Medicaid Inpatient Hospice

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QUALIS HEALTH

Advancing Healthcare
Improving Health

Medicaid Hospice Routine Home Care Service

- Adult Hospice Services (42 CFR Part 418)

Provider of Adult Hospice Services

- Hospital
- A hospice provider enrolled in a Medicare program
- A nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID)
- Public or private agency, or a subdivision whose primary focus is engaged in the care of the terminally ill patient

Beneficiary Eligibility Criteria for Adult Hospice Services

- Aged twenty two (22) or older
- Eligible for District Medicaid
- Resides in a home setting (includes a nursing facility or intermediate care facility for individuals with intellectual disabilities

  (ICF/IID)
- Is certified as terminally ill

  with a life expectancy of 6 months or less

Adult Hospice- Obtain Certification Each Election Period

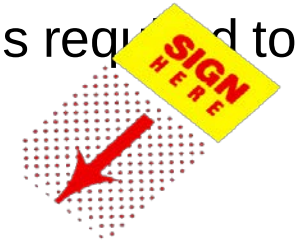
For each election period, the hospice shall obtain, no later than two (5) calendar days after the beginning of the election period, a written certification statement signed by:

1. The hospice medical director or the physician member of the hospice interdisciplinary team

2. The individual's attending physician, specialty care, or primary care physician

Certification Requirement

- **A statement that the beneficiary's prognosis is for a life expectancy of six (6) months or less if the terminal illness runs its normal course**
- **Clinical information and other documentation in support of the medical prognosis**
- **Physician (Medical Director, specialty care or primary care, beneficiary's attending, Hospice Director or the physician member of the hospice interdisciplinary team)**
- Physician signature is required to certify the terminal illness



Certification Requirement Cont.

Brief narrative : that explains the clinical findings that supports a life expectancy of six (6) months or less and includes the following

- The narrative is located or identified directly above the physician's signature
- Physician signature attesting that the narrative was written based on a review of the beneficiary's medical records or if applicable, the directly examination of the beneficiary
- The narrative must reflect the beneficiary's unique clinical condition without documentation via check box format

Certification Requirement Cont.

- Narrative for 3rd Election period and every subsequent recertification: documentation to support why the face to face encounter supports a lift expectancy of six (6) months or less

- Certification or Recertification period – don't complete more than fifteen (15) calendar days prior to the start date of an election period

The Election Statement Includes:

- Adult Hospice Provider
- The beneficiary or representative acknowledge that they are provided with full explanation of the hospice palliative care
- The beneficiary or approved representative acknowledge that they understand the election period to received hospice care which is a waiver of Medicaid services
- Start date of the Election Period to received Hospice care
- Signature of the beneficiary or approved representative

Beneficiary Election Period

- **Initial election period – Ninety (90) days**
- **Second election period- 2nd (90) days**
- **Third election period- should consist of single sixty day period**
- **Ongoing: 60 days for the next elections periods**

***** In order to received Adult hospice services, the beneficiary must complete and sign and election statement *****

Prior Authorization

- **Adult Inpatient Hospice Services for room and board in Nursing Home**
- **Submit 719A with documented revenue code of 0659**
- **Justification section on the 719A for that explains the clinical findings that supports the life expectancy of six (6) months or less**

Revenue Code	Hospice Service	Payment Rate	
0659	Hospice Room and Board Nursing Facility		

Documents for Prior Authorization Request Requirements

- **Completed 719-A form… signed and dated by a beneficiary's nursing facility physician**

- **A Medical Practitioner Orders for Hospice Service**
- **A completed signed and dated Hospice Election and Physician Certification form**
- **Hospice Termination form (beneficiary transferred to another hospice, death, no longer in need of hospice)**
- **Supporting Clinical documentation**

Questions ????

THANK YOU !!!!