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PURPOSE

The purpose of this policy is to describe the health plan's process for prior authorization decision-making conditions in which Hospice Services may be authorized according to the directives from state of Louisiana Medicaid.

SCOPE

The scope of this policy applies to the Louisiana Prior Authorization staff and all colleagues processing Louisiana authorization requests for Hospice Services.

POLICY

It is the policy of the plan that specific state directives, in addition to MCG® criteria are used when processing authorization requests for Hospice Services. Louisiana state qualifications, authorization and documentation requirements must be met. This policy defines additional Louisiana state qualifications and authorization and documentation requirements.

PROCEDURE

NA

STANDARD

Coverage of Hospice Services requires prior authorization. All Providers (both facility and ordering authorized healthcare professional must be registered in the state and the health plan's registry. The provider should be a preferred provider for the health plan.

Covered Services[1]

Hospice care includes services needed to meet the needs of the member as related to the terminal illness and related conditions. Core services must be available twenty-four (24) hours a day and include:

- Physician Services- that treat and management of the terminal illness and related conditions as well as directing the hospice multidisciplinary team.
- Nursing Services- any skilled nursing care provided by a registered nurse or under the supervision of a registered nurse.
- Medical Social Services- providing resource assistance, support and counseling.
- Counseling services- available to the terminally ill member and family during the illness and after death

[1] 2023 Louisiana Medicaid Service Manual Chapter 24.3 Hospice, pages 1-12 of 12

- Dietary Counseling- providing counseling on how to provide and prepare meals .
- Bereavement Counseling- during hospice and up to one year after death.
- Pastoral Care- Clergy visits are arranged according to member and family requests.
- Short-Term Inpatient Care- provides inpatient care in a hospital or a hospice inpatient setting. This may be needed for a procedure for pain control or acute or chronic symptom management or other comfort measures or for family respite. This cannot be provided in a nursing home or an intermediate care facility or a veteran's medical facility.
- Inpatient Respite Care- a short term inpatient respite care day to relieve family caring for the member at home. The inpatient respite care rate is paid daily for a maximum of five consecutive days which includes the admission day but not the discharge day. Respite care is not covered when the member resides in a nursing facility or ICF-IDD facility. Medical Appliances and Supplies- includes drugs and biologicals use for pain and symptom control or relief; Medical supplies and equipment is also provided to manage the member's terminal illness and related conditions. The provider must have a policy for dispensing and disposing of controlled drugs left in the home.
- Hospice Aide and Homemaker- provides personal care and household services to provide comfort and cleanliness of environment. All aides provide services under the supervision of a registered nurse.
- Therapy Services- may be provided with the purpose of symptom control or basic functional skills.
- Other services- Other services may be needed at the discretion of the hospice company, such as ambulance services for transportation to an inpatient facility.

Once a member elects to receive hospice services, the hospice is responsible for payment of all covered services. The member gives up the option for therapeutic care for any and all other related conditions. A member cannot elect hospice for one condition and not the other. The physician certified the condition that has resulted in a life expectancy of less than six months. For members under twenty-one (21) years of age may continue to receive life prolonging therapies that are focused on treating, modifying or curing a medical condition so that the member can live as long as possible. The hospice provider is not responsible for payment of the life prolonging services.

Reimbursement Rates[2]

There are four payment rates according to the level of care required.

- Routine Home care
- Continuous home care
- Inpatient respite care
- General Inpatient care

[2] 2023 Louisiana Medicaid Service Manual Chapter 24.3 Hospice page 6 of 9

Provider Responsibilities[3]

- Must have a Practitioner Referral and a signed authorized healthcare provider's signed order noting the hours requested and reviewed in the Plan of Care (POC) every 60 day.
- Providers must be an authorized healthcare provider and on the Aetna Better Health of Louisiana registry to provide services.
- All Hospice programs must obtain a license from the Louisiana Department of Health (LDH) and must ensure all employee requirements are met.
- A hospice provider must be Medicare -certified in order to qualify for enrollment as a Louisiana Medicaid hospice provider prior to billing for services .
- The hospice provider must provide an interdisciplinary group(IDG) composed of qualified medical professionals and social support staff from all core services with expertise in meeting the special needs of Hospice members and families. The interdisciplinary group must include a Physician, Registered Nurse, Social Worker and Pastoral or other counsel.
- Members may receive waiver services concurrently as long as the developmental disabilities diagnosis is not related to the terminal hospice condition and are not duplicative care.
- Members may receive early and periodic screening, diagnosis and treatment (PDHC), pediatric day health care (PDHC), personal care services (PCS) and intermittent or extended home health services concurrently.
- The provider must be responsible for coordinating all waiver services to ensure there is no duplication of services. [4]
- The hospice provider is responsible for providing durable medical equipment.

Hospice providers will cover payments for: any medical consultants, any services or inpatient charges when provided to the member on the day Hospice is chosen,

Beneficiary Criteria [5]

- To be eligible for hospice care, a member must meet all Louisiana Medicaid eligibility criteria and be certified as terminally ill. "Terminally Ill" is defined as a medical prognosis of limited expected survival, of approximately six months or less at the time of the referral to hospice, of a member who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone are no longer appropriate.
- Member should have the BHSF for Hospice-CTI or Certification of Terminal Illness and the BHSF-Form Hospice-NOE or Notice of election.
- The beneficiary must have an established Plan of Care (POC) by the medical team.

[3] 2023 Louisiana Medicaid Services Manual Chapter 24.5 Hospice page 1-8 and section 24.2 page 1-12
[4] 2023 Louisiana Medicaid Services Manual Chapter 24.2: Hospice page 1-2 of 2
[5] 2023 Louisiana Medicaid Services Manual Chapter 24.1 Hospice page 1-5

Plan of Care[6]

A plan of care is created by the hospice provider with the interdisciplinary team and the member. In establishing the initial POC, the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member (nurse, physician, or medical social worker or counselor) before writing the initial POC. At least one of the persons involved in developing the initial POC must be a nurse or physician. The POC is signed by the attending physician or an appropriate member of the interdisciplinary group. The POC must encompass plans on access to emergency care and address the condition of the beneficiary as a whole. All co-morbidities must be included even those not related to the terminal illness. In addition, the POC must meet general medical needs of beneficiaries to the extent that these needs are not being met by the attending physician. This information is being required to assess the beneficiary for complications and risk factors that would affect care planning (i.e., access to emergency care). Providers may not be responsible for providing care for the unrelated co-morbidities.

Prior Authorization

Prior authorization (PA) is required upon the initial request for hospice coverage. Requests for PA must be submitted within 10 calendar days of the hospice election date. If the PA is approved, it covers 90 days.

First Benefit Period (90 days)[7]

1. Hospice Election Form (primary diagnosis code(s) using the International Classification of Disease, Tenth Revision (ICD-10) or its successor; other codes)
2. Hospice Certification of Terminal Illness form (BHSF Form Hospice – CTI)
3. Clinical/medical information
4. Hospice provider plan of care (POC) includes the following:
    a. Progress notes (hospital, home health, physician's office, etc.)
    b. Physician orders for POC and
    c. Include Minimum Data Set (MDS) or jRaven form (original and current) if member is in a facility; weight chart; laboratory tests; physician and nursing notes.

Recertification and Authorization

If another 90-day election period is required, the Prior Authorization request must be submitted at least 10 days prior to the end of the current election period. This will ensure that requests are received and approved or denied before the preceding period ends.

- Denied - If this requirement is not met and the period ends, reimbursement will not be available for the days prior to receipt of the new request.

[6] 2023 Louisiana Medicaid Services Manual Chapter 24.5 Hospice page 2 of 8
[7] Louisiana Department of Health Provider Manual Chapter 24 HOSPICE p. 40

- Approved: If approved, reimbursement will be effective the date the Prior Authorization Unit (PAU) receives the proper documentation. The completed PA :
    - Includes the updated and signed "Hospice Certification of Terminal Illness (CTI)" (BHSF Form Hospice CTI) and
    - Includes all related documents,
    - Must be received before the period ends.
- Any PA request received after the period has ended will become effective on the date the request is received by the PAU if the request is approved.
- This policy also applies to PA packets received after Medicaid eligibility has ended.
- It is the responsibility of the provider to verify eligibility on a monthly basis.
- The PA only approves the existence of medical necessity, not member eligibility.
- (See Appendix B for detailed information regarding BHSF Form Hospice CTI).
- .

NOTE: PA is not required for dual eligible members (Medicare primary) during the two 90-day election periods and the subsequent 60-day election periods. However, they must submit a copy of the Medicare Common Working File screen showing the hospice segment through the ePA system and the signed CTI and Notice of Election (NOE) forms. ***Required Documentation***[8]

Documentation should paint a picture of the member's condition by illustrating the member's decline in detail. The following information will be required upon the initial request for hospice services.

- Last month's status compared to this month's status and should not merely summarize the member's condition for a month).
- Daily and weekly notes and
- Illustrate why the member is considered to be terminal and not "chronic."
- Explanation should include the reason the member's diagnosis has created a terminal prognosis and show how the systems of the body are in a terminal condition.
- Telephone courtesy calls are not considered face-to-face encounters and will not be reviewed for prior authorization.

Hospice Supplies[9]

Hospice supplies are reimbursable under the durable Medical Equipment (DME) program. Prior authorization for covered supplies must be obtained. Many Hospice supplies are included in the Hospice reimbursement.

APPLICABLE CPT CODES

[8] 2023 Louisiana Department of Health Provider Manual Chapter 24.5 HOSPICE p. 3 of 5
[9] 2023 Louisiana Medicaid Services Provider Manual Chapter 24.9 Hospice p.9 of 11

This policy applies the additional definitions, qualifications, criteria and documentation requirements to the procedure codes listed below. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS	Description
Q5001	Hospice or home health care provided in member's home/residence
Q5002	Hospice or home health care provided in assisted living facility
Q5003	Hospice care provided in nursing long term care facility (LTC) or non-skilled nursing facility (NF)
Q5004	Hospice care provided in skilled nursing facility (SNF)
Q5005	Hospice care provided in inpatient hospital
Q5006	Hospice care provided in inpatient hospice facility
Q5007	Hospice care provided in long term care facility
Q5008	Hospice care provided in inpatient psychiatric facility
Q5009	Hospice or home health care provided in a place not otherwise specified
Q5010	Hospice home care provided in a hospice facility
S9126	Hospice care, in the home, per diem
T2042	Hospice routine home care; per diem
T2043	Hospice continuous home care; per diem
T2044	Hospice inpatient respite care; per diem
T2045	Hospice general inpatient care; per diem
T2046	Hospice long term car, room and board only; per diem

DEFINITIONS:

1. **Aetna:** The subsidiaries of Aetna Inc. that provide traditional and consumer-directed health insurance products and related services.

    a. Aetna is the brand name used for products and services provided by one or more of the Aetna group of companies. (Aetna) means: "Aetna" is the brand name used for products and services provided by one or more of the Aetna group of affiliate companies. The Aetna companies that offer, underwrite or administer benefit coverage include Aetna Health Inc., Aetna Health of California Inc., Aetna Health of Iowa Inc., Aetna Better Health of Louisiana, Aetna Health of Michigan Inc., Aetna Health of Ohio Inc., Aetna Health of Utah Inc., Aetna Life Insurance

Company, Aetna Health Insurance Company of New York, Aetna Health Insurance Company, Coventry Health Plan of Florida, Inc., Coventry Health Care plans, Coventry Health and Life Insurance Company, HealthAmerica Pennsylvania, Inc., HealthAssurance Pennsylvania, Inc., MHNet Specialty Services, LLC and Aetna Health Management, LLC, and may also include Aetna health plans offering Medicaid, CHIP, dual eligible or other state- or federally-regulated health plans that are administered by Aetna Medicaid Administrators LLC or its affiliates. CVS Health Solutions LLC may also administer benefit coverage for the above companies.

2. **CMS:** U.S. Centers for Medicare & Medicaid Services
3. **Activities of Daily Living (ADLs):** The functions or basic self-care tasks which an individual performs in a typical day, either independently or with supervision/assistance. Activities of daily living include bathing, dressing, eating, grooming, walking, transferring and/or toileting.
4. **Adult Day Health Care (ADHC) Waiver:** A Medicaid Home and Community-Based Services (HCBS) Waiver program helps to bridge the gap between independence and institutional care by allowing a member to remain in their own home and community
5. **Attending Physician:** The physician most involved in the member's care at the time of referral and prior to election of hospice care.
6. **Bereavement Counseling:** Organized counseling provided under the supervision of a qualified professional to help the family cope with death and grief related to loss issues. This is provided for at least 1 year following the death of a member.
7. **Certification of Terminal Illness (CTI):** Written certification that due to the member's prognosis, his or her life expectancy is 6 months or less if the illness runs its normal course, also includes a brief narrative, and benefit period
8. **Clinical Condition:** A diagnosis or member state (physical or mental), that may be associated with more than one diagnosis or may be as yet undiagnosed.
9. **Concurrent Care:** Members who are under 21 years of age and elect hospice are entitled to receive a hospice benefit while continuing to receive all necessary disease-directed and life prolonging therapies with the goal of providing access to comprehensive care, in order to live as long and as well as possible.
10. **Core Services**: Nursing services, physician services, medical social services and counseling services, including bereavement counseling, dietary counseling, spiritual counseling and any other counseling services provided to meet the needs of the individual and family.
11. **Discharge:** The point at which the member's active involvement with the hospice services is ended and the hospice provider no longer has active responsibility for the care of the member.
12. **Hospice:** Hospice care is an alternative treatment approach that is based on recognition that impending death requires a change from curative treatment to palliative care for the

terminally ill patient and support for the family. Hospice care is an interdisciplinary approach to the delivery of care with attention to needs of both the member and of the family.

13. **I Raven assessment:** A standardized assessment used to determine patient needs and assist with appropriate placement setting.
14. **Level of Care:** Hospice care is divided into four categories of care rendered to the hospice member: (1) routine home care; (2) continuous home care; (3) inpatient respite care; and (4) general inpatient care.
15. **Life-Prolonging Therapies:** Any aspects of the member's medical plan of care that are focused on treating, modifying, or curing a medical condition so that the member may live as long as possible, even if that medical condition is also the hospice qualifying diagnosis. Members under age 21 are entitled to receive life-prolonging therapies in the concurrent care model of hospice.
16. **MCG ®:** A standard set of guidelines and criteria that offer evidence-based criteria, goals, optimal care pathways, and other decision -support tools for proactive care management, case review and assessment of people facing hospitalizations, treatments, and equipment. [10]
17. **Minimum Data Set (MDS)** A standardized evaluation form to help determine the acuity and needs of the member. It can assist in the determination of the appropriate setting for care.
18. **Plan of Care (POC):** A written document established and maintained for each individual admitted to a hospice program. Care provided to an individual must be in accordance with the plan. The plan includes an assessment of the individual's needs and identification of the services, including the management of discomfort and symptom relief.[11]
19. **Program of All-Inclusive Care for the Elderly (PACE):** Program which coordinates and provides all needed preventive, primary health, acute and long-term care services to qualified members aged 55 and older in order to enhance their quality of life and allow them to continue to live in the community.[12]
20. **Notice of Election (NOE):** A signed election from a member acknowledging that he or she wishes to enroll in hospice.[13]
21. **Relatives:** A relative is defined as all persons related to the member by virtue of blood, marriage, adoption, or court appointed legal guardians.[14]
22. **Terminally ill:** Defined as a member having a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.[15]

[10] MCG Health definition found at https://www.mcg.com
[11] Louisiana Department of Health Provider Manual Chapter 24.14 HOSPICE p. 1 of 4
[12] Louisiana Department of Health Provider Manual Chapter 24.14 HOSPICE p. 1 of 4
[13] Louisiana Department of Health Provider Manual Chapter 24 HOSPICE Appendix A p. 1 of 11
[14] Louisiana Department of Health Provider Manual Chapter 24.2 HOSPICE p. 4of 12
[15] Louisiana Department of Health Provider Manual Chapter 24.1 HOSPICE p. 1

REVIEW AND REVISION HISTORY

Date	Revision No.	Reason for Change	Sections Affected
03/13/24	1	New Policy	all

Aetna Better Health of Louisiana

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RELATED MATERIALS
NA

RESOURCES

- Federal and State regulations
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans
- State contract requirements