Medicaid Hospice Utilization Review

The Utilization Review Processes and Common Reasons for Recoupment of Funds

Disclosure to RN’s

To receive contact hours for this continuing education activity, the participant must:
• Read the disclosure given to you;
• Sign in and provide current contact information;
• Attend the entire activity; and
• Complete and turn in the course evaluation at the conclusion of the session

Who We Are

Texas Department of Aging and Disability Services (DADS)

Access and Intake Division (A&I)

Hospice Utilization and Management Review Unit (Hospice UMR)
What is Utilization Review?

Utilization Review (UR) for the Medicaid Hospice Program monitors and evaluates medical necessity and appropriateness of program services on a concurrent or retrospective basis.

Why Utilization Review?

- Medicaid dollars come from public monies;
- Texas and the United States contribute to the Medicaid Fund;
- Both governments have requirements for the expenditure and oversight of public monies.

Authority for Utilization Review

Federal Authorities:

- Social Security Act
  - Title XIX of the Social Security Act
- 42 Code of Federal Regulations (CFR)
  - §431.107 Required provider agreement
  - §456.23 Post payment review process
  - §456.3 State wide surveillance and utilization control program
- Title 42 United States Code, §1396u–6
Authority for Utilization Review

State Authorities:
- Texas Administrative Code (TAC)
  40 TAC, Chapter 49
- Texas State Plan

Types of Utilization Review

- Hospice Eligibility (HE)
- Length of Stay (LoS)
- Continuous Home Care (CHC)
- CHC Extension Requests

Hospice Eligibility Reviews

- 40 TAC, Part 1, Chapter 30 Medicaid Hospice Program
- CFR Title 42–Public Health, Part 418, Hospice Care
- CMS Benefit Policy Manual, Chapter 9, Hospice
- Palmetto GBA Local Coverage Determinations (LCDs) for Hospice
30 TAC, §30.10, Eligibility Requirements
An individual **MUST**: 
- Be Medicaid certified, 
- Be certified as terminally ill, and 
- Have an identified need.

30 TAC, §30.14, Certification of Terminal Illness
This is referring to DADS form 3074 
- It must be signed and dated by an MD before the claim is submitted 
- Must be based on individuals clinical condition 
- Must state individual has prognosis of six months or less

42 CFR §418.22 Certification of Terminal Illness 
- Federal requirement above and beyond DADS form 3074 
- Also called the Physician’s Narrative 
- Face to Face encounters
Rule 30.16, Election of Hospice Care

- Use of DADS form 3071
- An eligible individual or legal representative (LAR) elects hospice
- Specifies which hospice agency
- Acknowledges limitations of services
- Effective date
- Signature of individual or Legally Authorized Representative (LAR)

Rule § 30.18, Revoking the Election of Hospice Care

- Who revoked it,
- Why it was revoked,
- Date revocation was effective

Rule §30.30, General Contracting Requirements

- (a) A hospice participating in the Medicaid Hospice Program must comply with this chapter and applicable federal regulations and state rules...
- CMS Medicare Benefit Policy Manual, Chapter 9, Hospice
Palmetto GBA Local Coverage Determinations (LCDs) for Hospice

- Palmetto is the Medicare Administrator (MAC) for Texas.
- Palmetto has seven LCDs which:
  - “…provide reasonable and necessary indications and limitations of Medicare.”
- When there is no related LCD, extensive independent research is conducted to determine hospice eligibility.

Length of Stay Review

- Essentially a Hospice Eligibility Review
- Greater than 18 months of Hospice services
- Can cover several years and multiple changes to LCDs and rules.

Common Reasons for HE/LoS Recoupment

- Lack of documentation to support the late stage of the terminal diagnosis
- No documentation sent
- Records received late
- No physician narrative or physician narrative does not support the terminal condition
Continuous Home Care Review

- Rule §30.54, Special Coverage Requirements
- Applies to a specific Hospice service
- Retrospective review
- All rules carry the same legal weight

Is it a Crisis?

Crisis—A sudden paroxysmal intensification of symptoms that appropriate medical intervention and nursing services could reasonably be expected to ameliorate.

Does it Require a Nurse?

Nursing services—Nursing tasks that could not reasonably be delegated to family members or nurse aides.
Was Skilled Nursing Provided More Than Half the Time?

- 50% of the CHC services must be provided by a skilled nurse
- The nurse can be RN or LVN depending on the skill required
- The other 50% can be provided by non-skilled persons
- Reasons for Social Work or Chaplain services and their accomplishments must be documented in the record

Is There a Doctor’s Order?

The provider must have a physician’s order and a documented medical need for skilled nursing care in the recipient’s record and in the plan of care.

Was There a Plan of Care?

- Established by MD and IDT and coordinated by RN
- Includes needs of recipient and family
- Identify services to meet needs including scope and frequency of services
- Identify how symptoms will be managed or relieved
- Records show daily MD oversight
Was There an Alternate Placement Discussion?
- An alternate placement discussion must occur with the family or responsible party
- It must occur prior to providing CHC services
- It must be documented and placed in the records
- It must occur even if the individual resides in a nursing home

How Were the Hours Claimed?
- Minimum of 8 hours provided per day
- Day begins and ends at midnight
- Does not have to be continuous
- Example: 4 hours in morning and 4 hours in evening

Extension Request Review
- If crisis is likely to last beyond 5 days
- IDT discusses and documents temporary placement alternatives
- If after discussion the belief is that CHC is needed, a written request is sent to DADS at:
  Dept. of Aging and Disability Services
  Hospice Utilization Management and Review
  MC 0222
  8317 Cross Park Dr., Ste. 300
  Austin, Texas 78754
Extension Request Review

The request must include multiple specific criteria such as:
- All previous CHC documentation
- Description of crisis and a plan to resolve it
- Number of CHC days requested
- IDT discussion and reason why temporary alternate placement is not warranted

CHC extension will be denied if documentation is incomplete.

Common Reasons for Recoupment

- The problem did not rise to the level of crisis
- No physician order or not dated for care period
- No PoC or PoC was incomplete
- Skilled nursing not required
- Less than 50% of time was skilled nursing
- No alternate placement discussion
- Not all documents requested were received
- Other issues; e.g. billing discrepancies

How Can We Help You?

- We all have a job to do
- We are all required to follow the rules
- We have a common goal
- Transparency and understanding

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