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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

LSA Document #02-214(F)

DIGEST

Amends 405 IAC 1-16-2 to specify the payment level for hospice services on the date that an individual is discharged from inpatient or respite hospice care. Amends 405 IAC 1-16-4 to specify that, in order to receive Medicaid reimbursement for room and board for nursing home residents receiving hospice services, the hospice must have a written agreement with the nursing facility. Amends 405 IAC 5-34-1 to specify that the hospice provider must provide all services in compliance with the Medicaid provider agreement, the appropriate provider manual and all other Medicaid policy documents issued to the provider at the time services were rendered, and any applicable state or federal statute or regulations. Amends 405 IAC 5-34-2 to specify licensure and certification requirements for Medicaid hospice providers. Amends 405 IAC 5-34-3 to specify the requirements for Medicaid reimbursement for hospice services provided by out-of-state hospice providers. Amends 405 IAC 5-34-4 to specify the requirements for obtaining authorization for hospice services. Adds 405 IAC 5-34-4.1 regarding appeals of hospice authorization determinations. Adds 405 IAC 5-34-4.2 to provide for retrospective audit of hospice services including review for medical necessity. Amends 405 IAC 5-34-5 to specify requirements relating to the hospice physician certification form. Amends 405 IAC 5-34-6 to specify requirements relating to election and revocation of hospice services. Amends 405 IAC 5-34-7 to specify requirements relating to the hospice plan of care. Effective 30 days after filing with the secretary of state.

405 IAC 1-16-2
405 IAC 1-16-4
405 IAC 5-34-1
405 IAC 5-34-2
405 IAC 5-34-3
405 IAC 5-34-4
405 IAC 5-34-4.1
405 IAC 5-34-4.2
405 IAC 5-34-5
405 IAC 5-34-6
405 IAC 5-34-7

SECTION 1. 405 IAC 1-16-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-16-2 Levels of care
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 2. (a) Reimbursement for hospice care shall be made according to the methodology and amounts calculated by the **Centers for Medicare and Medicaid Services (CMS), formerly the** Health Care Financing Administration (HCFA). Medicaid hospice reimbursement rates are based on Medicare reimbursement rates and methodologies, adjusted to disregard offsets attributable to Medicare coinsurance amounts. The rates will be adjusted for regional differences in wages using the geographical areas defined by ~~HCFA~~ **CMS** and hospice wage index published by ~~HCFA.~~ **CMS.**

(b) Medicaid reimbursement for hospice services will be made at one (1) of four (4) all-inclusive per diem rates for each day in which a Medicaid recipient is under the care of the hospice provider. The reimbursement amounts are determined within each of the following categories:

(1) Routine home care.
(2) Continuous home care.
(3) Inpatient respite care.
(4) General inpatient hospice care.

(c) The hospice will be paid at the routine home care rate for each day the recipient is at home, under the care of the hospice provider, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

(d) Continuous home care is to be provided only during a period of crisis. A period of crisis is defined as a period in which a patient requires continuous care that is primarily nursing care to achieve palliation and management of acute medical symptoms. Care must be provided by either a registered nurse or a licensed practical nurse, and a nurse must provide care for over half the total period of care. A minimum of eight (8) hours of care must be provided during a twenty-four (24) hour day that begins and ends at midnight. This care need not be continuous and uninterrupted. The continuous home care rate is divided by twenty-four (24) hours in order to arrive at an hourly rate. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice provider for up to twenty-four (24) hours a day.

(e) The hospice provider will be paid at the inpatient respite care rate for each day that the recipient is in an approved inpatient facility and is receiving respite care. Respite care is short term inpatient care provided to the recipient only when necessary to relieve the family members or other persons caring for the recipient. Respite care may be provided only on an occasional basis. Payment for respite care may be made for a maximum of five (5) consecutive days at a time, including the date of admission, but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate.

(f) Subject to the limitations in section 3 of this rule, the hospice provider will be paid at the general inpatient hospice rate for each day the recipient is in an approved inpatient hospice facility and is receiving services related to the terminal illness. The recipient must require general inpatient care for pain control or acute or chronic symptom management that cannot be managed in other settings. Documentation in the recipient's record must clearly explain the reason for admission and the recipient's condition during the stay in the facility at this level of care. No other fixed payment rate (i.e., routine home care) will be made for a day on which the patient receives general hospice inpatient care. Services provided in the inpatient setting must conform to the hospice patient's plan of care. The hospice provider is the professional manager of the patient's care, regardless of the physical setting of that care or the level of care. If the inpatient facility is not also the hospice provider, the hospice provider must have a contract with the inpatient facility delineating the roles of each provider in the plan of care.

(g) When routine home care or continuous home care is furnished to a recipient who resides in a nursing facility, the nursing facility is considered the recipient's home.

(h) Reimbursement for inpatient respite care is available only for a recipient who resides in a private home. Reimbursement for inpatient respite care is not available for a recipient who resides in a nursing facility.

(i) When a recipient is receiving general inpatient or inpatient respite care, the applicable inpatient rate (general or respite) is paid for the date of admission and all subsequent inpatient days, except the day on which the patient is discharged. For the day of discharge, the appropriate home care rate is paid unless the patient dies as an inpatient. In the case where the member is discharged deceased, the applicable inpatient rate (general or respite) is paid for the date of discharge. *(Office of the Secretary of Family and Social Services; 405 IAC 1-16-2; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2377; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3634)*

SECTION 2. 405 IAC 1-16-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-16-4 Additional amount for nursing facility residents
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 4. (a) An additional per diem amount will be paid directly to the hospice provider for room and board of hospice residents in a certified nursing facility receiving routine or continuous care services, **when the office has determined that the recipient requires nursing facility level of care**. **Medicaid reimbursement is available for hospice services rendered to a nursing facility resident only if, prior to services being rendered, the hospice and the nursing facility enter into a written agreement under which the hospice takes full responsibility for the professional care management of the resident's hospice care and the nursing facility agrees to provide room and board to the individual.** In this context, "room and board" includes all assistance in the activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room,

and supervision and assisting in the use of durable medical equipment and prescribed therapies.

(b) The room and board rate will be ninety-five percent (95%) of the lowest per diem reimbursement rate Indiana Medicaid would have paid to the nursing facility for any resident for those dates of service on which the recipient was a resident of that facility.

(c) Medicaid payment to the nursing facility for nursing facility care for the hospice resident is discontinued when the resident makes an election to receive hospice care. Any payment to the nursing facility for furnishing room and board to hospice patients is made by the hospice provider under the terms of its agreement with the nursing facility.

(d) The additional amount for room and board is not available for recipients receiving inpatient respite care or general inpatient care. *(Office of the Secretary of Family and Social Services; 405 IAC 1-16-4; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2378; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3635)*

SECTION 3. 405 IAC 5-34-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-1 Policy
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 1. (a) Medicaid reimbursement is available for hospice services subject to the limitations in this rule and 405 IAC 1-16. Hospice services consist of the following:
(1) Palliative care for the physical, psychological, social, spiritual, and other special needs of a hospice program patient during the final stages of the patient's terminal illness.
(2) Care for the psychological, social, spiritual, and other needs of the hospice program patient's family before and after the patient's death.

(b) In order to receive Medicaid reimbursement for hospice services, a hospice provider must meet the requirements of section 2 of this rule.

(c) Notwithstanding any prior approval by the office, the provision of all services shall comply with the Medicaid provider agreement, the appropriate provider manual applicable at the time such services were provided, all other Medicaid policy documents issued to providers, and any applicable state or federal statute or regulation. *(Office of the Secretary of Family and Social Services; 405 IAC 5-34-1; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2379; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3635)*

SECTION 4. 405 IAC 5-34-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-2 Provider enrollment
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15; IC 16-25-3

Sec. 2. (a) In order to enroll as a hospice provider in the Indiana Medicaid program, a provider must submit a provider enrollment agreement as specified in 405 IAC 5-4. A separate provider agreement for hospice services must be completed even if the provider currently participates in the Indiana Medicaid program as a provider of another service.

(b) A hospice provider must be certified as a hospice provider in the Medicare program. A copy of the provider's Medicare Certification Letter from **the Centers for Medicare and Medicaid Services (CMS), formerly** the Health Care Financing Administration, must be submitted with the Medicaid provider enrollment agreement. **The hospice provider who operates at more than one (1) location must provide a copy of the Medicare Certification Letter from CMS that demonstrates that the regional office has approved each additional office location to be Medicare-certified as a either a satellite office of the home office location or as a separate hospice with its unique Medicare provider number.**

(c) The provider must comply with all state and federal requirements for Medicaid **and Medicare** providers in addition to the requirements in this section. **The hospice and all hospice employees must be licensed in accordance with applicable federal,**

state, and local laws and regulations as required under federal regulations at 42 CFR 418.72 and Indiana state hospice licensure at IC 16-25-3.

(d) The hospice provider must designate an interdisciplinary group composed of individuals who are employees of the hospice and who provide or supervise care and services offered by the hospice provider. At a minimum, this group must include all of the following persons:
(1) A medical director, who must be a doctor of medicine or osteopathy.
(2) A registered nurse.
(3) A social worker.
(4) A pastoral or other counselor.

(e) The interdisciplinary group is responsible for the following:
(1) Participation in the establishment of the plan of care.
(2) Provision or supervision of hospice care and services.
(3) Review and updating of the plan of care.
(4) Establishment of policies governing the day-to-day provision of care and services.

(f) A hospice provider may not discontinue or diminish care provided to the Indiana Medicaid recipient because of the recipient's source of payment.

(g) The provider must demonstrate respect for a recipient's rights by ensuring that the election of hospice services is based on the informed, voluntary consent of the recipient or the recipient's representative.

(h) A hospice provider may discharge a recipient from hospice services only if one (1) or more of the following occurs:
(1) The recipient dies.
(2) The recipient is determined to have a prognosis greater than six (6) months.
(3) The recipient moves out of the hospice's service area.
(4) The safety of the recipient, other patients, or hospice staff is compromised.
(Office of the Secretary of Family and Social Services; 405 IAC 5-34-2; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2380; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3635)

SECTION 5. 405 IAC 5-34-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-3 Out-of-state providers
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 3. (a) Subject to the conditions in this section **and section 2 of this rule,** and any applicable state or federal licensing laws or regulations, an Indiana resident may receive hospice services from an out-of-state hospice provider if the provider is:
(1) located in a designated out-of-state city listed in 405 IAC 5-5-2(a); and
(2) enrolled in the Indiana Medicaid program.

(b) Prior authorization may be granted for an Indiana resident to receive hospice services from an out-of-state hospice provider not located in a designated out-of-state city if any one (1) of the criteria listed at 405 IAC 5-5-2(c) is met.

~~(b)~~ **(c)** Routine home care and continuous home care hospice services may be provided by out-of-state hospice providers to Indiana residents in their own home or in a nursing facility located in Indiana.

~~(c)~~ **(d)** Inpatient respite care and general inpatient care hospice services may be provided in an out-of-state hospice provider's facility.

~~(d)~~ **(e)** Routine home care and continuous home care hospice services cannot be provided to an Indiana resident in a nursing facility outside of Indiana, even if the nursing facility is located in an out-of-state designated city listed in 405 IAC 5-5-2(a). *(Office of the Secretary of Family and Social Services; 405 IAC 5-34-3; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2380; readopted filed Jun 27,*

2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3636)

SECTION 6. 405 IAC 5-34-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-4 Hospice authorization and benefit periods
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 4. (a) Hospice services require ~~prior approval~~ **Medicaid hospice authorization** by the office or its contractor. ~~In order~~ **Medicaid reimbursement is not available for hospice services furnished without authorization.**

(b) To ~~obtain prior approval~~ **request hospice authorization for Medicaid-only eligible recipients for each hospice benefit period,** the provider must submit all of the following ~~as detailed in this rule:~~ **documentation on forms approved by the office:**
(1) **Medicaid** recipient election statement.
(2) **Medicaid** physician certification.
(3) **Medicaid** plan of care.

(c) Dually-eligible Medicare/Medicaid recipients residing in nursing facilities who elect hospice benefits must enroll simultaneously in the Medicare and Medicaid hospice benefits. To obtain hospice authorization, the hospice provider must submit the following forms as approved by the office for a one (1) time enrollment in the Medicaid hospice benefit:
(1) Medicaid Hospice Authorization Notice for Dually-Eligible Medicare/Medicaid Nursing Facility Residents.
(2) A copy of the hospice agency form reflecting the recipient's election of the Medicare hospice benefit. The form must reflect the signature of the recipient or the recipient's representative and the date on which the form was signed.
The hospice provider is required to resubmit the forms described in this subsection when a dually-eligible Medicare/Medicaid hospice recipient residing in a nursing facility reelects the Medicare and the Medicaid hospice benefit following a previous hospice revocation or hospice discharge.

(d) Hospice authorization is not required for the dually-eligible Medicare/Medicaid hospice recipient residing at home as Medicare is reimbursing for the hospice care.

~~(b)~~ **(e)** Hospice ~~eligibility~~ **authorization for the Medicaid-only hospice recipient** is available in the following consecutive benefit periods:
(1) One (1) period of ninety (90) days.
(2) A second period of ninety (90) days.
(3) An unlimited number of periods of sixty (60) days.

~~(c) Approval~~ **(f) Hospice authorization** must be granted separately for each benefit period **for the Medicaid-only hospice recipient.** If benefit periods beyond the first ninety (90) days are necessary, then recertification on the physician certification form and an updated plan of care are required for ~~prior approval~~ **authorization** of the second and subsequent benefit periods. **For the dually-eligible Medicare/Medicaid hospice recipient residing in a nursing facility, hospice authorization is granted one (1) time at the time of enrollment in the Medicaid hospice benefit. Hospice authorization is not required for each hospice benefit period. Hospice authorization is required when the dually-eligible Medicare/Medicaid hospice recipient residing in a nursing facility reelects the Medicare and the Medicaid hospice benefit following a previous hospice revocation or hospice discharge.**

(g) In order to obtain authorization and reimbursement for hospice services, the provider must submit the documentation listed in this section to the office or its contractor within ten (10) business days of the effective date of the recipient's election, and within ten (10) business days of the beginning of the second and subsequent benefit periods if required under this section.

(h) When there is insufficient information submitted to render a hospice authorization decision or the documentation contains errors, a hospice authorization request will be suspended for thirty (30) days and the office or its contractor will request additional information from the provider. The provider must make the corrections and resubmit the proper documentation to the office or its contractor within thirty (30) calendar days after the additional information or correction is requested. If the provider fails to resubmit the documentation with the appropriate corrections within the thirty (30) day

time period, the request for hospice authorization will be denied. If the provider submits additional documentation within thirty (30) days, but the documentation submitted does not provide sufficient information to render a decision, the office or its contractor may request additional information. The provider must submit the additional information within thirty (30) days after the additional information is requested. If the provider fails to submit the requested information within the additional thirty (30) days, or if the additional documentation does not provide sufficient information to render a decision, the request for hospice authorization will be denied.

(i) If a request for hospice authorization or supporting documentation are submitted after the time limits in this section, authorization may be granted only for services provided on or after the date that the request is received. Authorization for services furnished prior to the date of a request that does not comply with the time limits in this section may be granted only under the following circumstances:

(1) Pending or retroactive recipient eligibility. The hospice authorization request must be submitted within twelve (12) months of the date of the issuance of the recipient's Medicaid card.

(2) The provider was unaware that the recipient was eligible for services at the time services were rendered. Hospice authorization will be granted in this situation only if the following conditions are met:

(A) The provider's records document that the recipient refused or was physically unable to provide the recipient identification (RID or Medicaid) number.

(B) The provider can substantiate that the provider continually pursued reimbursement from the patient until Medicaid eligibility was discovered.

(C) The provider submitted the request for prior authorization within sixty (60) days of the date Medicaid eligibility was discovered.

(3) Pending or retroactive approval of nursing facility level of care. The hospice authorization request must be submitted within one (1) year of the date nursing facility level of care is approved by the office.

(j) The office will rely on current professional guidelines, including the local Medicare medical review policies for hospice services, in making the hospice authorization determination.

~~(d)~~ **(k)** When approval for a benefit period has been granted, a hospice provider may manage a patient's care at the four (4) levels of care according to the medical needs determined by the interdisciplinary team and the requirements of the patient and the patient's family or primary caregivers. Changes in levels of care do not require prior approval as long as these levels are rendered within a prior approved hospice benefit period. *(Office of the Secretary of Family and Social Services; 405 IAC 5-34-4; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2380; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3636)*

SECTION 7. 405 IAC 5-34-4.1 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-34-4.1 Appeals of hospice authorization determinations

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40-8

Affected: IC 12-15

Sec. 4.1. (a) Medicaid recipients may appeal the denial or modification of hospice authorization under 405 IAC 1.1.

(b) Any provider submitting a request for hospice authorization under this rule, which has been denied either in whole or in part, may appeal the decision under 405 IAC 1.1 after first submitting a request for reconsideration of the hospice authorization in accordance with the procedures set out in 405 IAC 5-7-2 and 405 IAC 5-7-3 for administrative reconsideration of prior authorization decisions.

(c) When there is insufficient information submitted to render a decision, or the documentation contains errors, a hospice authorization request will be suspended pursuant to section 4 of this rule, and the office or its contractor will request additional information from the provider. Suspension is not a final decision on the merits of the request and is not appealable. If the provider does not submit sufficient information within the time frames set out in section 4(h) of this rule, the request shall be denied. Denial is a final decision and may be appealed pursuant to subsections (a) and (b). *(Office of the Secretary of Family and Social Services; 405 IAC 5-34-4.1; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3638)*

SECTION 8. 405 IAC 5-34-4.2 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-34-4.2 Audit
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40-8
Affected: IC 12-15

Sec. 4.2. (a) The office or its contractor may conduct audits of hospice services, including services for which hospice authorization has been granted. Audit of hospice services shall include review of the medical record to determine the medical necessity of services based upon applicable current professional guidelines, including the local Medicare medical review policies for hospice services.

(b) If the office determines that hospice services for a member are not medically necessary, hospice authorization will be revoked for the dates during which hospice services did not meet medical necessity criteria for hospice care. Medicaid payment for hospice services is not available for services that the office determines are not medically necessary. *(Office of the Secretary of Family and Social Services; 405 IAC 5-34-4.2; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3638)*

SECTION 9. 405 IAC 5-34-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-5 Physician certification
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 5. (a) In order for an individual to receive Medicaid-covered hospice services, a physician must certify **in writing** that the individual is terminally ill and expected to die from that illness within six (6) months. **For a dually-eligible Medicaid/Medicare recipient, the hospice provider must comply with Medicare physician certification requirements, but the provider is not required to complete the Medicaid physician certification form or to submit the physician certification to the office. For a Medicaid-only hospice recipient, the Medicaid physician certification form must be completed and submitted to office as set out in this section.**

(b) **As required by federal regulations,** the certification in subsection (a) must:
(1) be completed **for the first period of ninety (90) days** by:
(A) the medical director of the hospice program or **the physician member of the hospice interdisciplinary group; and**
(B) ~~the physician member of the disciplinary group and~~ the recipient's attending physician if the recipient has an attending physician;
(2) be completed by one (1) of the physicians listed in subdivision(1)(A) for the second and subsequent periods;
~~(2)~~ **(3)** be signed and dated;
~~(3)~~ **(4)** identify the diagnosis that prompted the individual to elect hospice services;
~~(4)~~ **(5)** include a statement that the prognosis **for life expectancy** is six (6) months or less; and
~~(5)~~ **(6)** be submitted to the office or its designee within the time frames in subsection (c).

(c) The **Medicaid** physician certification must be submitted for the first period within ten (10) business days of the effective date of the **Medicaid-only** recipient's election. For the second and subsequent periods, the **Medicaid** physician certification must be submitted within ten (10) business days of the beginning of the benefit period.

(d) For the Medicaid-only hospice recipient, the Medicaid physician certification form must be included in the recipient's medical chart in the hospice agency and the recipient's medical chart in the nursing facility. *(Office of the Secretary of Family and Social Services; 405 IAC 5-34-5; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2381; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3638)*

SECTION 10. 405 IAC 5-34-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-6 Election of hospice services
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 6. (a) In order to receive hospice services, a recipient must elect hospice services by filing an election statement with the

hospice provider on forms specified by the office.

(b) Election of the hospice benefit requires the recipient to waive Medicaid coverage for the following services:
(1) Other forms of health care for the treatment of the terminal illness for which hospice care was elected, or for treatment of a condition related to the terminal illness.
(2) Services provided by another provider which are equivalent to the care provided by the elected hospice provider.
(3) Hospice services other than those provided by the elected hospice provider or its contractors.

(c) The recipient or recipient's representative may designate an effective date for the election that begins with the first day of hospice care or any other subsequent day of hospice care. The individual may not designate an effective date that is earlier than the date of election.

(d) **For Medicaid-only hospice recipient,** the **Medicaid** election form must be submitted to the office or its designee along with the **Medicaid** physician's certification required by section 5 of this rule when hospice services are initiated. It is not necessary to submit the **Medicaid** election form for the second and subsequent benefit periods unless the recipient has revoked the election and wishes to reelect hospice care.

(e) For the dually-eligible Medicare/Medicaid hospice recipient residing in the nursing facility, the hospice agency election form reflecting the Medicare hospice election date and the recipient's signature must be submitted with the Medicaid hospice authorization form for dually-eligible Medicare/Medicaid nursing facility residents. It is not necessary to submit the Medicare election form for the second and subsequent benefit periods unless the recipient has revoked the election and wishes to reelect hospice care under the Medicare and Medicaid hospice benefits.

~~(e)~~ **(f)** In the event that a recipient or the recipient's representative wishes to revoke the election of hospice services, the following apply:
(1) The individual must file a hospice revocation statement on a form approved by the office. The form includes a signed statement that the individual revokes the election of Medicaid hospice services for the remaining days in the benefit period. **The form must specify the date that the revocation is to be effective, if later than the date the form is signed by the individual or representative. An individual or representative may not designate an effective date earlier than the date that the revocation is made.**
(2) A recipient may elect to receive hospice care intermittently rather than consecutively over the benefit periods.
(3) If a recipient revokes hospice services during any benefit period, time remaining on that benefit period is forfeited.
(4) The revocation form must be completed for Medicaid-only hospice recipients as well as dually-eligible Medicare/Medicaid hospice recipients residing in nursing facilities. The hospice provider must submit this form to the office or its designee.
(5) The Medicaid hospice revocation form must be included in the recipient's medical chart in the hospice agency. If the Medicaid hospice recipient resides in a nursing facility, the Medicaid hospice revocation form must be included in the recipient's nursing facility medical chart as well.

~~(f)~~ **(g)** A recipient or a recipient's representative may change hospice providers once during any benefit period. This change does not constitute a revocation of services. **The following apply when a recipient changes hospice providers:**
(1) To change the designation of hospice programs, the individual or the individual's representative must complete the Medicaid Hospice Provider Change Request Between Indiana Hospice Providers Form or other form designated by the office for this purpose. This form is required for the Medicaid-only hospice recipient and the dually-eligible Medicare/Medicaid hospice member residing in the nursing facility. The original provider must submit this form to the office or its designee.
(2) The Medicaid Hospice Provider Change Request Between Indiana Hospice Providers Form, or other form designated by the office for this purpose, must be included in the recipient's medical chart in the hospice agency. If the Medicaid hospice recipient resides in a nursing facility, this form must be included in the recipient's nursing facility chart. This documentation requirement is for the Medicaid-only hospice member as well as the dually-eligible Medicare/Medicaid hospice member residing in a nursing facility.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-6; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2381; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3639)

SECTION 11. 405 IAC 5-34-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-34-7 Plan of care

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 7. (a) When an eligible recipient elects to receive services from a certified hospice provider, the provider shall develop a plan of care. **For the Medicaid-only hospice recipients,** the provider must submit the **Medicaid** plan **of care form** to the office or the office's contractor with the **Medicaid** physician certification and the **Medicaid** election statement.

(b) In developing the plan of care, the provider must comply with the following procedures:

(1) The interdisciplinary team member who drafts the plan must confer with at least one (1) other member of the interdisciplinary team.

(2) One (1) of the conferees must be a physician or nurse and all other team members must review the plan of care.

(3) All services stipulated within the plan of care must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.

(4) For the Medicaid-only hospice recipient, the Medicaid hospice plan of care must be included in the recipient's medical chart at the hospice agency. If the Medicaid-only recipient resides in a nursing facility, the Medicaid plan of care must also be included in the recipient's nursing facility medical chart.

(5) For the dually-eligible Medicare/Medicaid hospice recipient residing in a nursing facility, a coordinated plan of care prepared and agreed upon by the hospice and nursing facility must be included in the recipient's nursing facility medical chart.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-7; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2382; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3640)

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