Handouts

1. Example - Physician’s Certification Statement
2. Memo – Debility and Adult Failure to Thrive
3. Independent Physician Review for Extended Care
4. Utah Medicaid Prior Authorization Request Form
5. Pediatric Hospice Provider Attachment
PHYSICIAN’S CERTIFICATION FOR MEDICAID HOSPICE BENEFIT

Medicaid hospice providers must obtain written certification of a patient’s terminal illness for each election period. Medicaid will only consider prior authorization requests that are accompanied by a copy of the physician’s certification statement for each election period.

Patient’s name: ____________________________  Medicaid ID: ____________________________

☐ Certification for initial 90-day election period  Effective date: ____________________________

☐ Recertification for second 90-day election period  Effective date: ____________________________

☐ Recertification for a subsequent 60-day election period  Effective date: ____________________________

I have performed a medical evaluation of the above mentioned patient and certify that he/she is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

Primary terminal diagnosis: ____________________________

Provide a brief summary of clinical information and other medical documentation to support the patient’s medical prognosis and life expectancy of six months or less:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Signature — Hospice Medical Director, confirming that this certification and narrative is based on his/her direct review of the patient’s medical record and/or examination of the patient.

__________________________  Date signed

Signature — Attending Physician (when applicable), confirming that this certification and narrative is based on his/her direct review of the patient’s medical record and/or examination of the patient.

__________________________  Date signed

UDOH, Division of Medicaid and Health Financing  February 2015
Hospice Claims and Use of Debility, Adult Failure to Thrive, and Dementia Diagnoses

CMS expects that hospices not use 'debility' and 'adult failure to thrive' as the primary diagnosis on hospice claims effective immediately.
May 10, 2013 08:45 AM

In the April 30, 2013 edition of NAHC Report, a summary was provided for the FY2014 Hospice Wage Index proposal that included some details of the portion of the proposed rule related to multiple diagnoses on hospice claims and specifically hospices' use of 'debility', 'adult failure to thrive', and dementia as the principal diagnosis.

CMS indicated that hospices should not use these diagnoses as the principal diagnosis, and that in the future they will return to provider (RTP) claims with 'debility' or 'adult failure to thrive' as the principal diagnoses. In the CMS Open Door Forum (ODF) on May 8, 2013 CMS indicated that instruction to contractors for RTP'ing these claims would be coming out soon. No particular date was given but it is clear that CMS has warned providers about the need to RTP claims and that providers should not be coding these diagnoses as the principal diagnosis.

NAHC strongly recommends that all hospices review each case where 'debility' or 'adult failure to thrive' is listed as the principal diagnosis.

If those cases clearly have another diagnosis that is considered as a principal diagnosis, the hospice should change this for all future claims. It is possible that there is not a more specific principal diagnosis and the ICD-9 coding conventions do allow 'debility' and 'adult failure to thrive' when another more specific diagnosis is not present. Because of this it is of great concern to hospices that CMS will RTP any claims with 'debility' and 'adult failure to thrive' in the principal diagnosis field. However, at this time CMS clearly expects and is strongly communicating to hospices that these diagnoses not be the principal diagnosis.

In addition to adult failure to thrive and debility, CMS also clarified for providers that use of dementia and some other mental, behavioral, and neurodevelopmental disorders as a principal diagnosis is not appropriate. CMS indicates that the ICD-9-CM has a coding convention that requires the underlying condition be sequenced first, followed by the manifestation. CMS underscores that it expects hospice providers to follow ICD-9-CM coding guidelines and sequencing rules for all diagnoses and pay particular attention to the specified conventions for dementia codes as depending on the code they may or may not be used as principal diagnosis.

CMS also reiterated in the ODF the expectation that hospices observe longstanding policy of including all diagnoses related to the principal diagnosis on the hospice claim. This is the third time CMS has made this clarification, and they emphasized how serious they are about this issue.

CMS also referenced comments made in the 1983 hospice final rule:

"We are restating what we communicated in the December 16, 1983 final rule regarding what is related versus unrelated to the terminal illness: ...we believe that the unique physical condition of each terminally ill individual makes it necessary for these decisions to be made on a case-by-case basis. It is our general view that ... hospices are required to provide virtually all the care that is needed by terminally ill patients (48 FR 56010 through 56011). Therefore, unless there is clear evidence that a condition is unrelated to the terminal illness, all services would be considered related. It is also the responsibility of the hospice physician to document why a patient's medical need(s) would be unrelated to the terminal illness."

A very detailed analysis of the section of the proposed rule, FY2014 Hospice Wage Index Update, related to multiple diagnoses will be distributed soon by NAHC and HAA.
Medicaid Hospice Care
Independent Physician Review for Extended Care

Purpose:
Medicaid hospice benefits are reserved for terminally ill patients who have a medical prognosis to live no more than six (6) months if the illness runs its normal course.

When an adult patient (21 years of age or older) reaches 12 months in hospice care, an independent face to face physician review is required. Independent reviews are subsequently required every 12 months thereafter if the patient continues to receive extended hospice care.

Hospice agencies should advise patients of this requirement and provide this form to take with them to each independent review. Prior authorization requests for extended hospice care will be denied if this form is not submitted along with the PA request or if this form indicates the patient does not continue to meet program eligibility requirements.

Section 1 - Patient Information: (This section can be filled in by the hospice provider.)

Patient’s first name: ___________________________ Patient’s last name: ___________________________
Medicaid ID number: ___________________________ Patient’s DOB: _____/_____/_____
Hospice provider name: ___________________________

Section 2 - Independent physician evaluation results: (Completed by the independent physician.)

Does this patient have a terminal illness? [ ] Yes [ ] No [ ] Inconclusive
If yes, list the terminal diagnosis/es: ____________________________________________________________

Please note: principal diagnoses of ‘debility’ or ‘adult failure to thrive’ will not be accepted as meeting the eligibility criteria for Medicaid hospice.

Considering the normal course of the patient’s diagnosis/es, does it appear the patient’s life expectancy is six (6) months or less? [ ] Yes [ ] No [ ] Inconclusive

Section 3 – Independent physician’s certification statement:

I certify that I am a physician licensed in the state of Utah and that I am not affiliated with hospice agency listed in Section 1 above. I further certify that I (or my staff) entered the evaluation results listed above and that they are based on a face to face evaluation performed on ____________________(date). The conclusions listed are unbiased and free from influence.

Physician’s name: ___________________________ License #: ___________________________
Physician’s signature: ___________________________ Date: ___________________________

April 1, 2015
Utah Medicaid Prior Authorization Request for Hospice Services

<table>
<thead>
<tr>
<th>Hospice Provider Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NPI Provider Number:</td>
<td></td>
</tr>
<tr>
<td>Initial Hospice Admission Date:</td>
<td>(No matter the funding source)</td>
</tr>
<tr>
<td>□ Yes (Submit this form and a copy of the signed election statement and physician certification statement to Medicaid within 10 calendar days. If this form is not received timely, Medicaid will not reimburse for hospice services rendered prior to the date the PA request is received.)</td>
<td></td>
</tr>
<tr>
<td>□ No (Complete this form &amp; attach copies of the initial plan of care, physician certification statement and signed election statement but DO NOT submit anything to Medicaid until after client becomes Medicaid eligible. Medicaid will then require all three documents when determining post payment authorization.)</td>
<td></td>
</tr>
<tr>
<td>Is the client Medicaid eligible upon initial admission?</td>
<td></td>
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<tr>
<td>Who Signed the Election Statement?</td>
<td>□ Client □ Legal Representative as defined in R414-14A</td>
</tr>
<tr>
<td>Client’s Name:</td>
<td></td>
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<tr>
<td>Medicaid ID Number:</td>
<td></td>
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<tr>
<td>Client’s Social Security Number:</td>
<td></td>
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<tr>
<td>Client’s Date of Birth:</td>
<td></td>
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<tr>
<td>Diagnosis(es) Description: (Not codes)</td>
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<tr>
<td>Physician:</td>
<td></td>
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<tr>
<td>Hospice Contact Person:</td>
<td></td>
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<tr>
<td>Contact Person Phone Number:</td>
<td></td>
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<tr>
<td>Nursing Facility or ICF/ID Name:</td>
<td></td>
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<tr>
<td>NF or ICF/ID Admission Date:</td>
<td></td>
</tr>
<tr>
<td>Children only: Has UDOH approved an add-on rate?</td>
<td>□ Yes □ No (If yes, 10A #: ______________________)</td>
</tr>
<tr>
<td>Hospice Benefit Requested:</td>
<td>□ Routine □ Room &amp; Board □ Other</td>
</tr>
<tr>
<td>Prior Auth Effective Dates:</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Discharge date:</td>
<td>_______ / _______ / _______</td>
</tr>
<tr>
<td>• Fax to: 801-323-1562</td>
<td></td>
</tr>
<tr>
<td>Date of death:</td>
<td>_______ / _______ / _______</td>
</tr>
<tr>
<td>Date client revoked:</td>
<td>_______ / _______ / _______</td>
</tr>
<tr>
<td>(Send a copy of the revocation form signed by the client or legal representative.)</td>
<td></td>
</tr>
</tbody>
</table>
Pediatric Hospice Provider Attachment

ENROLLMENT
Hospice care for clients under 21 years of age.

Provider Name: __________________________
Effective Date: __________________________

*FOR DMHF USE ONLY*
Provider #: ____________________________
Provider Type: __________________________
Category of Service: ____________________

In accordance with R414-14A-10, pediatric hospice providers will develop a training curriculum to ensure that the hospice’s interdisciplinary team members, including volunteers, are adequately trained to provide services to clients under 21 years of age. All staff members and volunteers providing pediatric hospice care must receive the training prior to provision of services to clients who are under 21 years of age, and at least annually thereafter. At a minimum, the training will include the following pediatric specific elements:

(a) Growth and development,
(b) Pediatric pain and symptom management,
(c) Loss, grief and bereavement for pediatric families and the child,
(d) Communication with family, community and interdisciplinary team,
(e) Psycho-social/spiritual care of children, and
(f) Coordination of care with the child’s community.

Agencies wishing to enroll as a pediatric hospice provider must submit a copy of their training curriculum and this certification attachment along with their enrollment application to the Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services.

The undersigned Provider Representative certifies that all staff members and volunteers providing pediatric hospice care have received (or will receive) the required training prior to provision of services to clients under 21 years of age.

Signature of Provider Representative __________________________ Date __________________________

The Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services, has determined that the above provider meets all qualifications listed in R414-14A-10 for provision of pediatric hospice care. The undersigned Bureau Representative certifies that the above designated category of service and provider type are accurate.

Signature of Representative __________________________ Date __________________________
DMHF, Bureau of Authorization and Community Based Services

Utah Department of Health – DMHF
Form HACBS-Pediatric Hospice Provider Attachment
Effective February 1, 2012