gainwell

Vermont Medicaid Hospice Provider Manual

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Section 1 Introduction

Hospice is a comprehensive, holistic program of care and support for terminally ill members and their families. Hospice care focuses on comfort care and quality of life instead of care to cure the member's illness.

The goal of hospice is to help members live their remaining life fully and comfortably by providing care to alleviate pain and suffering and to treat symptoms. Hospice care helps a member be comfortable by addressing issues causing physical or emotional pain or suffering. Hospice care is provided utilizing a multidisciplinary team approach to address the physical, psychological, social, and spiritual needs of the member and their family. Hospice services can be utilized by members of all ages.

Hospice care can be provided in a variety of settings, including the member's home, the home of another person, an approved residential care home, assisted living facility, or an approved nursing home.

All services must be rendered in accordance with Medicaid guidelines and requirements under Health Care Administrative Rules.

Section 2 Medicaid State Plan

Hospice-eligible members have the right to select qualified hospice providers of their choice.

- Hospice services to terminally ill recipients are covered in accordance with Section 1905(o) of the Social Security Act and must comply with the requirement in section 4305 of the Medicaid State Plan. A physician must certify that the eligible person is within the last six (6) months of life. These services may be provided on a 24-hour, continuous basis. Coverage is available for an unlimited duration. All services must be performed by appropriately qualified personnel, for the nature of service being provided.
- When hospice care is furnished to a member in a nursing facility, the hospice agency must submit a claim for the hospice room and board charges. The hospice agency is responsible for paying the nursing facility for the hospice room and board charges. The hospice room and board rate equals at least 95 percent of the nursing facility per diem rate that would have been paid to the nursing facility under the Medicaid State Plan.
- Hospice services are reimbursed at the lower of the actual charge or the Medicaid rate on file. These rates follow the Medicare-defined urban/rural differential, with the exception of payment for physician services. Medicaid reimbursement for hospice care will be made at one of the following five predetermined rates for each day in which a member receives the respective type, duration and intensity of the services furnished under the care of the hospice agency.

    1. Routine Home Care (RHC) Hospice providers are paid one of two levels of RHC. This two-rate payment methodology will result in a higher RHC rate based on payment for days one (1) through sixty (60) of hospice services care and a lower RHC rate for days sixty-one (61) or later. A minimum of a sixty (60) day gap in hospice services is required to reset the counter which determines the member's payment category.
    2. Continuous Home Care
    3. Inpatient Respite Care
    4. General Inpatient Care
    5. Service Intensity Add-On

    The State does not apply the optional cap limitation on payments.

Section 3 Patient Bill of Rights

Chapter 042A: Patient's Bill of Rights for Palliative Care and Pain Management

(18 V.S.A. § 1871)

a) A patient has the right to be informed of all evidence-based options for care and treatment, including palliative care, in order to make a fully informed patient choice.

b) A patient with a terminal illness has the right to be informed by a clinician of all available options related to terminal care; to be able to request any, all, or none of these options; and to expect and receive supportive care for the specific option or options available.

c) A patient with pain has the right to request or reject the use of any or all treatments in order to relieve his or her pain.

d) A patient with a chronic condition has the right to competent and compassionate medical assistance in managing his or her physical and emotional symptoms.

e) A pediatric patient with a serious or life-limiting illness or condition has the right to receive palliative care while seeking and undergoing potentially curative treatment. (Added 2009, No. 25, § 3; amended 2013, No. 96 (Adj. Sess.), § 95.)

Section 4 Definitions

Attending Physician

A Doctor of Medicine or osteopathy legally authorized to practice medicine and surgery by the State, a nurse practitioner who meets the training, education, and experience requirements as described in 42 CFR § 410.75(b), or a physician assistant who meets the requirements of 42 CFR § 410.74(c) who is identified by the member at the time of election of hospice services as having the most significant role in the determination and delivery of the member's medical care.

Bereavement Counseling

Emotional, psychosocial, and spiritual support and services provided before and after the death of the member to assist with issues related to grief, loss, and adjustment.

Certification Of Terminal Illness

A statement signed by the physician certifying that the member has a medical prognosis with a life expectancy of six months or less if the illness runs its normal course.

Dual-Eligible Member

Dual eligible members are divided into two groups:

- Full benefit duals: These members have both Medicare and Medicaid.
- Partial duals: These members have Medicare and qualify for a Medicare Savings Plan (MSP).

Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)

EPSDT is a federally mandated benefit for all Vermont Medicaid eligible children under age 21. EPSDT services include periodic screenings to identify physical and mental conditions, vision, hearing, dental problems and follow-up diagnostic and treatment services, and assistance with transportation to medical appointments. It requires the state to provide any health care service that is medically necessary, even if the service is not covered for adults. For hospice care this includes coverage of curative care to treat a terminal illness. Services are covered according to Health Care Administrative Rules (HCAR) 4.106.

Election Period

One of three or more periods of care for which a member may elect to receive hospice services. Election periods consist of an initial 90-day period, a subsequent 90-day period, and an unlimited number of subsequent 60-day periods.

Hospice Agency

An entity administering or providing hospice services directly or through a contract arrangement for clients in places of temporary or permanent residence under the direction of an interdisciplinary team composed of at least a nurse, social worker, physician, spiritual counselor, and volunteer.

Hospice Care

A comprehensive, holistic program of care and support for terminally ill patients and their families. Hospice care focuses on comfort care and quality of life instead of care to cure the patient's illness.

Hospice Interdisciplinary Team (IDT)

The interdisciplinary team of professionals who support the physical, medical, psychosocial, emotional, and spiritual needs of both the hospice member and the hospice member's family.

Hospice Provider

A Medicaid enrolled public agency or private organization that is primarily engaged in providing pain relief (palliative care), respite care, symptom management, and supportive services to terminally ill people and their families. Hospice providers must be Medicare-certified and deliver services according to Medicare conditions of participation.

Licensed Professional

A Medicaid enrolled provider licensed to practice medicine within the scope of their profession to provide patient-care services in Vermont.

Levels of Care:

- Continuous Home Care **-** a day when both of these apply:
    - The patient gets hospice care in a home setting that isn't an inpatient facility (hospital, SNF, or hospice inpatient unit) **AND,**
    - The care consists mainly of nursing care on a continuous basis at home.
    - Patients can also get hospice aide, homemaker services, or both on a continuous basis. Hospice patients can get continuous home care only during brief periods of crisis and only as needed to maintain the patient at home.
- Routine Home Care **-** a day the patient elects to get hospice care at home and isn't getting continuous home care. A patient's home might be a home, a skilled nursing facility (SNF), or an assisted living facility. Routine home care is the level of care provided when the patient isn't in crisis.
- Inpatient General Care - a day the patient elects hospice care in an inpatient facility for pain control or acute or chronic symptom management, which can't be managed in other settings.
- Inpatient Respite Care - a day the patient elects to get hospice care in an approved inpatient facility for up to 5 consecutive days to give their caregiver a rest.

Nursing Facility

A facility that meets all criteria and certification requirements.

Terminal Illness

A condition in which the member has a medical prognosis of a life expectancy of six months or less if the illness runs its normal course.

Section 5 Hospice Services

Medicaid follows Medicare Hospice rules unless otherwise noted.

Covered Services

Appropriately qualified personnel must perform all services. The nature of the service determines the coverage category of the service. The following services are covered hospice services:

- Physician services - a physician must perform physicians' services as defined in 42 CFR 410.20(b)(1)(1).
- Nursing care (routinely available and/or on call on a 24-hour basis, 7 days a week) provided by or under the supervision of an RN functioning within a plan of care developed by the hospice Interdisciplinary Team (IDT) in consultation with the members attending physician, if the member has one.
- Medical social services by a qualified social worker under the direction of a physician.
- Counseling including, but not limited to, bereavement, dietary, and spiritual counseling with respect to care of the terminally ill member and adjustment to death. The hospice must make bereavement services available to the family and other members identified in the bereavement plan of care up to 1 year following the death of the member.
- Hospice aide may provide personal care.
- Physical Therapy, Occupational Therapy, and Speech Therapy may be provided for purposes of symptom control or to enable the member to maintain activities of daily living and basic functional skills.
- Medical supplies and appliances - Equipment is provided by the hospice for use in the member's home while the member is under hospice care. Medical supplies include those that are part of the written plan of care and that are for palliation and management of the terminal illness or related conditions.
- Drugs and biologicals - Hospices are to provide all drugs and biologicals for the palliation and management of pain and symptoms of a member's terminal illness and related conditions.
- Other Items and Services - Ambulance transports of a hospice member, which are related to the terminal illness, and which occur after the effective date of election, are the responsibility of the hospice.
- Short term inpatient care (including respite care and interventions necessary for pain control and acute and chronic symptom management) in a Medicare/Medicaid participating facility.
- Routine Home Care is received at the member's home; it is not continuous home care. Routine home care (revenue codes 651 [high rate for 0 – 60 days], [low rate for 61+ days] and 552 [service intensity add-on (SIA) payment for last seven days of life]) is reimbursable to hospice providers for each day the member is under the care of the hospice and not receiving another level of care, whether or not the member is visited in the home by the hospice provider on the days being billed. Revenue code 651 and is reimbursable for days

when no home visit is made, only if the service(s) provided are consistent with the member's plan of care.

- Continuous Home Care consists of continuous, predominately skilled nursing care provided on an hourly basis, for a minimum of eight hours during brief crisis periods. Home health aide and/or homemaker services may also be provided. When fewer than 8 hours of care are required, the services are covered as routine home care rather than continuous home care. Continuous home care is only furnished during brief periods of crisis and covered only as necessary to maintain the terminally ill member at home.
- Respite Care occurs when the member receives care in an approved inpatient facility on a short-term basis to provide relief for family members or others caring for the member. Each episode is limited to no more than five days.
- General Inpatient Care General inpatient care occurs when the member receives general care in an inpatient facility for pain control, or acute/chronic symptom management that cannot be managed in other settings.

Non-Covered Services

When a member is enrolled in hospice, separate payment will not be made, or treatment authorizations approved, for the following:

- Treatment intended to cure terminal illness and/or related conditions.
- Prescription drugs that aren't for terminal illness or related conditions.
- Care from any provider that wasn't set up by the hospice medical team
- Hospital outpatient services (like in an emergency room), care received as a hospital inpatient, or ambulance transportation, unrelated to terminal illness and related conditions, unless the hospice team arranges it.
- Room and board.

More information about Medicare hospice benefits.

Section 6 Periods of Care

Follow Medicare Guidelines for initial and subsequent certifications.

An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the member:

- Remains in the care of a hospice; and
- Does not revoke the election; and
- Is not discharged from the hospice.

Section 7 Eligibility

The member is certified as being terminally ill in accordance with § 418.22. A member is considered to be terminally ill if the medical prognosis is that the member's life expectancy is 6 months or less if the illness runs its normal course. Only a medical doctor, doctor of osteopathy, or naturopathic doctor (Medicaid-only for naturopathic doctor) can certify or re-certify a member as terminally ill. In the event that a member's attending physician is a nurse practitioner, or a physician assistant, the hospice medical director or the nurse practitioner of the hospice Interdisciplinary Group can certify the member as terminally ill.

Face-to-Face Encounter - For recertifications, a hospice physician or hospice nurse practitioner must have a face-to-face encounter (must be co-signed by physician) with each hospice member whose total stay across all hospices is anticipated to reach the 3rd benefit period. The face-to-face encounter must occur prior to, but no more than 30 calendar days prior to, the 3rd benefit period recertification, and every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care.

Section 8 Vermont Hospice and Choices for Care Services

Members currently participating in Vermont's Long-Term Care Medicaid, Choices for Care program who become eligible for, and in need of Home Health and Hospice services may do so without prior authorization from the Department of Aging and Independent Living (DAIL). It is the understanding of both DAIL and the Home Health and Hospice providers that dual participation will occur under the following conditions:

1. Hospice staff will inform the Choices for Care case manager immediately when a Choices for Care member is admitted to hospice.
2. Members must continue to meet the criteria for both Choices for Care and hospice services.
3. Hospice funded services must be maximized and utilized prior to Choices for Care services (e.g. LNA, Homemaker).
4. When appropriate, the Choices for Care case manager will submit a plan of care change to reflect any reduction in waiver personal care time for activities that are being provided by hospice (e.g. bathing, grooming, homemaker). It is the responsibility of the local home health agency to contact DAIL no later than one week after a Choices for Care member is admitted to hospice services.

The Hospice Care Plan must be kept in the case management records for Home and Community Based Choices for Care services.

It is the responsibility of the local home health agency to contact the DAIL no later than one week after a Choices for Care member is admitted to hospice services. DAIL will track the following information:

- Member name,
- Agency name,
- Hospice diagnosis,
- Anticipated length of hospice service,
- Hospice admission date,
- Payment source,
- Hospice contact,
- Copy of Hospice Plan

This information must be mailed, faxed or scanned and emailed to DAIL and Choices for Care case manager. Hospice Admission Form

Section 9 Admission, Revocation, Change in Provider, and Discharge Process

Admission

A Medicare member who resides in a Skilled Nursing Facility or Nursing Facility may elect the hospice benefit if:

- The residential care is paid for by the member; or
- The member is eligible for Medicaid and the facility is being reimbursed for the member's care by Medicaid, and
- The hospice and the facility have a written agreement under which the hospice takes full responsibility for the professional management of the member's hospice care and the facility agrees to provide room and board to the member.

Prior to admission to Hospice services the following 804B form must be completed and submitted to the Department of Vermont Health Access (DVHA).

Hospice Revocation

A member or representative may revoke the election of hospice care at any time in writing; however, a hospice cannot "revoke" a member's election.

Change in Provider

The receiving hospice agency must file a new Notice of Election; however, the benefit period dates are unaffected.

VT Choices for Care & Brain Injury 804 Change Report Form Process

Discharge from Hospice

Discharge from a hospice can occur as a result of one of the following:

- The member decides to revoke the hospice benefit;
- The member transfers to another hospice;
- The member dies;
- The member moves out of the geographic area that the hospice defines in its policies as its service area.

See Medicare Guidelines.

Section 10 Provider Agreement

All Choices for Care providers must:

1. Be authorized by DAIL to provide Choices for Care services;
2. Be enrolled as a Vermont Medicaid provider (see Provider Enrollment section below);
3. Demonstrate compliance with Universal Provider Standards.

Section 11 Provider Enrollment

To comply with Section 6401 of the Affordable Care Act of 2010 (ACA), Vermont Medicaid follows federal provider screening requirements during enrollment, re-enrollment, and revalidation. The Code of Federal Regulations, 42 CFR §§455 Subpart E—Provider Screening and Enrollment, sets forth specific provider and supplier screening, oversight, and reporting requirements. The Centers for Medicare and Medicaid Services (CMS) requirements are available for review at Medicare Enrollment for Providers & Suppliers.

To enroll, re-enroll, or revalidate with Vermont Medicaid, please visit the Medicaid Portal to learn more about enrolling through the online Provider Management Module.

Section 12 Record Requirements

Home Health and Hospice Agencies are expected to follow Medicare guidelines and must maintain records for availability upon request.

A clinical record containing past and current findings is maintained for each hospice member. The clinical record must contain correct clinical information that is available to the members attending physician and hospice staff. The clinical record may be maintained electronically.

To maintain and make available for inspection all medical, case or business records pertaining to the extent of services provided and any other information regarding payments, claimed or received, as they may pertain to the Department of Vermont Health Access programs. Additionally, the provider agrees to furnish these records and the other specified information to the Vermont Agency of Human Services, the U.S. Secretary of Health and Human Services and the Office of the Vermont Attorney General upon request. Such records shall be retained for seven (7) years.

Section 13 Advance Directives

Hospitals, nursing homes, home health agencies, hospices and prepaid health care organizations are required to provide certain members with information about their right to formulate advance directives and maintain written policies and procedures with respect to advance directives. They are also required to document in patients' files whether or not an advance directive is in effect, provide education for staff and the community on issues concerning advance directives, and ensure compliance with State law on advanced directives at their facilities. Providers are responsible for the confidentiality of member information in a manner consistent with the requirements in 45 CFR parts 160 and 164 and as required by state law. The Security Rule

Providers can obtain Advance Directive (AD) forms and additional information on AD from the Vermont Ethics Network website or by mailing your request to:

Vermont Ethics Network
61 Elm Street
Montpelier, Vermont 05602

Section 14 Billing Guidelines and Hospice Notification

For claim instructions and billing guidelines using the UB-04 claim form visit the VT Medicaid website. CMS-1500 and UB-04 Billing Guide

Notification of election of hospice:

a. The admitting facility should send DVHA a completed 804B form to indicate when the Medicaid member elects hospice coverage and to notify DVHA of the admitting facility.

b. When a Medicaid member elects hospice, they could be eligible for Long Term Care (LTC) Medicaid, community Medicaid, or on a waiver. They must notify their LTC worker/eligibility specialist of the hospice election.

c. A hospice election form is completed and signed by the member's physician, the member, and the agency. If the member has Medicare, the facility or home health agency must submit the completed hospice election form to Medicare. Once the hospice form is received by Medicare, the Medicare Eligibility Database is updated to identify the member is on hospice and the period hospice was approved.

d. Medicare sends hospice information to Vermont Medicaid in daily files. If the information is not correctly reported to Medicare, and the wrong provider, incorrect level of care, or incorrect hospice time period is sent to Medicaid, the claims for the member will not pay or will not pay the correct provider.

e. If a member has both Medicare hospice and Medicaid, Medicare will pay the home health agency a monthly all-inclusive rate for the hospice services-including medications. If the member requires care in a nursing home or is on a home and community-based waiver with supports, Medicaid pays for the hospice room and board in the nursing home or respite house.

Please reference the VT Medicaid General Billing and Forms manual for timely filing requirements.

Section 15 Medicaid Hospice & Room and Board Payments

Medicare does not cover room and board for home, nursing home or hospice inpatient facility.

Medicare Hospice Care

Hospice providers submit claims on a UB-04 claim form for services rendered and are reimbursed on a fee-for-service basis utilizing the Hospice Fee Schedule.

Section 16 Patient Share

Long Term Care Medicaid determines if a member is required to pay a monthly patient share amount. The member's LTC worker/eligibility specialist determines the amount based on the member's income, expenses, and allowable monthly deductions depending on where the member is located.

When the 804B form is received by DVHA indicating the hospice election (as indicated above under Admission), DVHA will bill the member or facility for the collection of the monthly patient share due to Medicaid.

Section 17 Copayments

Copays do not apply to members who are in hospice care.

Section 18 Forms

For forms and resources regarding how to report patient admissions, discharges, or changes, visit Forms and Applications.

a. VT Choices for Care & Brain Injury Program 804 Change Report Form and process can be located at the link above. This is for changes in care, settings, or services for members who are on the CFC program. Includes admission to new services or termination of current services.

b. General Inpatient Information

c. Certification Statement

d. Election Statement - make sure the form has the right content as in 20.2.1.1

e. Revocation Statement

f. Change of Hospice

g. Notification of death

h. Choices for Care Participant Admission to Hospice

i. 804B Nursing Home Change of Payment

Section 19 Telehealth

See Section 5.3.52 Telemedicine Services of the General Billing and Forms Manual.

Visit the DVHA Telehealth webpage for further information.

Section 20 Appeals

See Section 4.10 Member Grievance Process and 4.11 Member Internal Appeals & State Fair Hearings on Medicaid Services.

Visit the DVHA Appeals webpage for further information.

Section 21 Special Investigations Unit

Vermont Medicaid pays only for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the code(s) should be chosen that most accurately describes the service that was provided. It is a felony under Vermont law 33VSA Sec. 141(d) knowingly to do, attempt, or aid and abet in any of the following when seeking to receive reimbursement from Vermont Medicaid:

- Billing for services not rendered or more services than actually performed
- Providing and billing for unnecessary services
- Billing for a higher level of services than actually performed
- Charging higher rates for services to Vermont Medicaid than other providers
- Coding billing records to get more reimbursement
- Misrepresenting an unallowable service on bill as another allowable service
- Falsely diagnosing so Vermont Medicaid will pay more for services

For more information on overpayments and potential interest charges, visit the General Provider Manual, section 6. Suspected fraud, waste or abuse should be reported to the DVHA Special Investigations Unit at telephone 802.241.9210, or the Vermont Medicaid Fraud Control Unit of the Vermont's Attorney General's Office, telephone 802.828.5511.