Home Health & Hospice Regulations

Regulation of Home Health & Hospice Care

Anyone involved in healthcare is aware that it is a highly regulated industry. Home health and hospice are no exception. The Federal and State governments have specific standards of care written into law to protect consumers and assure quality care. As a Medicare certified, Joint Commission accredited program, Intermountain Homecare & Hospice must abide by the regulations and standards for these and many other agencies (e.g., Centers for Disease Control [CDC], Office of Inspector General [OIG], State Practice Acts, etc.). Almost everything done, or not done, in home health and hospice are related to a regulation, standard, or identified as best practice.

Joint Commission

The Joint Commission develops and maintains standards of quality that must be followed by an agency in order to be accredited. Joint Commission is not a government agency, and has no legal enforcement power, but offers an accreditation many agencies choose to obtain. Joint Commission accreditation is widely recognized as one of the most important seals of approval in the health care marketplace. Professionals employed by Joint Commission verify quality care and adherence to the standards by conducting Joint Commission surveys. One of the focuses of Joint Commission is patient safety. To address this issue, Joint Commission has identified several National Patient Safety Goals that must be followed to achieve or maintain accreditation.

National Patient Safety Goals for Homecare
(*file://co.ihc.com/root/HC/Dept/Education/Orientation%20Documents/Clinical%20Orientation/Clinical%20Handbook%20&%20%20Workbooks/2020/Regulation%20of%20Home%20Health%20&%20Hospice%20Care*)

Funding Sources

There are several funding sources a patient may utilize to fund home health or hospice services:

- Medicare
- Medicaid
- Commercial Insurance
- Private Pay
- Special Financial Consideration

Medicare

Medicare is a federally funded insurance program for people age 65 or older. In addition, it also provides health care coverage to certain people with disabilities who are under age 65. Medicare is the single largest payer for home health and hospice services. There are two types of Medicare, Traditional Medicare and Medicare Advantage Plans.

Medicare consists of several parts. Medicare "Part A" has no additional premium and includes hospital Insurance which pays for care in a hospital, skilled nursing facility, home health care, and Hospice care. Medicare "Part B" requires an additional premium and pays for doctors, outpatient hospital care, home medical equipment, and other medical services. Medicare "Part D" pays for medications and can be added to Traditional Medicare or Medicare Advantage Plans with an additional premium.

Medicare Advantage Plans (Part C) are offered by private companies approved by Medicare and include the same coverage as Traditional Medicare (Part A and B) as well as additional coverage. The additional benefits usually include things such as vision and hearing services, health screening tests and nurse helplines. Medicare Advantage Plans may or may not have an additional monthly premium, usually have low co-pays, and include an annual out-of-pocket maximum. Some Medicare HMOs in our area include: Select Health Medicare Advantage Plan, AARP, TriCare, etc.

Medicare consists of several parts.

All Medicare plans have strict eligibility and reimbursement criteria that must be met. Patients must be eligible for Medicare "Part A" in order to have home health or hospice coverage through Medicare.

Medicare certification is required for agencies to receive payment for home health or hospice care provided to Medicare and Medicaid patients. In order to be Medicare certified, the agency must follow the Medicare Conditions of Participation (CoP) for all patients, not just Medicare or Medicaid patients. There are separate CoPs for Home Health and Hospice, each with different requirements. Agencies are surveyed individually to determine whether and how each standard in the CoP is met. While an agency may be found non-compliant with one or more of the subsidiary standards during any given survey, the agency cannot be found non-compliant with a Condition of Participation. An agency cannot participate in providing care for Medicare patients unless it meets every COP or attains substantial compliance with the requirements.

Medicaid

Medicaid is a state and federally funded insurance for those who meet eligibility requirements. It is available through the State for people with low income or people who cannot afford the cost of healthcare.

Medicaid regulations are found in the State Administrative Rules. Most of the regulations are similar to Medicare. When differences in regulations exist, we must follow the higher standard or more stringent regulation.

Hospice care is a benefit through Medicaid and can be accessed when eligibility and reimbursement criteria are met. Medicaid does require prior authorization for hospice services with the initiation of

services and whenever there is a change in the level of care or admission to a nursing facility. The signed election statement and the physician certification statement must be received within 10 days of admission.

Medicaid requires all Home Health services beyond the initial admit visit to be pre-authorized. The prior authorization process for Home Health requires a complete Plan of Care and assessment note to be submitted to Medicaid. Medicaid must receive all required documentation within 10 days of admission. Admission documentation must be completed in a timely manner. A limited amount of supplies may be provided to the patient on the first visit only. All other supplies are to be provided by a Home Medical Equipment company.

Changes to the original Plan of Care must also be coordinated with the Central Pre-Authorization Team to process requests for payment of additional services.

Medicaid requires that an admission to Home Health must be completed by an RN, even when therapy services are the only skill ordered by a physician.

Commercial Insurance

Many people have insurance through a privately-owned company, often provided through their employer. Most insurance policies pay for home health or hospice services, but not all. Different insurances also provide different coverage and have different eligibility and reimbursement criteria.

Commercial insurance policies will often pay for both skilled and personal care services to be provided by home health. All home health services need to be pre-authorized. The pre-authorization process requires a complete Plan of Care and assessment note to be submitted in a timely manner (within 24-72 hours of admission). Changes to the original Plan of Care must be coordinated with the Central Pre-Authorization Team to process requests for payment of additional services.

Private Pay

Some patients who do not have insurance and do not qualify for Medicaid or Medicare may choose to pay for home health or hospice services independently. This means they will pay out of pocket for the Home Health or Hospice care received.

Special Financial Consideration

For patients who are unable to afford needed healthcare, Home Health or Hospice services may be covered through a financial assistance program offered by Intermountain Homecare & Hospice.

Patients must apply for this program in order to be considered to receive financial assistance.

Payment

Medicare, Medicaid, and most commercial insurances reimburse for hospice services based on a per-diem rate. This means the hospice receives payment for each day the patient is on service.

Adjustments to the rate are made based on the level of care the patient requires. Hospice must provide all services necessary (nursing, social work, medications, supplies, etc.) to treat the symptoms associated with the terminal diagnosis. Occasionally, insurance may pay for services on a fee for service

basis, meaning each service (each nursing visit, medication, etc.) is paid for individually. If a patient is going to pay privately for hospice services, they are charged the Medicare hospice per-diem charge. No patient will be refused hospice care based solely on ability to pay.

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Medicare pays for home health services using a Patient-Driven Groupings Model (PDGM). This model uses 30-day periods as a basis for payment. Thirty-day periods are categorized into 432 case mix groups for the purposes of adjusting payment in the PDGM. In particular, 30-day periods are placed into different subgroups for each of the following broad categories:

- **Admission source (two subgroups):** community of institutional admission source
- **Timing of the 30-day period (two subgroups):** early or late
- **Clinical Grouping (twelve subgroups):** musculoskeletal rehabilitation; neuro/stroke rehabilitation; wounds; medication management, teaching, and assessment (MMTA) surgical aftercare; MMTA – cardiac and circulatory; MMTA – endocrine; MMTA – gastrointestinal tract and genitourinary system; MMTA – infectious disease, neoplasms, and blood-forming disease; MMTA – respiratory, MMTA – other; behavioral health; or complex nursing interventions
- **Functional impairment level (three subgroups):** low medium, or high
- **Comorbidity adjustment (three subgroups):** none, low, or high based on secondary diagnoses.

Eligibility

Certain criteria must be met for patient's to be eligible for home health and hospice services. Eligibility is initially determined when a patient is admitted for services. Ongoing eligibility must be maintained to continue receiving services. Home health services must be re-evaluated, and the plan of care updated every 60 days. Hospice services are re-evaluated, and the plan of care updated initially at 90 days, then again in 90 days, and then every 60 days thereafter.

Home Health Eligibility

Different payer sources for Home Health have different qualifying conditions, services and treatments. You do not have to be an expert at all insurances, but you do need to know the basics to be successful in developing a patient plan of care.

Under Medicare, home health is a benefit that provides skilled care for those experiencing an acute episode of illness. The following conditions must be met for Medicare to cover Home Health Services:

- Patient is an eligible Medicare beneficiary
- Care is ordered by a physician

- Care is reasonable and necessary for the treatment of the illness or injury
- Patient is homebound
- Patient requires a skilled service
- Is no longer receiving curative treatment. (Exception: Pediatric continuous care patients may receive both curative and hospice services at the same time.)
- Medicaid requires a face to face encounter with a physician or nurse practitioner
- Safe home environment

The Hospice Benefit Election

To receive hospice services, patients must elect the hospice benefit. Medicare patients can elect the Medicare Hospice Benefit, an entitlement program under Part A. Medicaid patients may also elect the hospice benefit.

To elect the hospice benefit, a patient must complete an election statement that is filed with the Hospice agency.

By signing the Notice of Election form, the patient/representative acknowledges the following:

- That they have been given a full understanding of hospice care.
- That they understand certain Medicare/Medicaid services are waived by the election.
- That the patient/representative may revoke the election of the hospice benefit at any time.

The form must also include the name of the patient's attending physician, for whom payment for services may continue. The form must be submitted to Medicare within 5 days of signing. For every day the form is late, payment is denied.

To receive hospice services, patients must elect the hospice benefit.

While on the hospice benefit, the patient waives all rights to Medicare Part A and Part B benefits for the following services:

- Hospice care provided by a Hospice other than the designated Hospice (unless provided under contractual arrangement).
- Any services needed to diagnose, treat, or manage the **terminal condition**, except those provided by the designated Hospice (either directly or under arrangement).
- Physician services related to the **terminal illness** except those provided by the Attending Physician, the Hospice Physician or by a Consulting Physician (with a contractual arrangement) at the request of Hospice.

Treatment of conditions not related to the terminal illness will be eligible for coverage under the regular Medicare benefit.

The election to receive hospice care remains effective as long as the care is continuous. The care is considered continuous unless the patient revokes the hospice benefit or is discharged from Hospice and discontinues hospice care.

Care Ordered by a Physician

All ordered services for home health must come from a physician, defined as an MD, DO, or Podiatrist. An oral surgeon is acceptable only if the plan of care relates to that service being provided. Home Health cannot practice under the order of a Nurse Practitioner (NP) or a Physician Assistant (PA).

All ordered services for hospice must come from a Doctor of Medicine or osteopathy or a nurse practitioner.

The orders on the plan of care (POC) must specify the type of professional to provide services, frequency of the services, and types of individual services to be provided to the patient.

The physician is ultimately responsible for and directs care for the patient. Regarding doctor's orders the rules are simple:

- Know what the doctor's orders are for your patient.
- If it is ordered, you do it.
- Everything we have an order for is to be done and everything we do is to be covered by a doctor's order.
- If you don't follow an order, make it clear in your documentation why it wasn't appropriate or necessary to follow the order.
- Notify physician if the order was not followed.
- There are no standing orders in home health or hospice.
- Doctor's orders must be obtained prior to performing an intervention or treatment. It is not acceptable to "get the order later." This is practicing outside of your scope of practice.

Care is Reasonable & Necessary

Clinical evidence is required to show that Home Health services are reasonable and necessary. Medical necessity must be documented in the medical record and in the plan of care including:

- Medical condition
- Functional losses
- Treatment goals

- Patient's progress or lack of progress toward goals

Therapy services must be reasonable and necessary for the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the illness or injury.

Hospice care must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions.

Homebound

A patient is considered homebound if the following two criteria are met:

1. The patient must either:
    a. Because of illness or injury, need the aid of supportive devices (e.g., crutches, cane, walker, wheelchair, etc.) or the assistance of another person to leave their place of residence
    b. Have a condition such that leaving the home is medically contraindicated
2. There must exist a normal inability to leave home and leaving home must require a considerable and taxing effort.
    a. If the patient does leave home, it should be infrequent, for short periods of time, or to receive health care (e.g., kidney dialysis, chemotherapy or radiation).

Homebound status must be documented at every Home Health visit. Homebound documentation should be:

- Updated as the patient's condition changes
- Supported by diagnosis, symptoms, and/or medical condition
- Consistent in all discipline notes
- Stated in clear, concise, specific, and measurable terms

A patient would not be homebound if he:

- Leaves home frequently for non-medical reasons
- Drives a car
- Leaves the home against medical advice
- Leaves the home for business purposes or to attend school

A patient may leave home to attend church or a hairdresser appointment and still be considered homebound.

Pediatric patients can be considered homebound in the following situations:

- Leaving home is medically contraindicated

- Leaving home would require considerable and taxing effort
- Home ventilator dependence or the inability to ambulate with portable oxygen
- Immunocompromised patient who cannot be in public places due to risk of infection

Hospice patients do not need to be homebound to qualify for Medicare hospice benefits. Rather, people are encouraged to be as active as their condition allows. It is not uncommon for hospice patients to go on short trips to complete unfinished business while remaining on the hospice benefit.

Skilled Services

Skilled services are provided by registered nurses and rehab therapists (physical therapist, occupational therapist, and speech language pathologist). A therapy assistant can provide care under the supervision of a licensed therapist. A service is unskilled if the average non-medical person, without special training and supervision, can safely and effectively perform the service. Unskilled services do not become skilled when performed by a nurse or therapist. A skilled service that is taught by a nurse or therapist to be performed by a patient or caregiver is considered skilled.

Therapy services are considered skilled when they require the specialized skills, knowledge, and judgment of a qualified therapist to ensure the effectiveness of the treatment goals and ensure medical safety, or if they are needed to manage and periodically reevaluate the appropriateness of a maintenance program. More detailed information on individual therapy coverage requirements can be found in the Medicare Benefit Policy Manual: Chapter 7- Home Health Services.

A primary skilled service provider must oversee the care planning of patient services. The following are acceptable primary skilled service providers:

- Registered Nurse
- Physical Therapist
- Speech Language Pathologist
- Occupational Therapists may continue as a primary skilled service provider after service is established by one of the other three service providers. Occupational Therapists may not initiate a Plan of Care.

Nursing

Nursing skilled services are categorized into four major areas[1] :

- Observation and assessment
- Management and evaluation of a patient's care plan
- Teaching and training activities (Medicaid will only authorize up to a maximum of 4 teaching visits in a 60-day time period.)
- Performance of skilled treatments and procedures
    - Administration of medications

- Tube feedings
- Catheter care
- Nasopharyngeal and tracheostomy aspiration
- Wound care
- Ostomy care
- Heat treatments
- Medical Gases

- Rehabilitation nursing
  - Venipuncture (Not a stand-alone skill)

Physical Therapy

Skilled physical therapy services may include the following:

- Assessment
- Therapeutic Exercises
- Gait Training
- Range of Motion
- Maintenance Therapy
- Ultrasound, Shortwave, and Microwave Diathermy Treatments
- Hot Packs, Infra-Red Treatments, Paraffin Baths and Whirlpool Baths
- Wound Care Provided Within Scope

[1] Resource: Medicare Benefit Policy manual: Chapter 7- Home Health Services
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf

Speech-Language Pathologist

Speech-Language Pathologist services are not covered in Home Health by Utah Medicaid. Covered Medicare services may include:

- Assessment
- Speech/voice production
- Communication or feeding activities
- Voice-language communication tasks and cueing
- Maintenance program
- Speech and language rehabilitation for aphasia

- Control of vocal and respiratory systems for correct voice production with voice disorders

Occupational Therapy

Occupational Therapy services are not covered in Home Health by Utah Medicaid. Covered Medicare services may include:

- Assessment
- Planning, Implementing, and Supervision of Therapeutic Programs
- Selecting and Teaching Task Oriented Therapeutic Activities Designed to Restore Physical Function.
- Restore Sensory-Integrative Function
- Planning, Implementing, and Supervising of Individualized Therapeutic Activity Programs as Part of an Overall "Active Treatment" Program for a Patient with a Diagnosed Psychiatric Illness
- Teaching Compensatory Techniques to Improve the Level of Independence in the Activities of Daily Living
- Vocational and Prevocational Assessment and Training

Dependent services can only be provided under the home health benefit if the beneficiary is receiving a Medicare covered skilled service and requires the dependent services to facilitate the treatment of the illness or injury. Types of dependent services include:

- Medical Social Services
- Home Health Aide
- Registered Dietician

Home Health Aide Services

The reason for the visits by the home health aide must be to provide hands-on personal care of the patient or services needed to maintain the patient's health or to facilitate treatment of the patient's illness or injury.

Services may include:

- Personal Care: bathing, dressing, grooming, caring for hair, nail, and oral hygiene which are needed to facilitate treatment or to prevent deterioration of the patient's health, changing the bed linens of an incontinent patient, shaving, deodorant application, skin care with lotions and/or powder, foot care, and ear care; and feeding, assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the patient's condition, routine catheter care and routine colostomy care), assistance with ambulation, changing position in bed, assistance with transfers.
- Simple Dressing Changes
- Assistance with Medications
- Assistance with Activities to Support Skilled Therapy
- Incidental services

Medical Social Services

The following criteria are required to qualify for medical social services:

- Necessary to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the patient's medical condition or rate of recovery
- The plan of care must indicate how the services which are required necessitate the skills of a qualified social worker

Services which may be covered include:

- Assessment--social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care; relationship of the patient's medical and nursing requirements to the patient's home situation, financial resources and availability of community resources
- Action to obtain available community resources to assist in resolving the patient's problem
- Counseling services
- Medical social services furnished to the patient's family member or caregiver on a short-term basis (additional limitations apply)

Therapy Assessments

For each therapy discipline for which services are provided, a qualified therapist (instead of a therapy assistant) must assess the patient's function. The assessment must be made using a method which objectively measures activities of daily living such as, but not limited to, eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental cognitive factors. The measurement results must be documented in the clinical record.

Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must functionally assess the patient.

For each therapy discipline for which services are provided, a qualified therapist (instead of a therapy assistant) must provide services at least once every 30 days. This includes performing the ordered therapy service, functionally reassessing the patient, and comparing the resultant measurements to prior assessment measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of the therapy, or lack thereof. The 30-day clock begins with the first therapy service of that discipline, and the clock resets with each therapist's visit/assessment/measurement/ documentation of that same discipline. Results of therapy benefit or efficacy must be documented every 30 days.

Social Work & Chaplain Hospice Assessments

With each hospice admission a comprehensive assessment is required including physical, psychosocial, and spiritual assessments. A social worker and a chaplain must each perform a comprehensive assessment no later than 5 days after each admission. These assessments must be updated at least every 15 days.

Nursing Skilled Services must be Intermittent

Intermittent skilled care is a medically predictable recurring need for skilled services that is provided fewer than seven days each week, or fewer than eight hours each day, for periods of 21 days or less.

For Medicare, in an exceptional circumstance, if skilled care is provided seven days each week and is needed beyond 21 days, a finite and predictable endpoint to the daily skilled care is needed. An exceptional circumstance is daily insulin injections where the patient is mentally or physically incapable of self-injection and who has no willing or able caregiver available.

Usually the beneficiary requires skilled services at least once every 60 days. Certain situations may require the services only every 60 – 90 days.

For Medicare, usually one-time nursing visits will not meet intermittent criteria. If a patient is admitted for skilled therapy services and the therapy service qualifies the patient for the home health benefit, a one-time skilled nursing visit would be payable. Front-loading visits is preferred by Medicare and is proven to reduce Emergency Department visits and readmission rates.

Safe Environment

The patient must have a safe and adequate living environment, sufficient care providers, and other needed resources necessary for the provision of care. Home health care is provided to patients at their place of residence and is not generally covered for patients in a hospital or skilled nursing facility. Hospice care is provided to patients at any location (home, skilled nursing facility, or hospital with some limitations). The patient must have an appropriate caregiver available if they are unable to care for themselves. Patients are not required to have a 24-hour caregiver in the home as long as the patient is safe alone and continues to be safe. However, with hospice and the progression of the terminal illness, patients usually require a 24-hour caregiver. It is the role of the social worker and the hospice team to identify an alternative plan that can be quickly implemented when the patient reaches the point where he/she is no longer safe to be alone. To prevent a crisis, this plan for around-the-clock caregiving should be developed within the first couple of days after hospice admission, even if it will not need to be implemented for a long time.

Determining Terminal Illness

At the start of hospice care and for each recertification for hospice services, the patient must be evaluated for eligibility and the diagnosis of a terminal illness. As stated earlier, a terminal illness means that the individual has a medical prognosis of 6 months or less if the illness runs its normal course based upon the physician's judgment.

All Medicare Hospice claims are processed through a Medicare Administrative Contractor (MAC). The MAC that processes Utah claims is CGS Administrators, National Government Services (NGS) process claims for Idaho. Each MAC has a set of guidelines that is used in reviewing hospice claims and can be used by hospice providers as a guide to determine eligibility of patients for hospice services.

These guidelines are called Local Coverage Determinations (LCDs) for Hospice - Determining Terminal Status and should be used to help determine eligibility for hospice services both at the initial start of care and for each recertification. Please read and familiarize yourself with these guidelines. A summary of these guidelines is available in the help cards.

Lippincott – LCD Helpcard

The above guidelines refer to several assessment tools used to help determine prognosis; the Karnofsky Performance Status (KPS) or Palliative Performance Scale (PPS), the Functional Assessment Staging (FAST), and the New York Heart Association (NYHA) Functional Classification. The PPS is used for all hospice patients and should be assessed and documented on admission, recertification, and with changes in patient function. The FAST is used for dementia patients and should be assessed and documented on admission, recertification, and with changes in patient function. The NYHA Functional Classification is used for patients with heart disease and should be assessed and documented on admission, recertification, and with any changes to condition. These tools are included in the hospice SN assessment forms and are available in the help cards.

Physician Certification

Home Health Face to Face

The physician must document that he, or an allowed non-physician practitioner (NPP), has had a face-to-face encounter with the patient. The face-to-face encounter must occur within the 90 days prior to the start of home health care, or within the 30 days after the start of care and be related to the primary reason the patient required home health services.

The documentation must include the date when the physician or allowed NPP saw the patient, and support the patient's homebound status, need for skilled services, and reason for being admitted to Home Health.

Home Health Physician Recertification

At the time of each recertification, for all Medicare Home Health patients, the physician must recertify that there is a continuing need for Home Health services. The physician must include an estimate of how long Home Health skilled services will be required.

Hospice Certification of Terminal Illness

For the first 90-day hospice benefit period, both the patient's Attending Physician and the Hospice Physician must certify in writing that, the patient has a terminal illness with a prognosis of 6 months or less, if the disease were to run its normal course. The Attending Physician who signs the certification must be a Doctor of Medicine or osteopathy or a nurse practitioner and is identified by the patient at the time he or she elects the hospice benefit.

The Certification of Terminal Illness must be received from both physicians; either verbally or in writing, no more than 15 calendar days prior to the start of care and within 2 calendar days after hospice care is initiated. If verbal certification is given, the written Certification of Terminal Illness must be received prior to billing for hospice care. The written Certification of Terminal Illness is created by the admitting

nurse with the date that the verbal certification was received. If these requirements are not met, Medicare will not pay for any days prior to when the Certification of Terminal Illness is received.

For subsequent hospice benefit periods only the Hospice Physician must certify the patient has a terminal illness with a prognosis of 6 months or less, if the disease were to run its normal course. The certification can be either written or verbal and must be received no more than 15 calendar days prior to the start of the new benefit period and no later than 2 calendar days after the 1st day of the new benefit period. A signed Certification of Terminal Illness must be received prior to billing for hospice care.

For the initial and each subsequent certification, the Hospice Physician must write a narrative indicating why he/she believes the patient has a terminal illness.

Hospice Face to Face Medicare

The Hospice Physician must have a face-to-face visit with each hospice patient anticipated to reach the 3rd benefit period. The face-to-face must occur no more than 30 calendar days prior to the 3rd benefit period recertification. Subsequent face-to-face visits must occur for every recertification thereafter and must be no more than 30 calendar days prior to the recertification. The face-to-face visit is meant to gather clinical findings to determine continued eligibility for hospice care. The findings should be included in the Hospice Physician's written narrative.

Hospice Face to Face Medicaid

For patient's receiving hospice services under Medicaid, a physician or nurse practitioner must perform a face-to-face qualifying visit to certify a terminal condition within the 90 days prior to the start of hospice care.

"Terminally ill", according to Medicare, means that the individual has a medical prognosis of 6 months or less if the illness runs its normal course based upon the physician's judgment.

Independent Physician Review for Extended Care for Medicaid

Medicaid hospice patients receiving care for 12 or more consecutive months must have an independent utilization review performed every 12 months. A physician who is not employed by hospice must complete the "Independent Physician Review for Extended Care" form within 45 days before the end of the current 12-month period. The review must include sufficient evidence that the patient continues to meet eligibility criteria. This form should be requested and obtained by nurses or social workers.

Obtain the Independent Physician Review form your office manager.

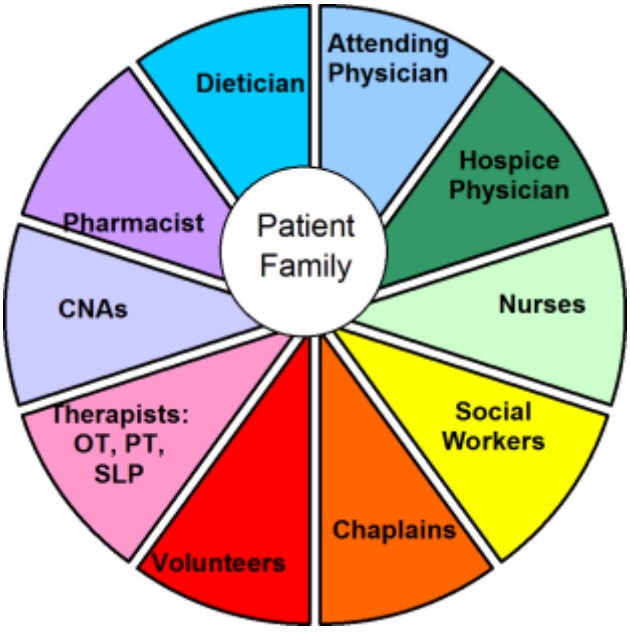
Hospice Services

A set of core services must be provided by Hospice employees. These services include nursing services, medical social services provided by social workers, and counseling services (spiritual, dietary, and bereavement counseling). Other services that must be provided by the Hospice include physician services, continuous home care, respite care, bereavement counseling, special modalities, and volunteer services. These services are explained in more detail throughout this module.

Covered Services

The Hospice Interdisciplinary Team consists of:

- Patient/Family



- Patient's Personal Physician (Attending)
- Hospice Physician – must be available 24 hours/day
- Nurses- must be available 24 hours/day
- Certified Nursing Assistants (CNAs)
- Social Workers
- Chaplains
- Trained Volunteers- volunteers may be used in administrative or direct patient care roles. All volunteers receive at least 12 hours of training.
- Pharmacist
- Dietician (if needed for dietary counseling)
- Speech, Physical, and Occupational Therapists (if needed)- provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills

The major responsibilities of the Hospice Interdisciplinary Team include:

- Providing professional management of the Hospice patient in accordance with the Plan of Care in all care settings.
- Assuring continuity of patient/family care in the home, outpatient, and inpatient settings.

- Managing the patient's pain and symptoms.
- Assisting the patient with emotional, psychosocial, and spiritual aspects of dying.
- Providing medications, medical supplies, and equipment (needed for comfort and management of the terminal illness). Medications must be available 24 hours/day.
- Coaching the family on how to care for the patient.
- Providing special services like speech and physical therapy when needed.
- Making short-term inpatient care available when pain or symptoms become too difficult to manage at home or the caregiver needs respite (see Inpatient Respite and General Inpatient Care).
- Providing bereavement care and counseling to surviving family and friends. The Intermountain Homecare & Hospice Bereavement Program includes mailed written materials regarding grief and bereavement, ongoing contact with caregivers to foster normal grief and bereavement, and limited grief support groups or referral to support groups if necessary.

Other special modalities or services that are provided by hospice include items outlined in the plan of care as necessary for the palliation and management of the terminal illness and related conditions. This may include tests or procedures approved in advance by the Hospice Team for a specific symptom related treatment such as: chemotherapy, radiation therapy, transportation to an inpatient facility, etc.

Intermountain Homecare & Hospice has a specific process when there is a request for services not currently on the plan of care. This process will identify which non-routine hospice services will be included in the hospice plan of care and will thus be paid for by Hospice.

Non-Covered Services

Services not included in the hospice plan of care will not be paid for by Hospice. Hospice will not cover the following services:

- Treatment intended to cure the terminal illness-Hospice provides comfort care to help manage symptoms related to the terminal illness but won't pay for treatment to cure the illness.
- Medications not related to the terminal diagnosis-Only medications for symptom control and pain relief related to the terminal diagnosis are covered. The hospice interdisciplinary team will determine which medications will and will not be covered.
- Care from another provider that is the same care Hospice provides-All care provided for the terminal illness must be given by the Hospice. Payment will not be given for similar services received from another provider or another Hospice.
- Nursing home room and board-Patients may receive hospice services wherever they live, including nursing homes, but the room and board charges are not covered by Medicare or Hospice for routine care. Medicaid **does** pay for room and board for eligible patients and reimbursement is coordinated through hospice to the facility.

Physician Services

Hospice Physician Administrative Activities

The Hospice Physician assumes the overall responsibility for the medical component of the Hospice's patient care program. The Hospice physician is responsible for participating in the establishment, review and updating of plans of care, face-to-face visits, supervising care and services, and establishing governing policies.

Hospice Physician Professional Services

The Hospice Physician may provide direct patient care services i.e., home visits to the patient. Direct patient care services provided by the Hospice Physician may be billed by Hospice, as a separate charge to Medicare, and are not part of the hospice per diem reimbursement. Only the professional services provided to the patient may be billed to Medicare. The technical components of the visit (i.e. lab services, x-rays, etc.) are not billable to Medicare and are paid for by Hospice. Face-to-face visits are considered an administrative function and are not billable unless medically reasonable and necessary care related to the hospice terminal diagnosis was also provided during the visit.

Independent Attending Physician Services

Patient care services provided by an independent Attending Physician (a physician who is not employed by or under contract with the Hospice) are not part of the hospice per diem reimbursement and are the only physician services that can be billed to Medicare Part B directly. The technical components of the visit (i.e. lab services, x-rays, etc.) are not billable to Medicare and are paid for by Hospice if they are approved by Hospice and included in the hospice plan of care (or paid for by the family if not approved).

Consulting Physician Services

The Hospice may refer the patient to a Consulting Physician as part of the hospice plan of care for help in the palliation or management of the terminal illness or related conditions. The physician bills Hospice for these services.

If Hospice has a contract with the Consulting Physician, these charges may be billed to Medicare Part A on the hospice bill. If Hospice does not have a contract with the Consulting Physician, Hospice is responsible to pay for these services.

Only the professional services provided to the patient may be billed to Medicare by the Hospice. The technical components of the visit (i.e. lab services, x-rays, etc.) are not billable to Medicare and are paid for by Hospice if they are approved by Hospice and included in the hospice plan of care (or paid for by the family if not approved).

Services provided by any physician, other than the Attending Physician, that are NOT included as part of the hospice plan of care, are not billable to Medicare or to Hospice and become the responsibility of the patient.

Hospice retains the responsibility for the overall management of the Hospice patient, even when they are referred to a Consulting Physician. The Nurse Case Manager is responsible to ensure that the Hospice Team approves proposed interventions and that the physician's office is aware of how they should bill for the patient's visit or care.

Professional Management

Hospice is responsible for the overall professional management of the patient's terminal illness and the provision of hospice services. Hospice is responsible to ensure services are furnished in a safe and effective manner, in accordance with the hospice plan of care, regardless of their location (home, outpatient, or inpatient facility). Hospice retains responsibility for patient/family assessment, interdisciplinary care conferences, and continuity of patient/family care, regardless of the setting.

Services provided by individuals or entities on behalf of Intermountain Homecare & Hospice must operate under a written agreement or contract. The contract must clearly stipulate that services may be provided only with the express authorization of the Hospice. Exceptions to this arrangement should be discussed with the Hospice Manager.

Hospice Item Set (HIS)

The Hospice Item Set (HIS) includes specific information that is pulled from individual patient assessments and sent to the Centers for Medicare & Medicaid Services (CMS). The information is then used to compare the quality of care provided by different Hospice agencies. If an agency does not submit the HIS for each patient on admission and discharge, the agency is given a deduction in payment the following year.

Hospice Levels of Care

The Medicare and Medicaid hospice benefit include four different levels of care. Commercial health insurances vary in their benefits and may or may not include more than one level of care. The needs of the patient/family determine the level of care. Patients are evaluated on an ongoing basis to determine if a higher level of care is appropriate.

The four levels of care are:

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

Following is a description of each level of care with the required criteria.

Routine Care

Most hospice care is "routine" care and is provided in the patient's home or permanent residence, in accordance with the patient's needs.

General Inpatient Care

General Inpatient Care (GIP) is available for pain control or symptom management that cannot be provided in any other setting. General Inpatient Care may be provided in a hospital or skilled nursing

facility with 24-hour/day nursing care. The facility must have a contract with Hospice to provide General Inpatient Care. General Inpatient Care is also appropriate for "imminent death" if the patient has symptoms that require management, (Continuous Home Care should also be considered). Once the pain is managed or symptoms stabilized, the patient must return to a routine level of care.

Respite Care

Inpatient Respite Care is provided to the patient when necessary to relieve the family members or other persons caring for the individual at home. Respite care does not require a worsening of the patient's condition. Inpatient Respite Care is not available for patients that are residents of long-term care or nursing facilities. Respite care is short term inpatient care limited to no more than five consecutive days at a time. This care is provided on an occasional basis. Respite Care may be provided in a hospital or skilled nursing facility as long as nursing services are available to meet the patient's needs. The facility must have a contract with the Hospice to provide Inpatient Respite Care.

Continuous Home Care

Continuous home care is to be provided during periods of crisis to maintain the patient at home. A period of crisis is a period of time when the patient requires continuous care for at least 8 hours in a 24-hour period (midnight to midnight) to achieve palliation or management of acute medical symptoms.

The care does not have to be "continuous" to qualify but must total eight hours or more of care within the 24-hour period. The care can be provided by a Nurse Practitioner, RN, LPN or Certified Nurse Assistant (CNA). However, a nurse must provide at least 50 percent of the total care provided.

All nursing and CNA services provided must be counted into the continuous care time. A hospice cannot choose to count fewer CNA hours than were provided in order to get the percentage of nurse hours up to 50 percent. Time spent doing documentation, modification of the plan of care, and supervision of aides does NOT count as part of the continuous care hours.

Assisted Living Facilities

Hospice services may be provided to residents of both type I and type II assisted living facilities. A written agreement or formal contract is not required.

Residents of type I assisted living facilities are required to be ambulatory, minimally dependent on staff for assistance with ADLs, in stable health, and able to take life-saving action in an emergency. The type I facility staff may only assist residents who self-medicate by providing reminders, opening child-proof caps, and opening unit-dosed packages.

Residents of type II assisted living facilities are either independent or semi-dependent and must be able to take life-saving action in an emergency with the assistance of one person. The type II facility staff may supervise medication administration.

Hospice patients are allowed to stay in their home to die, including an assisted living facility. The Hospice should obtain a copy of the Facility's "Service Plan" for the patient and should provide copies of the hospice plan of care to the Facility. The two plans should be reviewed to ensure that they are not in conflict.

When a patient is no longer able to get out of bed without assistance, a caregiver for the patient may be required. The Hospice staff and Facility staff must work together to coordinate caregiver coverage.

Assisted living facilities are required to obtain a variance from the 1) Department of Health, Bureau or Licensure, and 2) local Fire Marshall when the patient can no longer get out of the building in an emergency with the assistance of one person.

Patient Revocation of the Hospice Benefit

A patient or representative may revoke the hospice benefit at any time, for any reason. Hospice may not ask patients to revoke the hospice benefit. A patient's Medicare benefits are reinstated at the time the patient revokes the hospice benefit. A revocation form must be completed and must contain the date the revocation is effective and the reason for revocation. A revocation cannot be made for an earlier date than when the form is signed.

When a Medicare or Medicaid hospice patient revokes the hospice benefit, they lose any remaining days in that benefit period. The patient can re-elect the hospice benefit at any time, provided they meet the eligibility requirements. A new hospice benefit period (BP) is started at the time of re-election.

Patient Discharge by Home Health or Hospice

Home health or hospice may choose to withdraw services if the following apply:

- The agency has inadequate personnel, equipment, and resources available to provide services required.
- Patient or significant other is unable or unwilling to be compliant with the plan of care.
- The patient has an unsafe home environment.
- There is a perceived personal risk to the employee.

Home health and hospice must also discharge (or transfer) a patient that moves out of the service area.

Hospice must discharge a patient if it determines that the patient is no longer terminally ill, as defined by a prognosis of 6 months or less. The term for this type of discharge is decertification. Alternative placement of the patient (e.g., nursing facility) should be evaluated before discharging the patient and the Manager and Hospice Physician must be involved in the decision to withdraw services for one of the above reasons.

A patient's traditional Medicare or other regular medical benefits are reinstated at the time the patient is discharged from Hospice. When a Hospice patient is discharged, they lose any remaining days in that hospice benefit period. (This regulation had an impact years ago when there were limited hospice benefit periods. The only impact now is that the patient may move from the two 90-day benefit periods to 60-day periods quicker.) The patient may re-elect the hospice benefit at any time he/she is eligible and will start in the next benefit period.

Patient Transfer to another Hospice Agency

A patient may change Hospice providers once in each benefit period. To change Hospice providers, the patient or representative must file a signed statement with both the current Hospice provider and the newly designated Hospice which includes the following information: the name of the current Hospice provider, the name of the Hospice from which they wish to receive care and the date the change is to be effective.

The date of transfer should be agreed upon in advance by the patient/family and is a billable day by both Hospices if they both provide care to the patient on that day. The patient continues in the same hospice benefit period with the same dates for the benefit period. No days are lost from the benefit period.

Resources

There are many regulations that home health and hospice must follow in providing care to patients. Appendix A includes links for several Quick Resource Tables and a summary and comparison table of Home Health and Hospice Requirements and Coverage by Payor.

Intermountain Homecare & Hospice has incorporated these regulations into policies and processes. It is important that the policies are followed. Be sure you understand the policies well enough to incorporate the information into practice.

Intermountain Homecare & Hospice has memberships for both NHPCO (National Hospice and Palliative Care Organization) and UHPCO (Utah Hospice and Palliative Care Organization). These organizations have many resources that can be accessed by any of our employees or volunteers.

NHPCO

The NHPCO website can be accessed at: **www.NHPCO.org**. Many of the resources require signing into access. You can get your own membership by completing an Application Form (obtain from an Education Consultant) and faxing it to NHPCO. They will then send you information so you can log in and have full access.

UHPCO

The UHPCO website can be accessed at: **www.utahhospice.org**. On that website there are several online trainings. Once on the website select the Members and Providers picture. Then select the Online Training on the top menu bar. You will have to enter a user name and password which can be obtained from an Education Consultant or your manager. Once logged in you will have full access to the courses.

Palliative Care Network of Wisconsin

The Palliative Care Network of Wisconsin can be accessed at: http://www.mypcnow.org**.** This website, run by Dr. David Weissman, is a great resource for palliative care and symptom management. You may

access the information on the website or join the network and receive via email the “Fact Facts” sent out about twice a week.