

| | | |
|--------------------------------|--------------------|------|
| Manual Title | Chapter | Page |
| Hospice | VI | |
| Chapter Subject | Page Revision Date | |
| Utilization Review and Control | 7/23/2003 | |

CHAPTER VI
UTILIZATION REVIEW AND CONTROL

| | | |
|---|---------------------------------|-----------|
| Manual Title Hospice | Chapter VI | Page i |
| Chapter Subject Utilization Review and Control | Page Revision Date 7/23/2003 | |

**CHAPTER VI
TABLE OF CONTENTS**

| | <u>Page</u> |
|--|-------------|
| Introduction | 1 |
| Compliance Reviews | 1 |
| Hospice Admission Process | 2 |
| Admission Package | 2 |
| Revocation or Change of Hospice Benefits | 3 |
| Revocation with Subsequent Re-Election | 3 |
| Documentation Requirements | 3 |
| Utilization Review Visits | 4 |
| Reconsiderations and Appeals | 4 |
| Documentation Requirements | 5 |
| Physician Certification and Plan of Care | 5 |
| Nursing Documentation | 6 |
| Social Services Documentation | 7 |
| Counseling Services Documentation | 8 |
| Interdisciplinary Care Plan | 8 |
| Other Services - Documentation | 9 |
| Rehabilitative Therapies | 9 |
| Other Services | 9 |
| Volunteers | 9 |
| Fraudulent Claims | 10 |

| | | |
|--------------------------------|--------------------|------|
| Manual Title | Chapter | Page |
| Hospice | VI | ii |
| Chapter Subject | Page Revision Date | |
| Utilization Review and Control | 7/23/2003 | |

| | |
|--|----|
| Provider Fraud | 10 |
| Recipient Fraud | 11 |
| Referrals to the Client Medical Management Program | 12 |
| Exhibits | 13 |

| | | |
|--------------------------------|--------------------|------|
| Manual Title | Chapter | Page |
| Hospice | VI | 1 |
| Chapter Subject | Page Revision Date | |
| Utilization Review and Control | 7/23/2003 | |

CHAPTER VI UTILIZATION REVIEW AND CONTROL

INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by recipients. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic utilization reviews on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by DMAS.

COMPLIANCE REVIEWS

The Department of Medical Assistance Services routinely conducts compliance reviews to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455.

Providers and recipients are identified for review by systems generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group. An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases using available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Statistical sampling and extrapolation may be used in a review. The Department may use a random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the amount of invalid payments in the audit sample are compared to the total invalid payments for the same time period, and the total amount of the overpayment is estimated from this sample. Overpayments may also be calculated

| | | |
|--------------------------------|--------------------|------|
| Manual Title | Chapter | Page |
| Hospice | VI | 2 |
| Chapter Subject | Page Revision Date | |
| Utilization Review and Control | 7/23/2003 | |

based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, Medicaid may restrict or terminate the provider's participation in the program.

HOSPICE ADMISSION PROCESS

Admission Package

Medical record documentation must be kept on each recipient and will include, in addition to the necessary identifying information, the physician's progress notes (if applicable); the physician's certification and recertification of the need for hospice services; and the physician's plan of care which includes the orders, treatments, medications, services to be rendered, diagnostic studies, therapies, activities, social services, special procedures and diet, diagnoses, and a general statement of the prognosis.

The hospice will complete the DMAS-420 (pages 1 and 2). A copy of this completed form must be kept in the recipient's medical record.

A written certification statement must be signed by the hospice medical director or the physician member of the hospice interdisciplinary group and the recipient's attending physician (if the recipient has an attending physician) at the beginning of the first 90-day period of hospice coverage.

The hospice must ensure that the recipient choosing hospice services is eligible for Medicaid hospice benefits. The first page (Section I) of the Request for Hospice Benefits (DMAS-420) is the election statement for hospice services to be signed and dated by the recipient or his or her representative. Section II (located on page 2) of the DMAS-420 contains the hospice provider information that must be completed.

Section III is the required physician member certification and must be completed by the hospice medical director or physician member of the hospice interdisciplinary team and the recipient's attending physician (if the recipient has an attending physician). Section IV must be completed when Medicaid hospice benefits are terminated. DMAS must be notified within five (5) business days of this termination of service using the DMAS-421A.

Once the required information is completed on the DMAS-420 (pages 1 and 2), then the DMAS-421A must be completed and submitted to DMAS as outlined in Chapter IV of this manual. (See the "Exhibits" section at the end of this chapter for samples of these forms.)

| | | |
|--------------------------------|--------------------|------|
| Manual Title | Chapter | Page |
| Hospice | VI | 3 |
| Chapter Subject | Page Revision Date | |
| Utilization Review and Control | 7/23/2003 | |

REVOCAION OR CHANGE OF HOSPICE BENEFITS

A recipient (or representative) may change the designation of the particular hospice from which the hospice care will be received once in each election period by using the Hospice Benefits Revocation/Change Statement (see "EXHIBITS" at the end of this chapter for a sample of this form). The change of the designated hospice is not a revocation of the election period for which it is made. The form should be submitted by the hospice from which the recipient previously received services. The new hospice will submit a Request for Hospice Benefits form.

A recipient (or representative) may revoke the election of hospice care at any time during an election period using the Hospice Benefits Revocation/Change Statement which is found in the Revocation/Change Statement form (see "EXHIBITS" at the end of this chapter for a sample of this form). The hospice must notify DMAS within five (5) business days using the DMAS-421A of this revocation/change. Upon the revocation of the election of Medicaid coverage of hospice care, the recipient is no longer covered by Medicaid for hospice care, but if eligible, may resume Medicaid coverage under the regular scope of benefits. The recipient may at any time elect to receive hospice coverage for any other benefit period(s) that he or she is still eligible to receive.

An election to receive hospice care will continue without a break as long as the recipient remains in the care of a hospice, does not revoke the election of hospice services, and remains eligible for Medicaid. If a recipient revokes hospice benefits during a benefit period, the recipient is not eligible for the remainder of days in that benefit period. The recipient may elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

REVOCAION WITH SUBSEQUENT RE-ELECTION

When a recipient revokes hospice benefits and subsequently re-elects the hospice benefit, the recipient or his or her representative must sign and date a new election statement. The hospice medical director must sign and date the certification of the appropriate benefit period. If the hospice cannot obtain written certification within two calendar days for the re-election benefit period, it must obtain oral certification within two calendar days and written certification prior to requesting pre-authorization. The provider must submit to DMAS the DMAS-421A within 14 days from the physician's certification to obtain preauthorization.

DOCUMENTATION REQUIREMENTS

Documentation of hospice services shall, at a minimum:

- a. Describe the clinical signs and symptoms of the recipient's terminal illness;
- b. Document an accurate and complete chronological picture of the recipient's clinical course and treatments;

| | | |
|--------------------------------|--------------------|------|
| Manual Title | Chapter | Page |
| Hospice | VI | 4 |
| Chapter Subject | Page Revision Date | |
| Utilization Review and Control | 7/23/2003 | |

- c. Document that an interdisciplinary plan of care specifically designed for the recipient has been developed, updated as necessary and is in compliance with physician orders;
- d. Document all treatment rendered to the recipient in accordance with the plan with specific attention to the frequency, duration, modality, and response and will identify who provided care (include the full name, title, and date);
- e. Document the changes in each recipient's condition; and
- f. Identify the category of care as described in Chapter IV.

Services not specifically documented in the recipient's medical record as having been rendered will be deemed not to have been rendered, and no reimbursement will be provided. All categories of services provided must be documented in the recipient's medical record. (12 VAC 30-60-130(D)(ii)).

UTILIZATION REVIEW VISITS

Desk reviews will be made periodically of each Medicaid participating hospice provider. On-site visits may be made and can be unannounced. The utilization review will include an interdisciplinary professional review of the services provided by the hospice with respect to the:

- Care being provided to the recipients;
- Adequacy of the services available to meet current health needs and to provide the maximum physical and emotional well-being of each recipient;
- Necessity and desirability of the continued participation in hospice services by the recipient;
- Feasibility of meeting the recipient's health needs in alternate care arrangements; and
- Verification of the existence of all documentation required by Medicaid.
- Services not documented in the recipient record will be determined not to have been performed and reimbursement will be retracted. (12 VAC 30-50-270 C (4)).

Other subsequent visits may be made for the purpose of the follow-up of deficiencies or problems, complaint investigation, or technical assistance.

RECONSIDERATIONS AND APPEALS

| | | |
|--------------------------------|--------------------|------|
| Manual Title | Chapter | Page |
| Hospice | VI | 5 |
| Chapter Subject | Page Revision Date | |
| Utilization Review and Control | 7/23/2003 | |

At the conclusion of the review, DMAS will submit a letter to the provider with the results of the review. If retractions are necessary, the provider will be notified of the amount. If the provider does not agree with the results of the review, the provider has the right to request reconsideration and must state why the retraction should not be made and include all information as to why the retraction should not be made. All requests for reconsideration must be in writing and must be received within 30 days of the date of the notification of the retraction letter. Mail all reconsideration requests to:

Supervisor, Facility and Home Based Services Unit
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If the decision to continue denial of reimbursement is made by DMAS, the provider may request an informal fact finding conference by submitting a request in writing and include all information as to why the retraction should not be made. Requests must be submitted within 30 days of the notice of reconsideration results to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS upholds the decision to retract, the provider may further appeal by requesting a formal evidentiary hearing and submitting a request in writing within 30 days of the notice of the results of the informal fact finding conference. The request must be mailed to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DOCUMENTATION REQUIREMENTS

Physician Certification and Plan of Care

For the initial 90-day period of hospice care, the hospice medical director or physician member of the hospice interdisciplinary team and the recipient's attending physician must certify that a recipient is terminally ill (i.e., has a life expectancy of six months or less). The certification must be written on the Request for Hospice Benefits form. The certification must be signed by both physicians and fully dated with the month, day, and year. The physicians' certification must occur within eight (8) days of the recipient's signature and date on the DMAS 420. For the initial 90-day period, the hospice must obtain the written certification at the beginning of the hospice care. Certifications must be obtained prior to requesting preauthorization.

| | | |
|--------------------------------|--------------------|------|
| Manual Title | Chapter | Page |
| Hospice | VI | 6 |
| Chapter Subject | Page Revision Date | |
| Utilization Review and Control | 7/23/2003 | |

For the subsequent periods, the hospice must obtain the written recertification statement signed and dated by the medical director of the hospice or the physician member of the hospice's interdisciplinary team at the beginning of the hospice period of care. The recertification must include the statement that the recipient's medical prognosis is that his or her life expectancy is six months or less. The hospice must maintain the recertification statements in the recipient's medical record. Recertifications must be included in Section III of the DMAS 420 and on the DMAS 420-A if necessary.

The hospice medical director or physician member of the interdisciplinary team must review and renew the physician's plan as often as the severity of the recipient's condition requires, but not less than once every 60 days. The review must be conducted by the attending physician, hospice medical director, or the physician member of the interdisciplinary team in consultation with the interdisciplinary team. The professional staff involved in the care of the recipient shall promptly alert the attending physician or the hospice medical director of any changes in the recipient's condition which indicate a need to alter the care plan or to terminate the service. The plan must include the medication orders with dosages, frequencies, and routes of administration; the treatment orders; the diet order; and any orders for activities, social services, rehabilitative therapies, durable medical equipment and supplies, and ancillary services. This information may be incorporated in the interdisciplinary team plan of care as long as the attending physician or hospice medical director or physician member of the interdisciplinary team signs and dates the interdisciplinary team care plan as changes are made.

The physician progress notes should record the recipient status at the time of visits as well as any significant changes between visits. The physician is responsible for signing (name, title) and dating (month, day, year) this required documentation. Any dictated, typed reports must be signed in script and dated the actual date of the physician signature.

All physician's documentation must be signed with the initials, last name, and title and dated with the month, day, and year. A required physician signature for Medicaid purposes may include signatures, written initials, computer entry, or rubber stamp initialed by the physician. These methods do not preclude other requirements that are not for Medicaid purposes. If a physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide hospice administration with a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. When a rubber-stamped signature is used, the physician must initial and completely date (with month, day, and year) all rubber-stamped signatures.

Nursing Documentation

The following components are required for nursing documentation:

Nursing Assessment - A thorough evaluation must be made by a registered nurse at

| | | |
|--------------------------------|--------------------|------|
| Manual Title | Chapter | Page |
| Hospice | VI | 7 |
| Chapter Subject | Page Revision Date | |
| Utilization Review and Control | 7/23/2003 | |

the time of admission to hospice services. The nursing evaluation must include a pain assessment and management plan. This initial evaluation must be maintained in the recipient record.

Nursing Care Plan - Nursing care plans based on an admission assessment are required for all recipients and should indicate realistic recipient/family needs, measurable goals and objectives, and specifically state the method by which they are to be accomplished. The nursing care plan should be an integral part of the interdisciplinary team care plan and is not required as a separate document. If home health or homemaker aides are to be utilized, the care plan should reflect their duties and frequency.

Nursing Summaries - Nursing summaries, in addition to p.r.n. (as needed) notes, are required bi-weekly for hospice recipients. Nursing summaries must give a current, written picture of the recipient, his or her nursing needs, the care being provided, and the recipient's response to treatment. The summary should address the medical status, the functional status in activities of daily living, the emotional/mental status, any special therapies, the nutritional status, any special nursing procedures, and the identification and resolution of acute episodes. If the nursing documentation on the interdisciplinary care plan adequately reflects an overall assessment of the recipient's condition and needs, nursing summaries may not be needed. However, this decision is made by the Utilization Review Team and not the hospice program.

All nursing documentation must be signed with the initial, last name, and title and dated completely with the month, day, and year. A rubber stamp or initial(s) is never acceptable on any portion of the required nursing documentation.

Social Services Documentation

Social services must be provided as a part of the interdisciplinary care plan developed for each recipient. The social worker assists the interdisciplinary team in understanding the significant social and emotional factors related to terminal illness, in achieving the maximum social function of each recipient and the coping capacity of the recipient's family, in fostering the human dignity and personal worth of each recipient, in preparing the recipient for changes in his or her living situation, and in assisting the family in developing constructive and personally meaningful ways to support the recipient.

Social services documentation must include an initial social evaluation and history, a social services plan of care as part of the interdisciplinary team plan of care, and progress notes. The care plan must include measurable goals with realistic time frames. Progress notes must be written at the time of each contact with a recipient and/or family member. The social worker must participate in the development and periodic review of the interdisciplinary care plan.

| | | |
|--------------------------------|--------------------|------|
| Manual Title | Chapter | Page |
| Hospice | VI | 8 |
| Chapter Subject | Page Revision Date | |
| Utilization Review and Control | 7/23/2003 | |

Counseling Services Documentation

The hospice must ensure that recipients and their families receive visits, upon their request, from clergy or other members of religious organizations of their choice. Spiritual counseling may be provided through a working arrangement with individual clergy, clergy associations and other religious organizations in the community, or by a clergy person employed by the hospice. There must be at least one individual, employed by the hospice, who coordinates counseling services if a variety of individuals are providing counseling services. Counseling services must be available to both the recipient and the family. Spiritual counseling must include notice to recipients as to the availability of clergy.

Required documentation includes an initial assessment and a plan of care. The plan of care should be a part of the interdisciplinary team care plan; a separate care plan is not required. The plan of care for counseling services must reflect family needs and may include dietary, spiritual, and any other counseling required and must be reviewed and updated at intervals specified in the plan, but not less than at least once every 60 days. Progress notes for counseling services must be written at the time of any contact with a recipient and/or family member. The counselor must participate in the development and periodic review of the interdisciplinary care plan.

There must also be an organized program for the provision of bereavement services under the supervision of a qualified professional. The plan of care for bereavement services should clearly delineate the services to be provided, the individual(s) who will provide the services, the length of time the services will be provided, and the frequency of service delivery (up to one year following the death of the recipient). Dietary counseling, when required, must be provided by a qualified professional. Counseling may be provided by other members of the interdisciplinary team as well as by other qualified professionals or trained volunteers as determined by the hospice.

Interdisciplinary Care Plan

An overall plan of care must be established before services are provided and must be contained in each recipient's record. The plan should focus on the abilities, needs, and condition of the recipient as well as the special needs of the family and must include complete nursing, social services, and counseling care plans. The plan must also include the assessment of the individual's needs and identification of services related to the management of pain and discomfort and symptom relief. The plan should be goal-oriented and demonstrate measurable goals with realistic time frames formulated to meet the recipient's needs. The plan of care must be developed using a coordinated interdisciplinary team approach with the participation of each core service as well as any other discipline that is involved. The recipient and the family may participate in the team conferences.

In establishing the initial plan of care, the member of the basic interdisciplinary group who assesses the recipient's needs must meet or call at least one other group member (a nurse, physician, social worker, or counselor) before writing the initial plan of care. At least one

| | | |
|--------------------------------|--------------------|------|
| Manual Title | Chapter | Page |
| Hospice | VI | 9 |
| Chapter Subject | Page Revision Date | |
| Utilization Review and Control | 7/23/2003 | |

of the persons involved in developing the initial plan must be a nurse or a physician. If the date of the initial assessment is a Medicaid covered day of hospice care, the plan of care must be established on the initial assessment date. The other two members of the core interdisciplinary team must review the plan of care and provide their input of the written plan of care development within two (2) calendar days following the date of the initial assessment. Documentation must include signatures and dates in the medical record to show that the four core team members completed this collaborative process.

The plan must be reviewed and updated at intervals specified in the plan, but not less often than at least once every 60 days. These reviews must be documented.

OTHER SERVICES - DOCUMENTATION

Rehabilitative Therapies

If physical therapy, occupational therapy, or speech-language pathology services are rendered to a hospice recipient, there must be an initial assessment and recorded goals and objectives in the plan of care. This plan must be reviewed and updated biweekly. Progress notes must be written in the recipient's medical record at the time of each visit to a hospice recipient. None of the above services may be provided without a current physician's order which specifies the service treatment plan and frequency of the provision of the service. In the event that only therapy services are ordered, a nursing assessment is not required in addition to a therapy assessment. Reimbursement is not available for nursing assessments when only therapy services are provided.

Other Services

Consultations with any other ancillary health care professionals, such as dietary services, pharmacist, etc., must include an assessment and plan of care. Any documentation in the recipient's record must include the name and title of the individual providing the consultation, as well as a complete date (month, day, year). Each visit or consultation must be documented in the recipient's medical record.

Volunteers

The hospice must provide appropriate orientation and training to volunteers that is consistent with acceptable standards of hospice practice. Volunteers must be used in administrative or direct recipient care roles and be under the supervision of a designated hospice employee. A hospice must document active and ongoing efforts to recruit and retain volunteers. A hospice must have written policies and procedures regarding the training and use of volunteers.

The hospice must document the cost savings achieved through the use of volunteers. Documentation must include identification of necessary positions which are occupied by volunteers; the work time spent by volunteers occupying these positions; and estimates of

| | | |
|--------------------------------|--------------------|------|
| Manual Title | Chapter | Page |
| Hospice | VI | 10 |
| Chapter Subject | Page Revision Date | |
| Utilization Review and Control | 7/23/2003 | |

the dollar costs which the hospice would have incurred if paid employees occupied the positions for the time-period that the volunteers occupied the positions.

A hospice must document and maintain a volunteer staff sufficient to provide administrative or direct recipient care in an amount that, at a minimum, equals five percent of the total recipient care hours of all paid hospice employees and contract staff. The hospice must document a continuing level of volunteer activity. Expansion of care and services achieved through the use of volunteers, including the type of services and the time worked, must be recorded.

The hospice must make reasonable efforts to arrange for visits of clergy and other members of religious organizations in the community to recipients who request such visits and must advise recipients of this opportunity.

All services to hospice recipients, including those performed by volunteers, must be documented in the recipient's medical record.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Since payment of claims is made from both State and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or State court. The Program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable State and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit

| | | |
|--------------------------------|--------------------|------|
| Manual Title | Chapter | Page |
| Hospice | VI | 11 |
| Chapter Subject | Page Revision Date | |
| Utilization Review and Control | 7/23/2003 | |

Program Integrity Section
Division of Cost Settlement and Audit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 E. Main Street, 5th Floor
Richmond, Virginia 23219

Recipient Fraud

Allegations about fraud or abuse by recipients are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Program Integrity Section
Division of Cost Settlement and Audit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

| | | |
|--------------------------------|--------------------|------|
| Manual Title | Chapter | Page |
| Hospice | VI | 12 |
| Chapter Subject | Page Revision Date | |
| Utilization Review and Control | 7/23/2003 | |

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See “Exhibits” at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate recipients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voice mail receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Program Integrity Section
Division of Cost Settlement and Audit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-6548
CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the recipient and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the “Non-Emergency Use of the Emergency Room” Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

| | | |
|--------------------------------|--------------------|------|
| Manual Title | Chapter | Page |
| Hospice | VI | 13 |
| Chapter Subject | Page Revision Date | |
| Utilization Review and Control | 7/23/2003 | |

EXHIBITS

| | <u>Page</u> |
|---|-------------|
| Request for Hospice Benefits (DMAS - 420 revised 10/02) | 1 |
| Physician Certification/Re-Certification (Continued) (DMAS - 420A revised 10/02) | 2 |
| Hospice Benefits Revocation/Change Statement (DMAS - 421 revised 10/02) | 4 |
| Hospice Enrollment Authorization Request (DMAS - 421A 12/02) | 5 |

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Request for Hospice Benefits

NAME: _____

DATE OF BIRTH: ____/____/____

ADDRESS: _____

MEDICAID NUMBER: _____ (12 digits)

MEDICARE NUMBER: _____

OTHER INSURANCE: _____

POLICY NO: _____

SECTION I: ELECTION OF HOSPICE BENEFITS

I, _____, elect to participate in the Medicaid Hospice Benefit.

The hospice that I have chosen is _____.

I am aware of the prognosis of my illness and I understand that treatment is palliative rather than curative. I consent to the management of the symptoms of my disease as prescribed by my Attending Physician and/or the Hospice Medical Director. My family and I will help to develop and will participate in a plan of care based on our special needs.

I may receive benefits that include home nursing visits, counseling, medical social work services, drugs and biologicals, and medical supplies and equipment. If needed, I may also receive home health aides/homemakers, physical therapy, occupational therapy, speech/language pathology, inpatient care for acute symptoms, medical procedures ordered by my physicians and hospice, and continuous nursing care in the home during acute medical crises. I may request volunteer services, when available and appropriate. I realize that my family and I have the opportunity for limited respite or relief care in an approved inpatient facility.

In accepting these services, which are more comprehensive than regular Medicaid benefits, I waive my right to regular Medicaid services that are duplicative of services required to be provided by the Hospice except for payment to my attending physician or treatment for medical conditions unrelated to my terminal illness. I understand that I can revoke this benefit at any time and return to regular Medicaid benefits. I understand that the Hospice Benefit consists of benefit periods-two ninety-day periods, subsequent sixty-day periods extending until I am no longer in the hospice benefit. I may be responsible for hospice charges if I become ineligible for Medicaid services.

I understand that at the end of either the first ninety-day period or the second, because of an improvement in my condition, I may choose to save the remainder of the benefit period(s). I may revoke the Hospice Benefit at that time. I also understand that if I choose to do so, I am still eligible to receive the remaining benefit period(s). I am aware, however, that if I choose to revoke Hospice Benefits during a benefit period, I am not entitled to coverage for the remaining days of that benefit period.

I understand that if I choose to do so, once during each election period I may change the designations of the particular hospice from which hospice care will be received by filing a statement with the hospice from which care has been received and with the newly designated hospice. I understand that a change of hospice providers is not a revocation of the remainder of that election period.

I understand that, unless I revoke the Hospice Benefit, hospice coverage will continue.

I understand that if I am a Medicare recipient, I must elect to use the Medicare Hospice Benefit.

Check one:

_____ I am a Medicare recipient and have elected the Medicare Hospice Benefit. My Medicare eligibility for hospice benefits begins _____ (date).

_____ I am not a Medicare recipient.

Witness' signature

Medicaid Hospice Recipient's Signature or Legal Representative

Date

Medicaid Hospice Recipient (typed or printed)

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
Request for Hospice Benefits

SECTION II: HOSPICE PROVIDER INFORMATION

Hospice Provider: _____
Hospice Address: _____
Medicaid Provider Number: _____ Telephone: _____
Facility Contact Person (name and number): _____

SECTION III: PHYSICIAN CERTIFICATION/RE-CERTIFICATION

PATIENT'S NAME: _____
I certify that, in my best judgement, the reasonable, medical predictable life expectancy for this patient is 6 months or less. Based on this medical prognosis I am requesting Medicaid Hospice Benefits for this recipient beginning _____ (date). I understand that unless the recipient revokes Hospice Benefits, hospice services will continue as long as the recipient remains eligible for Medicaid.

| | |
|--|-------------------------------------|
| Attending Physician's Signature/Date | Medical Director's Signature/ Date |
| Attending Physician (typed or printed) | Medical Director (typed or printed) |

Having reviewed this patient's care and course of illness, I certify that in my best medical judgement this patient remains appropriate for hospice care.

Second benefit period (90) days _____
Hospice Medical Director or Attending Physician/ DATE

Second-day Extension (60) _____
Hospice Medical Director or Attending Physician/ DATE

SECTION IV: NOTICE OF TERMINATION OF HOSPICE BENEFITS

Hospice benefits for _____ (recipient) are hereby terminated effective _____, _____ for the following reason. Discharge Summary is attached with explanation.
____ Recipient is deceased. Date of death is _____, _____.
____ Other (Please clarify, be specific) _____

SECTION V: DMAS OFFICE USE ONLY

Approved _____, effective _____ / _____
Denied _____ Days Denied _____
Pending _____ Reason: _____

**SECTION III: PHYSICIAN CERTIFICATION/
RE-CERTIFICATION (CONTINUED)**
(This form may be copied for continued use)

PATIENT'S NAME: _____

MEDICAID #: _____

Having reviewed this patient's care and course of illness, I certify that in my best medical judgment this patient remains appropriate for hospice care.

Subsequent 60 day
period

Attending Physician/Hospice Medical
Director

Date

Subsequent 60 day
period

Attending Physician/Hospice Medical
Director

Date

Subsequent 60 day
period

Attending Physician/Hospice Medical
Director

Date

Subsequent 60 day
period

Attending Physician/Hospice Medical
Director

Date

Subsequent 60 day
period

Attending Physician/Hospice Medical
Director

Date

Subsequent 60 day
period

Attending Physician/Hospice Medical
Director

Date

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

HOSPICE BENEFITS

REVOCATION/CHANGE STATEMENT

NAME: _____ DATE OF BIRTH: ___/___/___

ADDRESS: _____

MEDICAID NUMBER: _____ (12 DIGITS)

MEDICARE NUMBER: _____

OTHER INSURANCE: _____ POLICY NO: _____

_____ I wish to change my designation of hospice from _____

(Hospice) to _____ (Hospice/

telephone), effective _____ (date). I understand

that the change of Hospice providers is NOT a revocation of the remainder of

this election period.

_____ I wish to revoke my election of Medicaid hospice services effective on

_____ (date).

I understand that any remaining days of this election period will not be available to me.

I understand that I may elect hospice care at a later time.

I understand that as of the date of this revocation, if I am still eligible, my regular Medicaid benefits will be restored.

Signature

Witness' Signature

Name (typed or printed)

Date

Date



Hospice Enrollment Authorization Request Mail or Facsimile Cover Sheet

| | |
|---|--|
| <p>TO:</p> <p>Deloris Harris, Administrative Office Specialist Facility and Home Based Services Unit Department of Medical Assistance Services 600 East Broad Street, 10th Floor Richmond, Virginia 23219</p> <p>Phone: (804) 225-4222 Fax: (804) 371-4986</p> | <p>FROM:</p> <p>Contact Person: _____</p> <p>Phone Number: _____</p> <p>Fax Number: _____</p> <p>Provider Name: _____</p> <p>Provider Number: _____</p> |
|---|--|

Please complete the following information for each Hospice enrollment. One recipient per form. You may mail (to the address listed above) or fax (to the number listed above) this form. Please print – information that cannot be read will be returned unprocessed.

1. Recipient Name: _____
2. Recipient Medicaid Number: _____
3. Hospice Election Date: _____
 Hospice Disenrollment Date: (if applicable) _____
4. Have both the Attending Physician and the Hospice Medical Director signed and dated the DMAS-420 Hospice Election form? (circle one) YES NO
5. Date Attending Physician signed: _____
 Date Hospice Medical Director signed: _____

CONFIDENTIAL – CONTAINS PATIENT IDENTIFIABLE INFORMATION

This electronic message transmission (FAX) contains patient-identifiable information, which is being forwarded to the Department of Medical Assistance Services (DMAS). It is intended for the review and use of no one but the identified FAX recipient listed above. State and Federal laws prohibit misuse or disclosure of this information. If you have received this communication in error, please notify the sender at the telephone number listed above immediately.