III. Determination Responsibilities and Appeals

The BCSS shall have the responsibility for making the determinations as to the matters set forth above. Persons who have elected or whose legal representatives have elected that they receive services under the Children's Choice Waiver have the right to appeal any determination of the department as to matters set forth above, under the regulations and procedures applicable to Medicaid fair hearings.

David W. Hood
Secretary

0206#059

RULE

Department of Health and Hospitals
Office of the Secretary
Bureau of Health Services Financing

Hospice (LAC 50:XV.Chapters 31 - 43)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, has adopted the following Rule as LAC 50:XV.Chapters 31-43 under the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act effective July 1, 2002. This Rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

Title 50
PUBLIC HEALTH- MEDICAL ASSISTANCE
Part XV. Services for Special Populations
Subpart 3. Hospice

Chapter 31. General Provisions

§3101. Introduction

A. Hospice care is an alternative treatment approach that is based on a recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and supporting family. Palliative care focuses on comfort care and the alleviation of physical, emotional and spiritual suffering. Instead of hospitalization, its focus is on maintaining the terminally ill patient at home with minimal disruptions in normal activities and with as much physical and emotional comfort as possible.

B. The bureau will implement a pilot project for hospice care under the Medicaid State Plan for persons who are eligible for Medicaid benefits. The pilot project will terminate two years after the effective date of this rule unless the department, prior to the termination date, promulgates an additional rule to either continue the pilot project or to establish hospice care as an ongoing Medicaid service program. During the two-year period, the bureau will monitor and evaluate the pilot project on an ongoing basis in order to determine whether or not to extend it.

C. The bureau will continue to make Medicaid payments under certain circumstances for specified services provided in conjunction with Medicare hospice care for dually eligible individuals who reside in Medicaid reimbursed nursing facilities as provided in §4307 of this Subpart and in accordance with §1905(o)(3) of the Social Security Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1466 (June 2002).

Chapter 33. Provider Participation

§3301. Conditions for Participation

A. Coverage of Medicaid hospice care under the pilot project shall be in accordance with 42 U.S.C. 1396d(o), the Medicare Hospice Program guidelines as set forth in 42 CFR Part 418, and §4305-4308.2 of the Federal Centers for Medicare and Medicaid Services' *State Medicaid Manual*, except in so far as they clearly conflict, in which case the *State Medicaid Manual* will be followed.

B. In order to participate in the pilot project, a hospice shall maintain compliance with the Medicare conditions of participation for hospices as set forth in 42 CFR Part 418.50-418.100 and shall have a valid Medicaid provider agreement.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1466 (June 2002).

Chapter 35. Recipient Eligibility

§3501. Election of Hospice Care

A. In order to be eligible to elect hospice care under Medicaid, a recipient must be terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

B. An election statement must be filed with a particular hospice for the individual who meets the eligibility requirements as set forth in §3501.A above.

1. The election must be filed by the eligible individual or by a person authorized by law to consent to medical treatment for such individual.

2. For dually eligible recipients, hospice care must be elected for both the Medicaid and Medicare programs at once.

C. Duration (Periods). Subject to the conditions set forth in §3501, an individual may elect to receive hospice care during one or more of the following election periods:

1. an initial 90-day period;
2. subsequent 90-day period; and
3. subsequent periods of 60 days each. These periods require prior authorization as outlined in §4101 of these Rules.

D. Order of Election. The periods of care are available in the order listed and may be used consecutively or at different times during the recipient's life span. The hospice interdisciplinary team shall help manage the patient's hospice election periods by continually assessing the patient's appropriateness for Medicaid hospice care, especially before the patient enters a new election period.

E. An individual may designate an effective date for the election period that begins with the first day of hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

F. Loss of Remaining Days in Period. When a recipient revokes or is discharged alive during an election period, the recipient loses any remaining days in the election period.

G. Election Statement Requirements. The election statement must include:

1. identification of the particular hospice that will provide care to the individual;

2. the individual's or his/her representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness;

3. acknowledgment that certain Medicaid services, as set forth in §3503 are waived by the election;

4. the effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement; and

5. the signature of the individual or his/her representative.

H. Duration of Election. An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual:

1. remains in the care of a hospice; and

2. does not revoke the election under the provisions of §3505.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 19:749 (June 1993), amended LR 28:1466 (June 2002).

§3503. Waiver of Payment for Other Services

A. For the duration of an election of hospice care, an individual waives all rights to Medicaid payments for:

1. hospice care provided by a hospice other than the hospice designated by the individual;

2. any Medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care, except for services provided by:

a. the designated hospice;

b. another hospice under arrangements made by the designated hospice; and

c. the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1467 (June 2002).

§3505. Revoking the Election of Hospice Care/Discharge

A. An individual or his/her representative may revoke the individual's election of hospice care for a particular election period at any time during an election period.

1. Required Statement of Revocation. To revoke the election of hospice care, the individual or his/her representative must file a statement with the hospice that includes:

a. a signed statement that the individual or his/her representative revokes the individual's election for Medicaid coverage of hospice care for the remainder of that election period;

b. the date that the revocation is to be effective. (An individual or his/her representative may not designate an effective date earlier than the date that the revocation is made.)

2. If a recipient is eligible for Medicare as well as Medicaid and elects hospice care, it must be revoked simultaneously under both programs.

3. Discharge

a. The hospice benefit is available only to individuals who are terminally ill; therefore, a hospice must discharge a patient if it discovers that the patient is not terminally ill.

b. Patients shall be discharged only in the circumstances as detailed in the Licensing Standards for Hospices (LAC 48:I.8229).

4. Service Availability upon Revocation or Discharge. An individual, upon discharge or revocation of the election of Medicaid coverage of hospice care for a particular election period:

a. is no longer covered under Medicaid for hospice care; and

b. resumes Medicaid coverage of the benefits waived as provided under §3503.

5. Re-election of Hospice Benefits. If an election has been revoked in accordance with the provisions of this §2505 the individual or his/her representative may at any time file an election, in accordance with §3501, for any other election period that is still available to the individual.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1467 (June 2002).

§3507. Change of Designated Hospice

A. An individual or his/her representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received. The change of the designated hospice is not a revocation of the election for the period in which it is made. To change the designation of hospice programs, the individual or his/her representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes:

1. the name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care; and

2. the date the change is to be effective.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1467 (June 2002).

Chapter 37. Provider Requirements

§3701. Requirements for Coverage

A. To be covered, a Certification of Terminal Illness must be completed as set forth in §3703, the Election of Hospice Care Form must be completed in accordance with §3501, and a plan of care must be established in accordance with §3705. Prior authorization requirements stated in Chapter 41 of these rules are applicable to all election periods beyond the initial 90-day period and one subsequent 90-day period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1467 (June 2002).

§3703. Certification of Terminal Illness

A. The hospice must obtain written certification of terminal illness for each of the periods listed in §3501.C, even if a single election continues in effect for two, three, or more periods.

1. Timing of Certification

a. These certifications may be completed no earlier than two weeks before the beginning of each election period.

b. For the first 90-day period of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated (that is, by the end of the third calendar day), certification of the terminal illness. If written certification is not obtained within two calendar days following the initiation of hospice care, a verbal certification must be made within two calendar days following the initiation of hospice care, with a written certification obtained before billing for hospice care. If these requirements are not met, no payment is made for the days prior to the certification. Instead, payment begins with the day of certification, i.e., the date verbal certification is obtained.

c. For the subsequent periods, a written certification must be on file in the recipient's record prior to the submission of a claim.

2. Content of Certification

a. The certification must specify that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.

b. The certification of terminal illness shall be based on the physician's clinical judgment regarding the normal course of the individual's illness.

c. The written certification must include the signature(s) of the physician(s).

d. If verbal certification is made, the referral from the physician shall be received by a member of the hospice Interdisciplinary Group (IDG). The entry in the patient's clinical record of the verbal certification shall include at a minimum:

i. the patient's name;
ii. physician's name;
iii. terminal diagnosis(es);
iv. prognosis; and
v. the name and signature of the IDG member taking the referral.

3. Sources of Certification

a. For the initial 90-day period, the hospice must obtain written certification statements (and oral certification statements if required) as provided in §3703.A.1 from:

i. the hospice's medical director or physician member of the hospice's interdisciplinary group; and

ii. the individual's attending physician if the individual has an attending physician. The attending physician is a doctor of medicine or osteopathy and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

b. For subsequent periods, the only requirement is certification by either the medical director of the hospice or the physician member of the hospice interdisciplinary group.

4. Maintenance of Records. Hospice staff must make an appropriate entry in the patient's clinical record as soon as they receive an oral certification; and file written certifications in the clinical record.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 19:749 (June 1993), amended LR 28:1468 (June 2002).

§3705. Plan of Care

A. A written plan of care must be established and maintained for each individual admitted to a hospice program in accordance with the provisions set forth in the Licensing Standards for Hospices (LAC 48:I.Chapter 82), and the care provided to an individual must be consistent with the plan and be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions.

B. The plan of care must be established before services are provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1468 (June 2002).

§3707. Record Keeping

A. The hospice must maintain and retain the business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided.

B. In accordance with the provisions set forth in the Licensing Standards for Hospices (LAC 48:I.Chapter 82), the hospice must establish and maintain a clinical record for every individual receiving care and services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1468 (June 2002).

§3709. Self-Assessment

A. In accordance with the provisions set forth in the Licensing Standards for Hospices (LAC 48:I.Chapter 82) the hospice must conduct an ongoing, comprehensive, integrated, self-assessment of the quality and appropriateness of care provided, including inpatient care, home care and care provided under arrangements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1468 (June 2002).

Chapter 39. Covered Services

§3901. Medical and Support Services

A. Hospice is a package of medical and support services for the terminally ill individual. The following services are covered hospice services.

1. Nursing care provided by or under the supervision of a registered nurse.

2. Medical social services provided by a social worker who has at least a master's degree from a school of social work accredited by the Council on Social Work Education, and who is working under the direction of a physician.

3. Physicians' services performed by a physician (as defined in 42 CFR 410.20). In addition to palliation and management of the terminal illness and related conditions, physician employees of the hospice and physicians under contract to the hospice, including the physician member(s) of the interdisciplinary group, must also meet the general medical needs of the patients to the extent that these needs are not met by the attending physician. The medical director of the hospice is to assume overall responsibility for the medical component of the hospice's patient care program.

4. Counseling services must be available to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care-giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death. Counseling includes bereavement counseling, provided after the patient's death as well as dietary, spiritual and any other counseling services for the individual and family provided while the individual is enrolled in the hospice.

a. There must be an organized program for the provision of bereavement services under the supervision of a qualified professional. The plan of care for these services should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery (up to one year following the death of the patient).

i. Bereavement counseling is a required hospice service, but it is not reimbursable.

b. Dietary counseling, when required, must be provided by a qualified individual.

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

d. Additional counseling may be provided by other members of the interdisciplinary group as well as by other qualified professionals as determined by the hospice.

5. Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

6. Medical appliances and supplies, including drugs and biologicals. Only drugs as defined in §1861(t) of the Social Security Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care.

a. The hospice must have a policy for the disposal of controlled drugs maintained in the patient's home when those drugs are no longer needed by the patient.

b. Drugs and biologicals shall be administered only by a licensed nurse or physician, an employee who has completed a state-approved training program in medication administration, the patient if his or her attending physician has approved, or any other individual in accordance with applicable state and local laws. The persons and each drug and biological they are authorized to administer must be specified in the patient's plan of care.

7. Home Health Aide Services Furnished by Qualified Aides and Homemaker Services. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Written instructions for patient care are to be prepared by a registered nurse. A registered nurse must visit the home site at least every 14 days when aide services are being provided, and the visit must include an assessment of the aide services.

8. Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

9. Any other item or service which is included in the plan of care and for which payment may otherwise be made under Medicaid is a covered service. The hospice is responsible for providing any and all services indicated in the plan of care as necessary for the palliation and management of the terminal illness and related conditions.

10. Core Services

a. Nursing care, physicians' services, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees, except that physicians' services and counseling services may be provided through contract. Supplemental services may be contracted for during periods of peak patient loads and to obtain physician specialty services. The hospice may contract for a physician to be a member of the hospice's interdisciplinary group. Also, the hospice's Medical Director does not have to be an employee of the hospice. If contracting is used for any core services, professional, financial and administrative responsibility for the services must be maintained and regulatory qualification requirements of all staff must be assured.

b. If located in a non-urbanized area, a hospice may apply for a waiver of the core nursing, physical therapy, occupational therapy, speech language pathology, and dietary counseling requirements in accordance with 42 U.S.C. §1395x(dd).

11. Level of Care. Hospice care is divided into four categories of care rendered to the hospice patient.

a. Routine Home Care Day. A routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous care.

b. Continuous Home Care Day. A continuous home care day is a day on which an individual who has elected to

receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Continuous home care is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill patient at home.

i. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

ii. A period of crisis is a period in which a patient requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care.

iii. A minimum of eight hours of care must be provided during a 24-hour day which begins and ends at midnight. This care need not be continuous, i.e., four hours could be provided in the morning and another four hours provided in the evening of that day.

iv. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient Respite Care Day. An inpatient respite care day is a day on which the individual receives care in an approved facility on a short-term basis to relieve the family members or other persons caring for the individual at home. An approved facility is one that meets the standards as provided in 42 CFR • 418.98(b).

d. General Inpatient Care Day. A general inpatient care day is a day on which an individual receives general inpatient care in an inpatient facility that meets the standards as provided in 42 CFR §418.98(a) and for the purpose of pain control or acute or chronic symptom management which cannot be managed in other settings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1468 (June 2002).

Chapter 41. Prior Authorization

§4101. Prior Authorization of 60-day Periods

A. Prior authorization is not required for the initial 90-day election period or the subsequent 90-day election period. However, prior authorization is required for all subsequent 60-day election periods as specified in §3501.C of this Subpart. The prognosis of terminal illness will be reviewed. A patient must have a terminal prognosis and not just certification of terminal illness. Authorization will be made on the basis that a patient is terminally ill as defined in federal regulations. These regulations require certification of the patient's prognosis, rather than diagnosis. Authorization will be based on objective clinical evidence contained in the clinical record about the patient's condition and not simply on the patient's diagnosis.

B. Written Notice of Denial. In the case of a denial, a written notice of denial shall be submitted to the hospice.

C. Reconsideration and Appeals. If the hospice does not agree with the denial of a subsequent period the hospice can request an informal reconsideration by the intermediary. The hospice has 30 days from the date of denial on the denial letter to submit a written request for reconsideration of the initial denial. All appeals will be reviewed within 30 days from receipt of the written request. If the denial is upheld upon reconsideration and the hospice disagrees with the decision, the hospice has the right to request a fair hearing with the department's Bureau of Appeals, which will be in accordance with the Administrative Procedure Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1470 (June 2002).

Chapter 43. Reimbursement

§4301. General

A. With the exception of payment for physician services, Medicaid reimbursement for hospice care is made at one of four predetermined rates, as detailed in §4305, for each day in which a Medicaid recipient is under the care of the hospice. The four rates are prospective rates; there are no retroactive adjustments other than the limitation on payments for inpatient care. The rate paid for any particular day varies depending on the level of care furnished to the recipient. The limitation on payment for inpatient care is described in §4309.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1470 (June 2002).

§4303. Levels of Care for Payment

A. Routine Home Care. The routine home care rate is paid for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day and is also paid when the patient is receiving hospital care for a condition unrelated to the terminal condition. This rate is also paid in the following situations:

1. if the patient is in a hospital that is not contracted with the hospice; or

2. if the patient is receiving outpatient services in the hospital; or

3. for the day of discharge alive from general inpatient care or respite care level of care.

B. Continuous Home Care. Continuous home care is to be provided only during a period of crisis (see §3901.A.11.b). If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

1. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate.

2. A minimum of eight hours must be provided.

3. For every hour or part of an hour of continuous care furnished, the hourly rate is paid for up to 24 hours a day.

C. Inpatient Respite Care. The inpatient respite care rate is paid for each day the recipient is in an approved inpatient facility and is receiving respite care (see §3901.A.11.c). Respite care may be provided only on an occasional basis and payment for respite care may be made for a maximum of five days at a time including the date of admission but not counting the date of discharge.

1. Payment for the sixth and any subsequent days is to be made at the routine home care rate.

2. Respite care may not be provided when the hospice patient is a nursing home resident.

D. General Inpatient Care. Payment at the inpatient rate is made when an individual receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings. General inpatient care and nursing home or intermediate care facility for the mentally retarded room and board cannot be reimbursed for the same recipient on the same covered days of service.

1. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient.

2. When the patient is deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1470 (June 2002).

§4305. Hospice Payment Rates

A. The payment rates for each level of care will be those used under Part A of Title XVIII (Medicare), adjusted to disregard cost offsets attributable to Medicare coinsurance amounts. For routine home care, continuous home care, and inpatient respite care, only one rate is applicable for each day. For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the recipient on that day.

1. Local Adjustment of Payment Rates. The payment rates referred to in §4301 and this §4305 are adjusted for regional differences in wages. The bureau will compute the adjusted rate based on the geographic location at which the service was furnished to allow for the differences in area wage levels, using the same method used under Part A of Title XVIII.

a. The hospice program shall submit claims for payment for hospice care only on the basis of the geographic location at which the services are furnished.

b. The nursing facility shall be considered an individual's home if the individual usually lives in the nursing facility.

2. Payment for Physician Services. The four basic payment rates for hospice care are designed to reimburse the hospice for the costs of all covered services related to the treatment of the recipient's terminal illness. This includes the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice. These activities are generally performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. Group activities include participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies. The costs for these services are included in the reimbursement rates for routine home care, continuous home care, and inpatient respite care.

a. The hospice is paid for other physicians' services, such as direct patient care services, furnished to individual patients by hospice employees and for physician services furnished under arrangements made by the hospice unless the patient care services were furnished on a volunteer basis.

b. The hospice is reimbursed in accordance with the usual Medicaid reimbursement policy for physicians' services. This reimbursement is in addition to the daily rates.

c. Physicians who are designated by recipients as the attending physician and who also volunteer services to the hospice are, as a result of their volunteer status, considered employees of the hospice in accordance with 42 CFR 418.3. All direct patient care services rendered by these physicians to hospice patients are hospice physician services, and are reimbursed in accordance with the procedures outlined in §4305.A.1. Physician services furnished on a volunteer basis are excluded from Medicaid reimbursement. The hospice may be reimbursed on behalf of a volunteer physician for specific services rendered which are not furnished on a volunteer basis (a physician may seek reimbursement for some services while furnishing other services on a volunteer basis). The hospice must have a liability to reimburse the physician for those physician services rendered. In determining which services are furnished on a volunteer basis and which services are not, a physician must treat Medicaid patients on the same basis as other patients in the hospice.

d. An independent attending physician is reimbursed in accordance with the usual Medicaid reimbursement methodology for physician services.

i. The only services billed by the attending physician are the physician's personal professional services. Costs for services such as lab or x-rays are not included on the attending physician's bill.

ii. Services provided by an independent attending physician must be coordinated with any direct care services provided by hospice physicians.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1470 (June 2002).

§4307. Payment for Long Term Care Residents

A. Instead of any payment otherwise made with respect to the facility's services, the hospice program will be paid an additional amount on routine home care and continuous home care days to take into account the room and board furnished by the facility for a Medicaid recipient:

1. who is residing in a nursing facility or intermediate care facility for the mentally retarded (ICF-MR);

2. who would be eligible under the State Plan for nursing facility services or services in an ICF-MR if he or she had not elected to receive hospice care;

3. who has elected to receive hospice care; and

4. for whom the hospice program and the nursing facility or ICF-MR have entered into a written agreement in accordance with the provisions set forth in the Licensing Standards for Hospices (LAC 48:I.Chapter 82), under which the hospice program takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual.

B. This amount is determined in accordance with the rates established under the Social Security Act §1902(a)(13)(B).