MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 11-45

Distribution: Hospice

Issued: October 1, 2011

Subject: Medicare Conditions of Participation and Affordable Care Act (ACA) of 2010 Update; Medicaid Policy Reminders

Effective: As Indicated

Programs Affected: Medicaid

The purpose of this bulletin is to:

1. Update Medicaid hospice policy and bring it in line with provisions of the Medicare Conditions of Participation (42 CFR § 418), including requirements set forth within the Affordable Care Act (ACA) of 2010. The Medicaid Provider Manual, Hospice Chapter, Section 2, Provider Requirements states that hospice providers must comply with the Medicare Conditions of Participation,

2. Clarify Medicaid coverage for General Inpatient Care and when the beneficiary elects to disenroll from hospice, and

3. Address hospice revocation, disenrollment, or discharge when the beneficiary is hospitalized.

Medicare Conditions of Participation and ACA Update

Hospice Election Periods

Medicare requires that the duration of hospice coverage be measured in election periods, also known as benefit periods. A beneficiary may elect to receive hospice care during one or more of the following election periods:

- An initial 90-day period;
- A subsequent 90-day period; or
- An unlimited number of subsequent 60-day periods.

Certification of the Terminal Illness

A hospice must obtain written certification of the terminal illness for each election period before a claim for services is submitted. If the hospice is unable to obtain a written certification within three days of initiation of hospice care, a verbal certification must be obtained, documented, and signed by the person receiving the certification. Statements covering a beneficiary's initial certification must be obtained from the hospice medical director or the physician member of the Interdisciplinary Group (IDG), and the beneficiary's attending physician if the beneficiary has an attending physician. The hospice medical director or the physician member of the IDG certifies the terminal illness for all subsequent election periods.

Each written certification must include:

1. A statement that the beneficiary's life expectancy is six months or less if the terminal illness runs its normal course;

2. Specific clinical findings and other documentation as needed to support the life expectancy of six months or less;

3. A brief narrative summary;

4. An explanation why the clinical findings of the face-to-face encounter support a life expectancy of six months or less (beginning with the third benefit period and thereafter); and

5. Physician signature(s), date signed, and specific election period dates covered by the certification or recertification.

Documentation of all written/verbal certifications must be prepared no more than 15 calendar days prior to the effective date of election and must be kept in the beneficiary's medical record.

Narrative Summary

Effective October 1, 2009, Medicare required that each hospice certification and recertification be accompanied by a brief narrative describing the clinical findings supporting the beneficiary's life expectancy of six months or less. Each narrative must reflect the clinical circumstances and should not contain check-boxes or non specific, standard language.

Face-to-Face Encounter

In response to the condition outlined in Section 3132(b) of the Affordable Care Act (ACA) of 2010, the Michigan Department of Community Health (MDCH) is implementing the requirement that a hospice physician or hospice nurse practitioner (NP) must have a face-to-face encounter with every hospice patient prior to the 180th day of recertification of the patient's terminal illness, for the purpose of determining continued eligibility. The 180th day recertification is defined as the recertification that occurs at the start of the third benefit (election) period or the benefit period following the second 90-day benefit period. Additionally, a face-to-face must be conducted at each subsequent recertification (every 60 days thereafter) for as long as the beneficiary is in hospice. Face-to-face encounters must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to each subsequent benefit period thereafter.

Effective November 1, 2011, hospice providers are required to implement the face-to-face requirement for their Medicaid patients when applicable. This requirement is effective for the third and subsequent benefit periods which occur on or after November 1.

The hospice physician or NP must attest in writing to the face-to-face encounter with the beneficiary and include the date of the visit. A NP is allowed to perform and attest to the face-to-face encounter however, the hospice physician must certify and recertify the terminal illness.

Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the recertification of the terminal illness requirement. This results in the beneficiary no longer being eligible for the hospice benefit. If this should happen, the hospice must complete a Hospice Membership Notice (DCH-1074) form with the last date of the benefit period as the effective disenrollment date. A comment in the Remarks Section of the form is required to explain the reason for the disenrollment.

There may be an occasional case when a hospice admits a beneficiary who received services previously from another hospice provider and the beneficiary chose to revoke or was discharged from that provider. When this occurs the admitting hospice may begin their care with the beneficiary's first benefit period unless the beneficiary is a direct transfer from the other hospice. When this is the case the beneficiary's benefit period remains the same and the transferring hospice should provide the receiving hospice with all required documentation. A hospice resuming care for a beneficiary formerly served by their hospice must restart care in the next or subsequent benefit period.

Medicaid Policy Reminders

General Inpatient Care

General inpatient care is covered when the beneficiary's condition is such that their symptoms cannot be adequately treated under the routine hospice care benefit. This brief episode of care is usually for pain control, or acute or chronic symptom management, that cannot reasonably be treated in another setting. General inpatient care is not to be used solely if a beneficiary requires care in a facility setting. Unlike Medicare, Michigan Medicaid provides payment for room and board in a nursing facility or licensed hospice residence if the beneficiary's hospice care would be more appropriately provided in one of these settings under the routine hospice benefit.

Beneficiary Elects to Disenroll (Revoke Their Hospice Election)

A beneficiary may chose to disenroll from or revoke their election of hospice care at any time during an election period. The hospice must obtain written documentation, signed and dated by the beneficiary or their representative, stating they are revoking the hospice benefit for the remainder of that election period. The disenrollment or revocation is effective with the date of the beneficiary's/representative's signature.

Hospice Revocation, Disenrollment, or Discharge When Beneficiary is Hospitalized

A beneficiary should not revoke, disenroll, or be discharged from hospice for the purpose of admission to the hospital for care related to the hospice diagnosis. Medicaid does not reimburse the hospital separately unless the hospitalization is **not** related to the terminal illness. When this is the case, the hospice may continue to provide care to the beneficiary under the routine hospice care benefit.

Manual Maintenance

Retain this bulletin until applicable information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

APPROVED

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