**TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES**

**ARTICLE 5. MEDICAID SERVICES**

**Rule 34. Hospice Services**

**405 IAC 5-34-1 Policy**

Authority: 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 authorization 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; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed* *Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

**405 IAC 5-34-2 Provider enrollment**

Authority: 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 Medicaid 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 Medicaid 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 member because of the

member's source of payment.

(g) The provider must demonstrate respect for a member's rights by ensuring that the election of hospice

services is based on the informed, voluntary consent of the member or the member's representative.

(h) A hospice provider may discharge a member from hospice services only if one (1) or more of the following occurs:

(1) The member dies.

(2) The member is determined to have a prognosis greater than six (6) months.

(3) The member moves out of the hospice's service area.

(4) The safety of the member, 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; readopted filed Sep 19, 2007, 12:16 p.m.:20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

**405 IAC 5-34-3 Out-of-state providers**

Authority: 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 area pursuant to 405 IAC 5-5-1; and

(2) enrolled in Medicaid.

(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.

(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.

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

(e) Routine home care and continuous home care hospice services cannot be provided to an Indiana resident in a nursing facility outside of Indiana. *(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; readopted filed Sep* *19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed* *Aug 1, 2016, 3:44 p.m.: 20160831-IR 405150418FRA; filed Apr 19, 2018, 11:29 a.m.: 20180516-IR-405170306FRA)*

**405 IAC 5-34-4 Hospice authorization and benefit periods**

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

Affected: IC 12-15

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

(b) To request hospice authorization for Medicaid-only eligible members for each hospice benefit period, the provider must submit all of the following documentation on forms approved by the office:

(1) Member election statement.

(2) Medicaid physician certification.

(3) Medicaid plan of care.

(c) Dually-eligible Medicare/Medicaid members 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 member's election of the Medicare hospice benefit. The form must reflect the signature of the member or the member'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 member 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 member residing at home as Medicare is reimbursing for the hospice care.

(e) Hospice authorization for the Medicaid-only hospice member 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.

(f) Hospice authorization must be granted separately for each benefit period for the Medicaid-only hospice member. 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 authorization of the second and subsequent benefit periods. For the dually-eligible Medicare/Medicaid hospice member 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 member 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 member'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 member eligibility. The hospice authorization request must be submitted within twelve (12) months of the date of the issuance of the member's Medicaid card.

(2) The provider was unaware that the member 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 member refused or was physically unable to provide the member 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.

(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 authorization 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; readopted* *filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

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

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

Affected: IC 12-15

Sec. 4.1. (a) Members 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; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

**405 IAC 5-34-4.2 Audit**

Authority: 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 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 services are medically necessary 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 medically necessary 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; readopted filed Sep 19, 2007, 12:16 p.m.:* *20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44* *p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)*

**405 IAC 5-34-5 Physician certification**

Authority: IC 12-8-6.5-5; IC 12-15

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 member, 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 member, 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 the:

(A) medical director of the hospice program or the physician member of the hospice interdisciplinary group; and

(B) member's attending physician if the member has an attending physician;

(2) be completed by one (1) of the physicians listed in subdivision (1)(A) for the second and subsequent periods;

(3) be signed and dated;

(4) identify the diagnosis that prompted the individual to elect hospice services;

(5) include a statement that the prognosis for life expectancy is six (6) months or less; and

(6) be submitted to the office 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 member'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 member, the Medicaid physician certification form must be included in the member's medical chart in the hospice agency and the member's medical chart in the nursing facility.

(e) Prior to the beginning of the member's third benefit period or one hundred eightieth day of hospice service and prior to each subsequent benefit period, a hospice physician or hospice nurse practitioner (NP) must have a face-to-face encounter with the member to gather clinical findings to determine continued eligibility for hospice care and must attest in writing that such a visit took place. The face-to-face encounter must occur not more than thirty (30) calendar days prior to:

(1) the third benefit period recertification; and

(2) every subsequent recertification thereafter.

*(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; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Feb 14, 2013, 9:48 a.m.: 20130313-IR-405120451FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

**405 IAC 5-34-6 Election of hospice services**

Authority: IC 12-8-6.5-5; IC 12-15

Affected: IC 12-15

Sec. 6. (a) In order to receive hospice services, a member must elect hospice services by filing an election statement with the hospice provider on forms specified by the office.

(b) For members at least twenty-one (21) years of age, election of the hospice benefit requires the member 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 that 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) For members less than twenty-one (21) years of age who elect the hospice benefit, the member may receive concurrent curative care services in conjunction with hospice services for the terminal illness. This allows the member or the member's representative to elect the hospice benefit, without forgoing any curative service the member is entitled to under Medicaid for treatment of the terminal illness.

(d) The member or member'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.

(e) For Medicaid-only hospice member, the Medicaid election form must be submitted to the office 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 member has revoked the election and wishes to reelect hospice care.

(f) For the dually-eligible Medicare/Medicaid hospice member residing in the nursing facility, the hospice agency election form reflecting the Medicare hospice election date and the member'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 member has revoked the election and wishes to reelect hospice care under the Medicare and Medicaid hospice benefits.

(g) In the event that a member or the member'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 member may elect to receive hospice care intermittently rather than consecutively over the benefit periods.

(3) If a member 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 members as well as dually-eligible Medicare/Medicaid hospice members residing in nursing facilities. The hospice provider must submit this form to the office.

(5) The Medicaid hospice revocation form must be included in the member's medical chart in the hospice agency. If the Medicaid hospice member resides in a nursing facility, the Medicaid hospice revocation form must be included in the member's nursing facility medical chart as well.

(h) A member or a member'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 member 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 member and the dually-eligible Medicare/Medicaid hospice member residing in the nursing facility. The original provider must submit this form to the office.

(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 member's medical chart in the hospice agency. If the Medicaid hospice member resides in a nursing facility, this form must be included in the member'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; readopted filed Sep 19, 2007, 12:16 p.m.:20071010-IR-405070311RFA; filed Feb 14, 2013, 9:48 a.m.: 20130313-IR-405120451FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

**405 IAC 5-34-7 Plan of care**

Authority: IC 12-8-6.5-5; IC 12-15

Affected: IC 12-15

Sec. 7. (a) When an eligible member elects to receive services from a certified hospice provider, the

provider shall develop a plan of care. For the Medicaid-only hospice members, 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. For members less than twentyone (21) years of age concurrently receiving hospice and curative care services, the providers rendering those services must submit an updated coordinated plan of care, including delineation of hospice and curative care services, to the office or the office's contractor.

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

(5) For the dually-eligible Medicare/Medicaid hospice member 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 member's nursing facility medical chart.

(6) For members less than twenty-one (21) years of age concurrently receiving hospice and curative care services, the Medicaid plan of care must include the information identified previously in this section, and a coordinated plan of care must be prepared and agreed upon by the hospice interdisciplinary team and the provider or providers rendering the curative care services. The plan of care must include the following:

(A) An assessment of the member's needs.

(B) The curative care and hospice services the member is receiving along with the scope and frequency of these services and the manner in which the services and assessments are coordinated. The plan of care must be included in the member's medical charts of both the hospice and curative care providers. The advanced directive, if applicable, must be included in the member's medical charts of both the hospice and curative care providers.

*(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; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Feb 14, 2013, 9:48 a.m.: 20130313-IR-405120451FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

**405 IAC 5-34-8 Covered services**

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

Affected: IC 12-15

Sec. 8. Services covered within the hospice per diem reimbursement rates include the following:

(1) Nursing care provided by or under the supervision of a registered nurse.

(2) Medical social services provided by a social worker who has at least a bachelor's degree and who is working under the supervision of a physician.

(3) Physicians' services provided by the medical director or physician member of the interdisciplinary team that may be characterized as follows:

(A) General supervisory services.

(B) Participation in the establishment of the plan of care.

(C) Supervision of the plan of care.

(D) Periodic review.

(E) Establishment of governing policies.

(4) Counseling services provided to the member and the member's family or other person caring for the member.

(5) Short term inpatient care provided in a hospice inpatient unit, participating hospital, or nursing home, subject to the limits in 405 IAC 1-16-3.

(6) Medical appliances and supplies, including palliative drugs, that are related to the palliation or management of the member's terminal illness.

(7) Home health services furnished by qualified aides.

(8) Homemaker services that assist in providing a safe and healthy environment.

(9) Physical, occupational therapy, and speech-language pathology services provided for purposes of symptom control.

(10) Inpatient respite care, subject to the limitations in 405 IAC 1-16-2.

(11) Room and board for members who reside in long term care facilities, as set out in 405 IAC 1-16-4.

(12) Any other item or service specified in the member's plan of care, if the item or service is a covered service under the Medicare program.

*(Office of the Secretary of Family and Social Services; 405 IAC 5-34-8; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2382; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

**405 IAC 5-34-9 Levels of care**

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

Affected: IC 12-15

Sec. 9. (a) Covered hospice services will be delivered and reimbursed at one (1) of four (4) levels, the utilization of which shall be determined by the hospice provider within the context of the overall utilization and reimbursement limitations contained in this rule and 405 IAC 1-16.

(b) The levels of care are as follows:

(1) Routine home hospice care.

(2) Continuous home hospice care.

(3) Inpatient respite care.

(4) General inpatient hospice care.

(c) When routine home care and continuous home care are furnished to a member who resides in a nursing facility, the nursing facility is considered the member's home. *(Office of the Secretary of Family and Social Services; 405 IAC 5-34-9; filed* *Mar 9, 1998, 9:30 a.m.: 21 IR 2382; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16* *p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016,* *3:44 p.m.: 20160831-IR-405150418FRA)*

**405 IAC 5-34-10 Location of care**

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

Affected: IC 12-15

Sec. 10. (a) The usual home of the hospice member determines the location of care for that member. For purposes of this rule and 405 IAC 1-16, hospice location of care will be categorized according to one (1) of two (2) locations.

(b) Private home location of care applies if the member usually lives in his or her private home.

(c) Nursing facility location of care applies if the member usually lives in a nursing facility.

(d) The additional room and board amount available for nursing facility residents under 405 IAC 1-16-4 is available only if the hospice member meets the criteria for nursing facility level of care under 405 IAC 1-3. *(Office of the Secretary of Family* *and Social Services; 405 IAC 5-34-10; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2382; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR* *3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

**405 IAC 5-34-11 Prior authorization for nonhospice services**

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

Affected: IC 12-15

Sec. 11. (a) Except as provided in subsection (b), prior authorization is required for any Medicaid-covered service not related to the hospice member's terminal condition if prior authorization is otherwise required under this article.

(b) Notwithstanding any other provision of this article, prior authorization is not required for the following services when provided to hospice patients:

(1) Pharmacy services, for conditions not related to the patient's terminal condition. Pharmacy services related to the patient's terminal condition do not require prior authorization because they are included in the hospice per diem.

(2) Dental services.

(3) Vision care services.

*(Office of the Secretary of Family and Social Services; 405 IAC 5-34-11; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2383; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

**405 IAC 5-34-12 Reservation of beds for hospice members in nursing facilities**

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

Affected: IC 12-15

Sec. 12. (a) Although it is not mandatory for providers to reserve beds, Medicaid will reimburse for reserving nursing facility beds for hospice members at one-half (1/2) the room and board payment provided that the criteria as set out in this section are met.

(b) Hospitalization must be ordered by the hospice physician for treatment of an acute condition that cannot be treated in the nursing facility by the hospice provider. The maximum length of time allowed for payment of a reserved bed for a single hospital stay is fifteen (15) days.

(c) A leave of absence must be for therapeutic reasons, as prescribed by the hospice attending physician and as indicated in the hospice member's plan of care. The maximum length of time allotted for therapeutic leave in any calendar year is limited to eighteen (18) days, which need not be consecutive.

(d) Although prior authorization by the office is not required to reserve a bed, the hospice member's physician's order for the hospitalization or therapeutic leave must be on file in the nursing facility.

(e) In no instance will Medicaid reimburse a nursing facility for reserving nursing facility beds for hospice members when the nursing facility has an occupancy rate of less than ninety percent (90%). For purposes of this rule, the occupancy rate shall be determined by dividing the total number of residents in licensed beds, excluding residential beds, in the nursing facility taken from the midnight census as of the day that a Medicaid hospice member takes a leave of absence, by the total number of licensed nursing facility beds, excluding residential beds. *(Office of the Secretary of Family and Social Services; 405 IAC 5-34-12; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2383; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:34 p.m.: 25 IR 2476;* *readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-*

*405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*