice patients at office location B and office location B is **not** Medicare-certified, this can be seen as program misuse under the federal Medicare program. In this instance, the federal Medicare fiscal intermediary can recoup overpayments for services provided by the hospice provider.

  Regarding the impact Medicare certification has on IHCP hospice provider enrollment for each hospice location, including all hospice satellite offices of the parent location, the IHCP cannot enroll a hospice provider until the provider has submitted a Medicare certification letter for that office location. An IHCP provider enrollment agreement and verification of current Indiana State hospice license or approval must also be submitted when applying for enrollment in the IHCP. When a hospice provider fails to notify the ISDH and the RO of a new hospice location and bills

the IHCP for that patient under another hospice office location's provider number, the following issues arise:
- The hospice provider is non-compliant with *405 IAC 5-34-2* of the provider enrollment.
- The hospice provider will be subject to IHCP recoupment and rebilling procedures under the hospice agency review process. When the inappropriate billing is identified, the IHCP will recoup the overpayments made to hospice office location A for patients seen at hospice office location B and then require hospice office location B to rebill the IHCP for those patients under the correct hospice provider number. This policy is consistent with current review standards for the Long Term Care Unit and current Surveillance and Utilization Review (SUR) policy.

- *Mandatory State Hospice Licensure and Reciprocal Agreements with Other State Survey Agencies:* The ISDH is the State survey agency that must enforce State hospice licensure. The ISDH has informed the OMPP that Indiana law does not permit the ISDH to enter into reciprocal agreements with other state survey agencies with respect to State hospice licensure. In other words, the ISDH cannot accept any other state license (Ohio, Illinois, Michigan, or Kentucky) as meeting the survey criteria for Indiana State hospice licensure. This means for an out-of-state provider to render services to Indiana Medicare and IHCP members, the hospice provider must be licensed or approved by the ISDH.

  Because the ISDH does not have the legal authority to cross state lines to survey out-of-state hospice providers, the out-of-state hospice providers need to take the following steps to obtain an Indiana State hospice license or approval:
  - Open a fully-operational, fully-staffed hospice office location in Indiana that complies with all the federal *Conditions of Participation for Hospice Care* in *42 CFR Part 418 Hospice Care.*
  - Contact the ISDH Acute Care Division to obtain information about the application process to obtain a State hospice license or approval.
  - Contact the ISDH Acute Care Division to obtain an application for Medicare certification for the Indiana hospice office location.

  > *Note: If the hospice decides to have the state survey agency of the parent office perform the Medicare certification survey, the hospice should provide the ISDH Acute Care Division with a copy of that Medicare certification letter.*

  The fact that the ISDH cannot enter into reciprocal agreements with other state survey agencies impacts the current enrollment requirements for out-of-state hospice providers located in designated cities as listed in *405 IAC 5-34-3.*

- *State-Only Indiana Hospice License or Approval:* When a hospice agency applies for a state-only hospice license or approval, the hospice agency cannot receive reimbursement for IHCP members. The hospice agency should not bill the IHCP for IHCP hospice members under any other IHCP hospice provider number until the hospice agency has received the CMS approval letter indicating the Indiana hospice office location and all Indiana hospice satellite offices are Medicare-certified.

Direct further questions about the Medicare certification and the State hospice licensure application process to the ISDH Acute Care Division at (317) 233-7474 or submit questions in writing to the following contact at the ISDH:

**Ms. Lana Richmond, RN, RC**
**Program Director, Acute Care Services Division**
**Indiana State Department of Health**
**2 North Meridian St**
**Section 4A**
**Indianapolis, IN 46204**

Direct questions about the IHCP provider enrollment application process to the Provider Enrollment Unit at 1-877-707-5750, option 3. The provider enrollment application is also available on the IHCP

Web site at www.indianamedicaid.com. Hospice providers are reminded to direct questions about State hospice licensure or Medicare certification application to the ISDH. Provider enrollment staff will refer hospice providers to the ISDH about these issues or concerns.

**Language Modified or Superseded in *IHCP Hospice Manual*, August 2002: These changes supersede current language published in *Section 2: Provider Enrollment* of the current manual.**

## 405 IAC 5-34-3 *is amended to specify the requirements for IHCP hospice services reimbursement rendered by out-of-state providers.*

**The Provider Enrollment Unit will send letters to IHCP-enrolled hospice providers the last week of July 2003 to provide information about the necessary steps providers must take to ensure continued enrollment in the IHCP when the change to the hospice rule is implemented. Out-of-state providers in designated areas must work in good faith with the ISDH to comply with State hospice licensure as outlined in this bulletin.**

> ***Note:*** *If an out-of-state hospice provider fails to provide the necessary documentation to the Provider Enrollment Unit by the October 15, 2003, deadline, the Provider Enrollment Unit will end-date program eligibility on November 1, 2003.*

**To ensure ongoing enrollment in the IHCP, out-of-state hospice providers must comply with the ISDH survey requirements as well as submit the following documentation to the Provider Enrollment Unit.**

- The following documentation should be provided for enrollment of an Indiana hospice office location:
  - The CMS letter indicating the Medicare certification for a new Indiana office location.
  - A new provider enrollment application agreement for the Indiana office location.
  - Verification of Indiana State hospice license or approval.
- In an effort to minimize any delay in the IHCP hospice authorization and IHCP billing by the out-of-state provider in a designated area, the Provider Enrollment Unit will permit the Indiana hospice office location to maintain the same IHCP-enrolled hospice provider and treat the process as an address change.

> *Note: The Provider Enrollment Unit cannot process the IHCP enrollment application until the provider has submitted a complete packet and the ISDH has sent the Provider Enrollment Unit a certificate and transmittal (C&T) verifying the Medicare certification and the initial State hospice licensure.*

Direct further questions about Medicare certification and the State hospice licensure application process to the ISDH Acute Care Unit at (317) 233-7474. Direct questions about the provider enrollment application process to the Provider Enrollment Unit at 1-877-707-5750, option 3. **Hospice providers are reminded that the Provider Enrollment Unit is not the authority on State hospice licensure or the Medicare certification application processes; therefore, the Provider Enrollment Unit will refer hospice providers to the ISDH regarding these inquiries.**

**Language Modified or Superseded in *IHCP Hospice Manual*, August 2002: The following changes supersede current policy published in *Section 2: Provider Enrollment* of the current manual.**

### 405 IAC 5-34-4 *is amended to specify the requirements for obtaining authorization for hospice services.*

**State hospice regulations in *405 IAC 5-34-5* are amended to reflect the changes to the IHCP hospice authorization process. The following information provides a detailed explanation for each of these changes:**

- *One-Page Hospice Authorization Notification for Dually-Eligible Medicare/IHCP Hospice Members Residing in Nursing Homes:* This is a change to the required documentation for IHCP hospice authorization for dually-eligible hospice members residing in nursing facilities for whom the IHCP pays room and board as specified in *405 IAC 1-16-4,* and for whom Medicare pays for the hospice services. Because the medical necessity for hospice care is determined by the Medicare fiscal intermediary, the IHCP decided to change the documentation requirements to a one-page notification that permits the Hospice Authorization Unit to enter the hospice authorization without evaluating medical necessity. A sample copy of the one-page notification form is included with this bulletin. The provider must complete the information in each box and ensure the form is signed by the patient care coordinator to obtain hospice authorization.

  *Note: Failure to properly complete the form will result in the IHCP prior authorization contractor returning the paperwork to the hospice provider for correction.*

  When systems modifications for the Health Insurance Portability and Accountability Act (HIPAA) are made by the end of August 2003, the IHCP will prioritize the change systems request in September 2003 that will permit the hospice provider to submit the form once for each member. The form needs to be resubmitted if a member had to be re-enrolled following a prior hospice revocation or prior hospice discharge. When the systems modifications are complete, the IHCP will notify all hospice providers through a banner page article stating when hospice providers can start submitting the one page notification during the initial enrollment of the member or re-enrollment following a prior hospice revocation or hospice discharge.

  In the interim, to ensure the system recognizes the individual as a hospice member, hospice providers must submit the one page notification to the Hospice Authorization Unit **for each hospice benefit period** so that the hospice agency can successfully bill the IHCP without receiving an EOB *2024 – This member not eligible for this hospice level of care for these dates of service.*

  **The hospice rule should be effective on or around July 12, 2003. The Prior Authorization Unit will start accepting the one page notification on August 1, 2003, for each hospice benefit.** The FSSA forms management and the OMPP will neither release the form to the State Forms Distribution Center nor permit the form to be posted on the State forms Web site until the hospice rule is effective.

- *Time Frames for Submitting Hospice Authorizations and Penalty for Untimeliness*: Hospice providers are required to submit IHCP hospice authorization forms to the Prior Authorization Unit within 10 business days of the effective date of the member's election of hospice services, or within 10 business days of the beginning of the second and subsequent benefit periods. For each day the request is past the 10-business day limit, the start date of the hospice benefit period will move forward one day. For example, if the request is received on the twelfth business day after the date of election or the start of the benefit period, the start date will be authorized two calendar days after the start date of the hospice benefit period.

  The following example should clarify this policy for hospice providers: A member elects the IHCP hospice benefit on March 1, 2003. The hospice forms are due to HCE on March 14, 2003, and HCE receives the forms on March 17, 2003. The hospice authorization is effective with a start date of March 4, 2003, because of the untimely submission.

> *Note: The penalty for untimely submission applies to the one-page notification for dually-eligible Medicare/IHCP hospice members residing in nursing homes; therefore, it is **very important** that hospice providers submit this form on a timely basis.*

When there is insufficient information submitted to render a hospice authorization decision, or the documentation contains errors, the hospice authorization request will be suspended for 30 days and the IHCP or its contractors will request additional information from the provider. The provider must make the corrections and resubmit the proper documentation within 30 calendar days after the additional information or correction is requested. **If the provider fails to resubmit the documentation with the appropriate corrections within the 30-day time period, the request for hospice authorization will be denied.**

If the provider submits additional documentation within the 30-day time period, but the documentation submitted does not provide sufficient information to render a decision, the IHCP or its contractors, can request additional information. **If the provider fails to submit the requested information within the additional 30 days, or if the additional documentation does not provide sufficient information to render a decision, the request for hospice authorization will be denied.**

The hospice provider can appeal the denied hospice authorization. The following explanation provides information about the administrative reconsideration and the appeals process.

- *Exceptions to the Penalty for Untimely Submissions:* If a request for hospice authorization or supporting documentation is received after the time limits listed in the following information, authorization can be granted only for services provided on or after the date the request is received.

  The following circumstances list when authorization can be granted for services furnished prior to the date of a request that does not comply with the time limits in this section:

  - *Pending or retroactive member eligibility*: The hospice authorization must be submitted within 12 months of the date the member's Hoosier Health Card was issued.
  - *The provider is unaware the individual was Medicaid-eligible*: If the provider is unaware the member was eligible for services at the time services were rendered, hospice authorization will be granted only under the following circumstances:
    - The provider's records document that the member refused, or was physically unable, to provide the member identification (RID) or the IHCP number.
    - The provider can substantiate that the provider continually pursued reimbursement from the patient until IHCP eligibility was discovered.
    - The provider submitted the request for prior authorization within 60 days of the date IHCP eligibility was discovered.
  - *Pending or retroactive approval of nursing facility level of care*: The hospice authorization must be submitted within 12 months of the date the nursing facility level of care was approved by the IHCP.
- *Review of Medical Necessity*: To make hospice authorization decisions, the IHCP will rely on current professional guidelines, including the Medicare Local Medical Review Policy (LMRP) for hospice services.

  According to the Palmetto Government Benefits Administrator (PGBA), the Medicare fiscal intermediary (FI) for Indiana, Medicare coverage for hospice care depends on a physician's certification of an individual's prognosis for a life expectancy of six months or less. Recognizing that determination of life expectancy during the course of a terminal illness is difficult, the Medicare FI has established medical criteria for determining prognosis for non-cancer diagnoses. These criteria form a reasonable approach to the determination of life expectancy based on

research, and can be revised as more research is available, particularly because remedial care is a new and changing field. The Medicare program indicates that coverage of hospice care for patients not meeting the criteria under a specific LMRP could be denied. However, some patients may not meet the criteria, yet still be appropriate for hospice care because of other diseases or rapid decline. **Coverage for these patients can be approved individually.**

The IHCP recognizes that the LMRP is only a guide to assist in determining if a patient is appropriate for hospice care and is not meant to replace the overall clinical evaluation either by the hospice provider or by the IHCP and its contractor in evaluating the unique clinical condition of each hospice member. Each hospice authorization is reviewed as a stand-alone request taking into consideration the hospice member's unique clinical history.

Hospice providers must adhere to the LMRP published by the Medicare FI for the state of Indiana when evaluating an IHCP-only hospice member for hospice care appropriateness.

**Language Modified or Superseded in *IHCP Hospice Manual*, August 2002: *Section 3: Member Eligibility* and *Section 5: Hospice Authorization* in the IHCP manual is impacted by this rule change as explained in the following descriptions.**

- S*ection 3: Member Eligibility,* pages 3-14 to 3-15, Certification Forms for Dually-Eligible Medicare/IHCP Hospice Members. This section is no longer applicable and is replaced with the policy and procedures published in this bulletin for the one page notification.
- *Section 5: Hospice Authorization,* pages 5-1 to 5-2, Election/Plan of Care/Benefit Period Process. The rule changes noted in this bulletin should be used as supplemental information to this current section because there are changes to documentation requirements and time frames for hospice authorization submission deadlines.

## 405 IAC 5-34-4.1 *is amended for appeals of hospice authorization determinations.*

An explanation of the appeals procedures is listed in the following information:

- IHCP members can appeal the denial or modification of hospice authorization under *405 IAC 1.1.*
- Any provider submitting a request for hospice authorization that was denied in whole or in part under this rule, can appeal the decision under *405 IAC 5-7-2* and *405 IAC 5-7-3* for administrative consideration of prior authorization decisions.
- When insufficient information is submitted to render a decision, or the documentation contains errors, a hospice authorization will suspend pursuant to *405 IAC 5-34-4* and the IHCP or its contractor will request additional information from the provider. **Suspension is not a final decision on the merits of the request and cannot be appealed.** If the provider does not submit sufficient information within the time frames listed in *405 IAC 5-34-4(h*), the request will be denied. **Denial is a final decision and can be appealed pursuant to subsections (a) and (b).**
- *The Administrative Review Process*: Pursuant to *405 IAC 5-7-2*, an IHCP-enrolled provider entitled to submit prior authorization requests wishing a review of a denial or modification of a prior authorization decision, must request an administrative review before filing an appeal under *405 IAC 1.1.*
  - An administrative review request by the provider submitting the prior authorization request must be initiated within seven working days of the receipt of modification or denial. The request must be forwarded in writing to the IHCP prior authorization contractor. Telephone requests cannot be accepted.
  - Pursuant to *405 IAC 5-7-3*, the IHCP prior authorization contractor will perform the review. The review will assess medical information pertinent to the case in question. The review

decision of the IHCP contractor will be rendered within seven working days of the request. **The time limit for issuance of a decision does not commence until the provider submits a complete request including all necessary documentation required by the contractor to render the decision.** The requesting provider and member will receive written notification of the decision containing the following information:

- The determination reached by the IHCP contractor, and the rationale for the decision.
- The provider and member appeal rights through the OMPP.

- *Administrative Law Judge (ALJ) Hearings and Appeals:* Pursuant to *405 IAC 1.1-1-3*, any party complaining of an OMPP or county Office of Family and Children (OFC) action can file a request for an administrative hearing as provided in this section.

  Unless otherwise provided by statute, regulation, or rule, appeal requests by members or applicants must be filed in writing with the local county OFC, the state Division of Family and Children (DFC), or the FSSA Hearings and Appeals Section, no later than 30 days following the effective date of the action being appealed. Applicant and member appeal hearings should be conducted at a reasonable time, place, and date.

  A continuance of a hearing will be granted only for good cause. An objection to a request for a continuance must be considered before a continuance is granted or denied. Requests for a continuance must be in writing and accompanied by adequate documentation of the reasons for the request. Good cause includes the following same factors as cause for a continuance in the *Supplemental Security Income* program (*20 CFR 416.1436*):
  - Inability to attend the hearing because of a serious physical or mental condition
  - Incapacitating injury
  - Death in the family
  - Severe weather conditions making it impossible to travel to the hearing
  - Unavailability of a witness and the evidence cannot be obtained otherwise
  - Other reasons similar to those listed in this section

  The request for continuance must also include alternative dates for the scheduling of a new hearing when the appellant is represented by counsel. However, the FSSA Hearings and Appeals Section could schedule a new hearing without respect to the requested date, if such date cannot be accommodated or confirmed with the requesting attorney within a reasonable time of the request.

  The FSSA Hearings and Appeals Section, upon application of any party, or at its own discretion, could consolidate appeals to promote administrative efficiency. The FSSA Hearings and Appeals Section may consolidate hearings only in cases where the sole issue involved is one of federal or state law or policy.

  Any party filing the appeal under this article is not excused from exhausting all interim procedures that could be required by statute or rule for the administrative review prior to the filing of an appeal. Any issues not presented in a timely manner within the interim review process are waived and will not be an issue during the evidentiary hearing. The FSSA Hearings and Appeals Section will schedule evidentiary hearings and will issue notices to the parties about the date, time, and location of the hearing.

- *Conduct of Agency Review*: Any party not satisfied with the decision of the administrative law judge can request an agency review of the decision within 10 days of receipt of the decision in accordance with instructions issued with the decision.

  After receiving a request for an agency review of a hearing decision, the FSSA Hearings and Appeals Section will notify all parties as to when the decision will be reviewed. The agency review will be completed by the secretary or the FSSA's designee. All such reviews will be conducted and recorded as defined in *IC 4-21.5-3-33*, except that a transcript of the oral testimony will not be necessary for review unless a party requests a transcript at its expense.

No new evidence will be considered during the agency review; however, any party wishing to submit a memorandum of law, citing evidence in the record, may do so pursuant to instructions issued by the FSSA Hearings and Appeals Section.

**Language Modified or Superseded in *IHCP Hospice Manual*, August 2002:** ***Section 3: Member Eligibility*** **and** ***Section 5: Hospice Authorization*** **of the** ***IHCP Hospice Manual.***

## 405 IAC 4.2 *language is added to provide for retrospective audit of hospice services including review for medical necessity.*

Effective January 2000, the IHCP initiated a comprehensive audit process for the IHCP hospice benefit. The hospice agency review process is a post-payment review process conducted by registered nurses who are part of the hospice review team in the Long Term Care Unit. The purpose of these reviews is to educate and assist hospice providers in achieving IHCP compliance for documentation and billing. This section of the rule formally recognizes this process and also provides language to authorize the hospice review team to revoke hospice authorization dates for which hospice services did not meet medical necessity criteria for hospice care. Hospice providers are asked to refer to the language explaining medical necessity under the previous section of this bulletin explaining changes to *405 IAC 5-34-4*.

The following criteria is used when a hospice review is conducted at the hospice agency as well as all services billed to the IHCP by hospice and non-hospice providers for the specified review time period:

- The medical documentation of the hospice and non-hospice providers must support the services billed to the IHCP.
- Services must be IHCP benefits.
- Services must be reasonable and medically necessary to treat the terminal condition and related illnesses.
- Services must be billed in the quantities ordered and documented in the medical record as provided.
- Services must be specifically identified on either the provider's itemized statements or the charge receipt maintained by the facility.
- Services must be billed to the IHCP only after other medical insurance has been exhausted.
- Services must be billed in accordance with established IHCP policy.
- The physician must order services in writing as indicated in the medical documentation.

The following documentation is not acceptable legally or from patient care perspective under the IHCP guidelines, and would subject the hospice and non-hospice providers to recoupment:

- Failure to document the IHCP member's name on each page of the service record. A patient's name is essential to ensure that the documentation is returned to the correct record, and that the record pertains to the member being reviewed.
- Scratch outs, whiteouts or alterations, missing dates, and missing signatures are not acceptable. All documentation errors should be corrected using the following universally accepted medical records method: draw a line through the entry (in ink), do not obliterate the word, enter the correct information, initial, and date the change.
- Signatures are required to authenticate all documentation of services rendered. While it is recommended that a full signature be used for **each entry,** each individual entry must be signed, including at a minimum, the first initial and last name.

- If a first initial and last name is used, a master signature file must be maintained. The file should contain a complete (first and last name) signature and the corresponding initial and last name to be used for documentation purposes.
- If a service requires a certain licensure level, that individual should include his or her title or credential in the signature.

Hospice providers are reminded that prior authorization is not a guarantee of payment. Therefore, if the hospice review team or the SUR department identifies an overpayment issue that requires recoupment, the fact that the provider has prior authorization does not keep the IHCP from initiating the recoupment process.

The changes in the hospice rule will also impact the forms required at the hospice agency or the nursing facility. The hospice provider is required to keep all IHCP hospice forms that were submitted, or should have been submitted to the Prior Authorization Unit, in the hospice member's clinical chart at the hospice agency. The IHCP also expects hospice providers to include the same documentation in the hospice member's clinical chart at the nursing home.

While the IHCP expects these forms to be in the member's clinical chart, the review process will not include any penalty if the forms are not located in the chart during the review. The hospice provider will be instructed in the summary of findings letter to correct the documentation discrepancy to make sure the hospice member's clinical records reflect accurate documentation of the member's enrollment in the IHCP hospice benefit.

The following table lists the documentation requirements after the rule changes for hospice providers to include in the patient's clinical record at the hospice agency for IHCP-enrolled only members and those having dual eligibility with Medicare.

Table 1 – Documentation Requirements for Hospice Providers

| **Documentation Requirements for Hospice Providers** | |
|---|---|
| **IHCP-Only Hospice Members (private home and nursing home hospice members)** | **Dually-eligible Medicare/IHCP Hospice Members Residing in Nursing Homes** |
| Medicaid Hospice Election Form | One-page hospice authorization notification with corresponding hospice agency form reflecting Medicare hospice election date. |
| Medicaid Physician Certification Form | Hospice agency physician certification form no longer required for IHCP post payment review process, but still required for state hospice survey process. |
| Medicaid Hospice Plan of Care | The IHCP requires the hospice provider to meet the documentation requirements under the *SOMS Section 2082* to reflect a coordinated plan of care between hospice and nursing facility agencies that demonstrates the hospice care philosophy supersedes in the care of the nursing facility resident. The plan of care should be updated to reflect appropriate changes in the member's medical condition regarding the terminal illness and related conditions. |
| Medicaid Hospice Revocation Form | Medicaid Hospice Revocation Form |
| Medicaid Hospice Discharge Form | Medicaid Hospice Discharge Form |
| Medicaid Change of Provider Form | Medicaid Change of Provider Form |
| Medicaid Change in Status of Hospice Member | Medicaid Change in Status of Hospice Member |

**Language Modified or Superseded in *IHCP Hospice Manual*, August 2002: This language supplements current policy for the hospice agency review process as outlined in *Section 7: IHCP Recoupment* of the *IHCP Hospice Manual.***

## 405 IAC 5-34-5 *is amended to specify requirements relating to the hospice physician certification form.*

Because the IHCP will only require the hospice provider to submit the one page notification to enroll the dually-eligible hospice member residing in the nursing facility, in the IHCP hospice benefit, the hospice provider will not be required to include the hospice agency physician certification form in the member's clinical chart in the nursing facility for post payment review purposes. Hospice providers must include the IHCP physician certification form in the hospice member's nursing facility chart for each hospice benefit period because those documentation requirements have not changed. Providers should refer to Table 1 that outlines documentation requirements for the rule changes for the *405 IAC 4.2* audit. Hospice providers are reminded that the documentation requirements for hospice authorization for the IHCP-only hospice members have not changed under this rule.

**Language Modified or Superseded in *IHCP Hospice Manual,* August 2002: The following sections of the *IHCP Hospice Manual* are modified.**

*Section 3: Member Eligibility,* pages 3-12 to 3-15, Benefit Periods and Certification
*Section 5: Hospice Authorization*
*Section 7: Recoupment*

## 405 IAC 5-34-6 *is amended to specify requirements relating to election and revocation of services.*

The hospice rule recognizes the following amendments relating to hospice election:

- The hospice agency is required to submit the hospice agency form reflecting the member's Medicare hospice election with the one page IHCP hospice authorization notification for the dually-eligible hospice member residing in the nursing home.
- The hospice agency is required to resubmit the above documentation when a dually-eligible hospice member re-elects hospice following a prior hospice revocation or hospice discharge.
- The documentation requirements for the IHCP-only hospice member remain unchanged under this rule. The IHCP requires the hospice provider to use the IHCP hospice election form.

The hospice rule recognizes the following amendments relating to hospice revocation:

- The amendment adds language, reflected in the current *IHCP Hospice Manual,* that states the form must specify the date the revocation is to be effective, if later than the date the form is signed by the individual or a representative. An individual or representative cannot designate an effective date earlier than the date the revocation is made. This language is consistent with federal regulations regarding hospice revocation as published in *42 CFR Section 418.28(b)(2).*
- The amendments add language specifying that the IHCP hospice revocation form for IHCP-only members and dually-eligible hospice members, must be submitted to the IHCP prior authorization contractor.
- The amendment adds language specifying that the IHCP hospice revocation form must be in the hospice member's clinical chart at the hospice agency and the contracted nursing facility.

The hospice rule recognizes the following changes relating to hospice providers:

- The rule change adds language to the current policy published in the *IHCP Hospice Manual* specifying that a change in hospice providers is allowed once during any hospice benefit period and that this change does not constitute a revocation. The following information specifies that the *Medicaid Change In Hospice Provider* form must be completed for IHCP-only hospice members and dually-eligible hospice members residing in a nursing facility. This language is consistent with federal regulations in *42 CFR Section 418.30(a) and (b)*.
- The rule change adds language to the current policy published in the *IHCP Hospice Manual* specifying that this form must be in the hospice member's clinical chart at the hospice agency and the contracted nursing facility.

**Language Modified or Superseded in the *IHCP Hospice Manual*, August 2002: *Section 4: Election and Revocation***

## 405 IAC 5-34-7 *is amended to specify requirements relating to the hospice plan of care.*

The hospice rule makes the following amendments to the hospice plan of care:

- The amendment adds language to the current *IHCP Hospice Manual* that specifies the IHCP hospice plan of care must be included in the member's clinical chart at the hospice agency and contracted nursing facility for IHCP-only hospice members.
- The amendment adds language that a coordinated plan of care prepared and agreed upon by the hospice and nursing facility must be included in the member's clinical chart at the contracted nursing facility.

**Language Modified or Superseded in *IHCP Hospice Manual*, August 2002: *Section 7: Recoupment***

- *Changes to IHCP Hospice Forms:* The OMPP has made revisions to four hospice forms based on comments received from IHCP hospice providers.

  Due to clarification received from the customer service line at PGBA, the OMPP changed the signature requirements for the plan of care. The initial policy that two signatures would be sufficient for the drafting of the plan of care is incorrect. Therefore, the requirement for three signatures is correct. **Effective August 1, 2003,** hospice providers will be required to include a third signature on the hospice plan of care to ensure compliance with the *Medicare Conditions of Participation for Hospice Care*. The OMPP will revise the hospice plan of care to include a third signature line.

Copies of the revised forms are included with this bulletin. The forms are also available at the State Forms Management Distribution Center. To obtain these new forms, hospice providers should refer to *Section 3* of the *IHCP Hospice Manual* for the proper procedures.

Following is a list of the revised forms:
- Medicaid Hospice Physician Certification Form, *State Form 48736 (R2/12-02)/OMPP 0006*
- Medicaid Hospice Plan of Care Form, *State Form 48731 (R/12-02)/OMPP0011*
- Hospice Provider Change Request Between Indiana Hospice Providers, *State Form 48733 (R/12-02)/OMPP 0009*
- Medicaid Hospice Discharge Form, *State Form 48734 (R/ 12-02)/OMPP 0008*

These forms are available as fill-in versions and can be obtained from the FSSA PDF catalogs or providers with Internet and Adobe Acrobat 5 can access these forms on the Web at http://www.state.in.us/icpr/webfile/formsdiv/fssa.html. Type the information required in each field,

and print the document for a staff member to sign. This fill-in version should not be saved for future use.

The one page hospice notification for dually-eligible hospice members residing in nursing facilities will not be available for use until the hospice rule is effective. However, the form was issued the following title and State form number:

- Hospice Authorization Notice for Dually-Eligible Medicare/Medicaid Nursing Facility Residents, *State Form 51098 (3-03)/OMPP 0014.*

When the hospice rule is in effect, the OMPP will notify the FSSA Forms Management Unit to forward a supply of the form to the State Forms Management Distribution Center and make the form available on the FSSA Web site. A future banner page article will notify hospice providers of the availability of the form.

A copy of this form along with the four revised hospice forms described in this bulletin are included with the bulletin.

This reminds hospice providers the federal *Medicare Conditions of Participation for Hospice Care* is currently being revised. If any of the changes to the federal law require the OMPP to further revise the IHCP hospice forms, the OMPP will notify providers of any changes through a banner page article.

Direct questions about the IHCP hospice benefit to the Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

**HOSPICE AUTHORIZATION NOTICE FOR DUALLY-ELIGIBLE MEDICARE / MEDICAID NURSING FACILITY RESIDENTS**

State Form 51098 (3-03) / OMPP 0014

**This completed form is CONFIDENTIAL according to 405 IAC 1-16, 5-2-10.1, 5-1-10.2, 5-5-1, and 5-34.**

The purpose of this form is to enroll nursing facility residents who elect the Medicare hospice benefit in the Medicaid hospice benefit to ensure payment of room and board services as required under 405 IAC 1-16-4. The hospice provider understands that the only time this enrollment form must be completed again is if the individual reelects hospice care following a hospice discharge or hospice revocation. **Through the primary hospice nurse's signature on the bottom of this form,** the hospice provider certifies that all medical documentation has been completed according to the Medicare Conditions of Participation for Hospice Care and Medicaid program guidelines and that all required Medicaid forms have been included in the patient's medical chart in the hospice agency and contracted nursing facility.

**The hospice provider must still complete the Medicaid hospice election form, Medicaid physician certification form and Medicaid hospice plan of care for the Medicaid-only nursing facility resident as required for each hospice benefit period.**

| Date of the original Medicare hospice election: (*Attach signed copy of Medicare election statement*) | Previous hospice enrollee? |
|---|---|
| May 14, 2003 | ☐ Yes ☒ No |
| Date of Medicare hospice re-election (*This section is for the date that the member re-elects hospice following a preceding hospice revocation or hospice discharge.*) | |
| Current hospice benefit period: (1) 2 3 4 5 6 7 8 9 10 | |

**A. RECIPIENT INFORMATION**

| Primary hospice diagnosis (ICD#) | | |
|---|---|---|
| Name of recipient (*last, first, middle initial*) | Recipient's Medicaid number | |
| Doe, Jane C. | 999999999999 | |
| Address or other location if not private home (*number and street, apt. number, city, state, ZIP code*) | | |
| 222 Pleasant Run, Indianapolis, IN 22222 | | |
| Recipient's Social Security number | Telephone number | Date of birth (*month, day, year*) |
| 111-22-3333 | ( 317 ) 843-3333 | March 1, 1940 |
| Name of parent, guardian or representative | | Sex of recipient: ☐ Male ☒ Female |

**B. PROVIDER'S INFORMATION**

| Date of physician's verbal approval of hospice care (*month, day, year*) | | |
|---|---|---|
| Name of hospice provider | | Medicaid hospice provider number |
| Hospice 1 | | 123456789 |
| Name of attending physician | | Hospice telephone number |
| John Smith, M.D. | | (317) 222-3434 |
| Attending physician Medicaid provider number | Name of nursing facility (*if applicable*) | Nursing facility Medicaid provider number |
| 888888888 | | |

| Signature of Primary Hospice Nurse (RN) and title | Date (*month, day, year*) |
|---|---|
| Nancy Pinkerton, RN | 5/15/03 |

This form must be completed in its entirety to be processed by the Medicaid prior authorization contractor to ensure hospice authorization. Hospice authorization is required for the dates of service that the hospice bills for room and board services.

## MEDICAID HOSPICE PLAN OF CARE

State Form 48731 (R / 12-02) / OMPP 0011

The information contained on this completed form is **CONFIDENTIAL** according to 405 IAC 1-16, 5-2-10.1, 5-2-10.2, 5-5-1, and 5-34.

| **A. RECIPIENT INFORMATION** | Primary hospice diagnosis (*ICD-#*): |
|---|---|
| Name of recipient (*last, first, middle initial*) | Recipient's Medicaid number |
| Recipient's Social Security number | |

| **B. HOSPICE PROVIDER INFORMATION** | |
|---|---|
| Name of hospice provider | Hospice provider number |

**C. ASSESSMENT:** Complete the following using the problem severity code listed at the bottom of the chart.

| ASSESSMENT | PROBLEM SEVERITY CODE | ASSESSMENT | PROBLEM SEVERITY CODE |
|---|---|---|---|
| Altered Physical Comfort | | Alltered Urinary Elimination | |
| Altered Respiratory Status | | Altered Bowel Elimination | |
| Altered Cardiovascular Status | | Altered Sleep Pattern | |
| Altered Nutritional Status | | Altered Grief/Spiritual (*patient*) | |
| Altered Skin Integrity | | Altered Grief/Spiritual (*family*) | |
| Altered Mobility Status | | Altered Oral Mucosa | |
| **ACTIVITIES OF DAILY LIVING** | **PROBLEM SEVERITY CODE** | **ACTIVITIES OF DAILY LIVING** | **PROBLEM SEVERITY CODE** |
| Eating / Feeding | | Toileting | |
| Grooming / Hygiene | | Continence | |
| Bathing | | Transferring | |
| Dressing | | Mobility | |

**PROBLEM SEVERITY CODE**

0 = None: no problem present
1 = Problem: controlled at time of assessment
2 = Mild: function could be improved.
3 = Moderate: able to function with support
4 = Marked: able to function only with daily intervention
5 = Severe: incapacitated by the problem

**D. SERVICES:** Document the proposed services for this benefit period (*include frequency and expected outcome*).

| Services Required | Frequency | Expected Outlook |
|---|---|---|
| Skilled Nursing | | |

(*Continued on the reverse side*)

| E. SERVICES (*continued*) | | |
|---|---|---|
| **Services Required** | **Frequency** | **Expected Outlook** |
| Home Health | | |
| Therapy | | |
| DME | | |
| Pharmacy | | |
| Spiritual | | |
| Other enhanced services | | |

| **F. SIGNATURES:** Date and sign the following. Signatures must represent the Medical Director as well as one signature from any of the other disciplines listed above. | | |
|---|---|---|
| Signature | Title | Date |
| Signature | Title | Date |

Effective August 1, 2003, a third signature will be required on this form to ensure authorization. The OMPP will be revising this form to reflect a third signature box.

## MEDICAID HOSPICE PHYSICIAN CERTIFICATION

State Form 48736 (R2 / 12-02) / OMPP 0006

The information contained on this completed form is **CONFIDENTIAL** according to 405 IAC 1-16, 5-2-10.1, 5-2-10.2, 5-5-1, and 5-34.

| **A. RECIPIENT INFORMATION** | Primary hospice diagnosis (*ICD-#*): |
|---|---|
| Name of recipient (*last, first, middle initial*) | Recipient's Medicaid number |
| Recipient's Social Security number | |

| **B. PROVIDER INFORMATION** | |
|---|---|
| Name of hospice provider | Hospice Medicaid provider number |

Please check the appropriate benefit period below:

1st hospice benefit period _____

2n hospice benefit period _____

3rd hospice benefit period _____

Should additional hospice care be required after the first 60 days of the Third Benefit Period, please complete this page again and check the appropriate box below.

| **THIRD BENEFIT PERIOD (*SUBSEQUENT 60 DAY PERIODS*)** | | | | |
|---|---|---|---|---|
| 2nd 60 days | 3rd 60 days | 4th 60 days | 5th 60 days | 6th 60 days |

Please specify the number of any subsequent benefit period _____

**C.** Having reviewed this patient's care and the course of his / her illness, I certify that this patient's medically predictable life expectancy is (6) months or less, given that the illness runs its normal course, as evidenced by the following clinical indications.

| Signature of Attending Physician (*Required first hospice benefit period*) | Certification date (*month, day, year*) |
|---|---|
| Signature of Medical Director or Hospice Physician | Certification date (*month, day, year*) |

## HOSPICE PROVIDER CHANGE REQUEST BETWEEN INDIANA HOSPICE PROVIDERS

State Form 48733 (R / 12-02) / OMPP 0009

The information contained on this completed form is **CONFIDENTIAL** according to 405 IAC 1-16, 5-2-10.1, 5-2-10.2, 5-5-1, and 5-34.

| A. PROVIDER CHANGE REQUEST EFFECTIVE DATE OF CHANGE: | ☐ FIRST BENEFIT PERIOD ☐ THIRD BENEFIT PERIOD<br>☐ SECOND BENEFIT PERIOD |
|---|---|

| B. RECIPIENT INFORMATION | Primary hospice diagnosis (*ICD-#*): |
|---|---|
| Name of recipient (*last, first, middle initial*) | Recipient's Medicaid number |
| Recipient's Social Security number | |

THE ABOVE NAMED RECIPIENT REQUESTS THAT THE DESIGNATION OF HIS / HER HOSPICE BE CHANGED FROM (*completed by sending hospice*):

| C. PROVIDER LEAVING | |
|---|---|
| Name of Hospice Provider | Hospice Medicaid Provider number |
| Signature of Provider RN | Hospice telephone number |
| Name of Attending Physician | Physician Medicaid Provider number |

TO THE FOLLOWING HOSPICE PROVIDER (*completed by receiving hospice*):

| C. PROVIDER ENTERING | |
|---|---|
| Name of Hospice Provider | Hospice Medicaid Provider number |
| Signature of Provider RN | Hospice telephone number |
| Name of Attending Physician | Physician Medicaid Provider number |

As a hospice recipient, I understand that this change in hospice providers is not a revocation of the remainder of my current election benefit period.

| E. Signature of recipient or representative | Signature of witness | Date |
|---|---|---|
| | | |

**NOTES:**
(1) Patient must be accepted for transfer by the new provider prior to leaving current provider.
(2) Each hospice must maintain a copy of the Provider Change Request. It is the responsibility of the receiving hospice to forward a completed copy to the Medicaid Prior Authorization Unit within 5 days of the effective date stipulated in Part A above.
(3) A change of ownership is not considered a change in the patient's designation of a hospice and requires no recipient action.

## MEDICAID HOSPICE DISCHARGE

State Form 48734 (R / 12-02) / OMPP 0008

The information contained on this completed form is **CONFIDENTIAL** according to 405 IAC 1-16, 5-2-10.1, 5-2-10.2, 5-5-1, and 5-34.

| **A. RECIPIENT INFORMATION** | Primary hospice diagnosis (*ICD-9*): |
|---|---|
| Name of recipient (*last, first, middle initial*) | Recipient's Medicaid number |
| Recipient's Social Security number | |

| **B. HOSPICE PROVIDER INFORMATION** | |
|---|---|
| Name of Hospice Provider | Hospice Provider number |

**C. DISCHARGE STATEMENT**

Hospice benefits for the above named recipient, enrolled with the above named provider since _____ / _____ / _____ have terminated on _____ / _____ /_____ for the following reasons:

- ☐ Recipient is deceased. Date of death was _____ / _____ / _____ .
- ☐ Prognosis is now greater than six months.
- ☐ Safety of recipient or hospice staff is compromised (*explain below and attach revelent documentaion*).
- ☐ Recipient moved out of service area.
- ☐ Other (*explain below*)

| Signature of Medical Director or Patient Care Coordinator | Date |
|---|---|