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8.325.4 HOSPICE CARE SERVICES

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TITLE 8 SOCIAL SERVICES
CHAPTER 325 SPECIALTY SERVICES
PART 4 HOSPICE CARE SERVICES

8.325.4.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.325.4.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 3-1-06]

8.325.4.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.325.4.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 3-1-06]

8.325.4.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.325.4.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 3-1-06]

8.325.4.4 DURATION: Permanent
[2/1/95; 8.325.4.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 3-1-06]

8.325.4.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[2/1/95; 8.325.4.5 NMAC - Rn, 8 NMAC 4.MAD.000.5 & A, 3-1-06]

8.325.4.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/95; 8.325.4.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 3-1-06]

8.325.4.7 DEFINITIONS: [RESERVED]

8.325.4.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/95; 8.325.4.8 NMAC - Rn, 8 NMAC 4.MAD.002, 3-1-06]

8.325.4.9 HOSPICE CARE SERVICES: Hospice services are covered as an optional medical service for New Mexico medicaid program (medicaid) recipients. Hospice services provide palliative and supportive services to meet the physical, psychological, social, and spiritual needs of terminally ill medicaid recipients and their families. This part describes eligible providers covered services, service limitations, and general reimbursement methodology.
[2/1/95; 8.325.4.9 NMAC - Rn, 8 NMAC 4.MAD.763, 3-1-06]

8.325.4.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation by the New Mexico medical assistance division (MAD), hospice agencies meeting the following conditions are eligible to be reimbursed for providing hospice care services:

(1) meet the conditions for participation: see 42 CFR 418.50 et. seq.;

(2) licensed and certified by the licensing and certification bureau of the New Mexico department of health (DOH); and

(3) are a public or private non-profit or for profit agency or a subdivision of either, primarily engaged in providing care to terminally ill individuals.

B. Once enrolled, providers receive a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.
[2/1/95; 8.325.4.10 NMAC - Rn, 8 NMAC 4.MAD.763.1 & A, 3-1-06]

8.325.4.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, and the State Medicaid Fraud Act. Providers also agree to conform to MAD policies and instructions as specified in this manual and it appendices, as updated. See, 8.302.1 NMAC, *General Provider Policies*. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance. Providers must maintain records to fully disclose the nature, quality, amount, and medical necessity of the services furnished to recipients who are currently receiving or who have received medical services in the past [42 CFR 431.107(B)]. Documentation supporting medical necessity must be legible and available to medicaid upon request. See 8.302.1 NMAC, *General Provider Policies*.
[2/1/95; 8.325.4.11 NMAC - Rn, 8 NMAC 4.MAD.763.2 & A, 3-1-06]

8.325.4.12 ELIGIBLE RECIPIENTS: To be eligible for hospice care, a physician must provide a written certification that the recipient has a terminal illness. Recipients must elect to receive hospice care for the duration of the election period.

A. **Certification of terminal illness:** The hospice must obtain a written certification statement signed by the hospice medical director, physician member of the hospice interdisciplinary team or recipient's attending physician that the recipient is terminally ill. The physician must sign the written certification within seven (7) calendar days of the date services are initiated. Certification statements must include information that is based on the recipient's medical prognosis, and the life expectancy is six (6) months or less if the terminal illness runs its typical course.

(1) If a recipient receives hospice benefits beyond 210 days, the hospice must obtain a written recertification statement from the hospice medical director or the physician member of the hospice interdisciplinary group before the 210-day period expires.

(2) Hospice benefits furnished beyond the 210-day period may be subject to medical review.

B. **Election of hospice care:** Recipients who are eligible for hospice care must elect to receive hospice services. Recipients or their legal representatives elect hospice services by filing an election statement with a particular hospice designee.

(1) For the duration of the election, recipients who elect hospice care, waive their right to medicaid payment for the following services:

(a) services related to treatment of the terminal condition or related condition for which hospice care was elected; and

(b) services equivalent to hospice care, such as home health services, and private duty nursing services under enhanced early and periodic screening, diagnosis and treatment (EPSDT).

(2) Recipients who are receiving home and community based waiver services or other in-home services based on a plan of care must have the plan of care coordinated with the hospice provider and adjusted as necessary to avoid duplicative or unnecessary services.

(3) Hospice coverage continues for 210-day time periods, as long as recipients remain in hospice care and do not cancel the election.

(4) Recipients or their representatives can designate an effective date for the election. The effective date begins with the first or any subsequent day of hospice services.

C. **Election statement:** The election statement must include the following elements:

(1) designation of the hospice that will provide care;

(2) designation of the recipient's attending physician;

(3) acknowledgement that the recipients or representatives has been given a full understanding of the palliative rather than curative nature of hospice care;

(4) effective date of the election; and

(5) the recipient's or the representative's signature.

D. **Revocation of hospice care services:**

(1) A recipient or representative can cancel the election of hospice care at any time by filing a statement with MAD or its designee. The statement must include the following information:

(a) recipient is revoking his/her election for medicaid coverage of hospice care;

(b) effective date of the revocation, which is not earlier than the actual date of the revocation; and

(c) the recipient's or the representative's signature.

(2) Upon revocation of the election of hospice services, recipients are no longer covered for medicaid hospice services.

(3) Recipients can elect to receive hospice care services again at any time. The same process for approval of services must be followed when the second election occurs. A new plan of care, certification statement, and election statement must be submitted to MAD or its designee.

E. **Change of designated hospice:**

(1) Recipients or their representatives can change designated hospice providers by filing statements with MAD or its designee. A statement must contain the following information:

(a) name of the hospice the recipient is leaving;

(b) name of the hospice the recipient is entering; and

(c) effective date of the change.

(2) A change in ownership or name of a hospice is not considered a change in the recipient's designated hospice.

[2/1/95; 8.325.4.12 NMAC - Rn, 8 NMAC 4.MAD.763.3 & A, 3-1-06]

8.325.4.13 COVERED SERVICES AND SERVICE LIMITATIONS: For recipients electing hospice care, medicaid covers hospice core services furnished to eligible recipients that are reasonable and necessary for the palliation or symptom management of a recipient's terminal illness and related conditions. Hospice core services include the medications, durable medical equipment and medical supplies needed to deliver palliative care. Hospice providers are reimbursed for the delivery of core services based on daily rate.

A. The hospice services necessary for a specific recipient must be documented in an individualized treatment plan. The plan must be developed by attending physicians, medical directors and interdisciplinary groups and must meet certain requirements: See 42 CFR 418.50 et. seq..

(1) Hospices must designate a registered nurse to coordinate the implementation of each recipient's plan of care.

(2) The interdisciplinary group, including nursing services, medical social services, physician services and counseling services practitioners are responsible for the following:

(a) developing the plan of care;

(b) providing or supervising hospice care and services;

(c) reviewing and updating the plan of care;

(d) establishing policies for daily provision of hospice care and services; and

(e) coordinating with other medicaid support service providers such that the plan of care is not duplicative of hospice services.

(3) All hospice services must be available twenty-four (24) hours per day to the extent necessary to meet the needs of the terminally ill recipients.

B. **Core services:** Medicaid covers the following nursing, medical social service, physician and counseling services as core hospice services:

(1) nursing services furnished by or under the supervision of registered nurses and based on the treatment plan and recognized standards of practice;

(2) medical social services furnished by a qualified social worker under the direction of a physician;

(3) physician services performed by a doctor of medicine or osteopathy, including palliation and management of terminal illness and related conditions and the recipient's general medical needs not met by the recipient's attending physician;

(4) counseling services available to recipients and family members; counseling can be furnished for training families to provide care and preparing recipients and families to adjust to the recipient's approaching death; counseling includes dietary, spiritual and other counseling for recipients and families and bereavement counseling furnished after a recipient's death; the following counseling services must be furnished by hospices:

(a) organized program of bereavement services under the supervision of qualified professionals; the plan of care for these services must reflect family needs and provide a clear outline of the type, frequency and duration of counseling; bereavement counseling is a required but non-reimbursed service;

(b) dietary counseling, when applicable, furnished by qualified professionals;

(c) spiritual counseling, including notice to recipients of the availability of clergy; and

(d) other counseling, furnished by members of the interdisciplinary group or other qualified professionals.

(5) home health aide and homemaker services at frequencies sufficient to meet the needs of recipients; home health aides must meet training and qualification requirements; see 42 CFR 484.36; registered

nurses must visit a recipient's residence every two (2) weeks to assess the performance of the aide or homemaker services;

(6) physical therapy, occupational therapy and speech-language therapy must be available if needed to control symptoms or maintain activities of daily living;

(7) durable medical equipment, medical supplies, and pharmacy services related to the palliation and management of the terminal illness and related conditions:

(a) See 8.324.5 NMAC, *Durable Medical Equipment and Medical Supplies*.

(b) Medicaid covers only drugs and biologicals defined in Section 1861 (t) of the Social Security Act and used primarily for pain relief and symptom control related to terminal illness. All drugs and biologicals must be administered in accordance with accepted standards of practice.

(c) Every hospice must have a policy for the disposal of controlled drugs kept in the recipient's home when those drugs are no longer needed.

(d) Drugs and biologicals are to be administered only by the following individuals:

(i) a licensed nurse or physician;

(ii) the recipient with the approval of the attending physician; and

(iii) any other individual in accordance with applicable state and local laws; the individual and each drug and biological they are authorized to administer must be specified in the recipient's plan of care.

(8) short-term inpatient services for pain control and symptom management delivered in a facility which is a medicaid provider; and

(9) short-term inpatient respite services furnished in a facility which is a medicaid provider; medicaid covers five (5) consecutive days of inpatient respite care which can be needed on an infrequent basis to provide respite for the recipient's family or primary caregivers.

(a) The need for and duration of inpatient respite services must be specified in the treatment plan.

(b) Inpatient respite must be furnished by a hospice facility, hospital, or nursing facility that meets the requirements in 42 CFR Section 418.100.

C. **Continuous nursing care services:** Medicaid covers continuous nursing care required to achieve pain control and symptom management. Continuous care can be covered during a period of crisis if the recipient needs such care to achieve palliation and manage acute medical symptoms at home.

(1) To be considered continuous care, nursing care must be furnished for eight (8) consecutive hours in a twenty-four (24) hour period. Medicaid covers the homemaker and/or aide services furnished during the other sixteen (16) hours as routine home care.

(2) Medicaid covers continuous nursing services for a maximum of seventy-two (72) consecutive hours.

[2/1/95; 8.325.4.13 NMAC - Rn, 8 NMAC 4.MAD.763.4 & A, 3-1-06]

8.325.4.14 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: Hospice services are subject to utilization review for medical necessity and program compliance. These reviews can be performed before services are furnished, after services are furnished and before payment is made, after payment is made, or at any point in the service or payment process. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive utilization review instructions and documentation forms which assists in the receipt of prior authorization and claims processing.

A. **Prior authorization:** Hospice services do not require prior authorization. Services remain subject to review at any point in the payment process for medical necessity.

B. **Eligibility determination:** Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who are dissatisfied with a utilization review decision or action can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

[2/1/95; 8.325.4.14 NMAC - Rn, 8 NMAC 4.MAD.763.5 & A, 3-1-06]

8.325.4.15 NONCOVERED SERVICES: Hospice services are subject to the limitations and coverage restrictions that exist for other medicaid services. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602]. Medicaid does not cover the following hospice services.

A. Core services furnished by nonemployees. Core services when furnished routinely by non-employees or contracted staff are not covered by medicaid. A hospice can bill only for contracted staff necessary to supplement hospice employees in meeting recipient needs during periods of peak patient loads.

B. Bereavement counseling furnished to families after a recipient's death is a required hospice service, however, hospice agencies are not paid an additional amount for furnishing these services.

C. Inpatient respite care for more than five (5) consecutive days. After five (5) days, additional inpatient respite care is reimbursed as routine home care. Respite care cannot be furnished if the recipient lives in a long-term care facility.

D. Hospice services furnished by nondesignated hospices are not a covered benefit.

[2/1/95; 8.325.4.15 NMAC - Rn, 8 NMAC 4.MAD.763.6 & A, 3-1-06]

8.325.4.16 PATIENT SELF DETERMINATION ACT: All adult recipients must be informed of their right to make health decisions, including the right to accept or refuse medical treatment, as specified in the Patient Self-Determination Act. See 8.302.1 NMAC, *General Provider Policies.*

[2/1/95; 8.325.4.16 NMAC - Rn, 8 NMAC 4.MAD.763.7, 3-1-06]

8.325.4.17 REIMBURSEMENT: Hospice providers must submit claims for reimbursement on the UB-92 claim form or its successor. Election documentation must be submitted with the initial claim. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing. Medicaid reimbursement for hospice care is made at one of four prospective daily rates, depending on the level of care furnished. The only retroactive adjustment to reimbursement is the year-end application of the limitation on inpatient care payment. Physician services are reimbursed separately from the hospice daily rate.

A. **Payment for hospice care:**

(1) Payment rates for hospice care services are determined by the centers for medicare and medicaid services (CMS), with local adjustments for wage differences within each category. Reimbursement for hospice services is based on one of four all-inclusive daily rate categories. The daily rate for each category includes all services necessary for palliative care, such as the purchase of needed medications, durable medical equipment, and medical supplies. The following are basic categories of hospice care:

(a) "routine home care day" defined as a day on which the recipient receives hospice care at home that is not defined as continuous care;

(b) "continuous home care day" defined as a day on which the recipient is not in an inpatient facility and receives nursing services for eight (8) consecutive hours in a twenty-four (24) hour period; this care is furnished only during brief periods of crisis to maintain the recipient at home; home health aide and/or homemaker services can also be furnished on a continuous basis, but these services are considered routine care;

(c) "inpatient respite care day" defined as a day on which a recipient receives care in approved facilities on a short-term basis to provider respite for the recipient's family or primary caregiver; and

(d) "general inpatient care day" defined as a day on which a recipient receives care in inpatient facilities for pain control or acute or chronic symptom management that cannot be managed in other settings.

(2) Reimbursement is made to a hospice for each day on which recipients are eligible for hospice care. Reimbursement is based on the appropriate payment amount for each day, regardless of the category of services furnished on any given day.

(3) Reimbursement for a continuous home care day varies, depending on the number of hours of continuous nursing services furnished. The continuous home care rate is divided by twenty-four (24) to yield an hourly rate. The number of hours of care furnished during the continuous home care day is multiplied by the hourly rate to yield the continuous home care payment for that day. Medicaid reimbursement for continuous home care is limited to a maximum of seventy-two (72) consecutive hours of service.

(4) The inpatient reimbursement rate for approved facility for short-term inpatient care depends on the category of care furnished, either inpatient respite or general inpatient.

(a) Reimbursement for inpatient respite care is limited to a maximum of five (5) consecutive days at a time. Medicaid pays for the sixth and any subsequent day of respite care at the routine home care rate.

(b) Medicaid pays the inpatient rate for the admission date and all subsequent inpatient days. For the discharge day, the applicable home care rate is reimbursed. Reimbursement for the discharge day when the recipient is discharged deceased is made at the inpatient rate.

(c) Reimbursement for all inpatient care is subject to a limitation that total inpatient care days for medicaid recipients cannot exceed twenty percent (20%) of the total days for which these recipients elected

hospice care. The calculation and any necessary retroactive adjustment of overall payments per provider is completed during the cap period. See 42 CFR 418.302 (f).

B. **Reimbursement for physician services:**

(1) Medicaid covers the following services performed by hospice physicians as part of the general reimbursement rate for hospice care services:

(a) general supervisory services of the medical director; and

(b) participation in establishing, reviewing and updating plans of care, supervision of care and services, and establishment of governing policies by the physician member of the interdisciplinary group.

(2) For direct patient care services furnished by a hospice employee or a physician working under arrangement with the hospice, not listed above, medicaid reimburses the hospice for each procedure at the lesser of the medicaid fee schedule or the amount billed.

(3) Medicaid does not pay for physician services furnished on a volunteer basis.

(4) Medicaid does not cover physician services furnished by the recipient's attending physician as a hospice service, if he or she is not an employee of the hospice or providing services under arrangements with the hospice. Only the attending physician can bill for these services.

[2/1/95; 8.325.4.17 NMAC - Rn, 8 NMAC 4.MAD.763.8 & A, 3-1-06]

8.325.4.18 HOSPICE SERVICES FOR RECIPIENTS IN NURSING FACILITIES: If a recipient does not have family or friends to provide the necessary care to allow the recipient to remain at home (home does not include an adult foster care setting or a home for the aged), a recipient living in a nursing facility (NF) can elect to receive hospice care. The NF is considered the recipient's place of residence. The NF and the designated hospice must sign a cooperative agreement that the hospice is responsible for the professional management of the recipient's hospice care and the NF provides room and board.

A. **Room and board services:** The agreement must specify that the NF provides the following room and board services:

(1) perform personal care services;

(2) help with activities of daily living;

(3) provide socializing activities;

(4) administer medication;

(5) maintain room cleanliness; and

(6) supervise the use of durable medical equipment and prescribed therapies.

B. **Reimbursement for nursing facility room and board:** For medicaid recipients living in a NF who elect hospice care, medicaid pays the hospice an additional per diem amount for routine home care and continuous home care days for the NF room and board services.

(1) The room and board reimbursement is ninety-five percent (95%) of the medicaid rate paid to the specific NF for that recipient.

(2) For dual-eligible medicare/medicaid recipients who live in an NF and elect the medicare hospice benefit, medicaid pays the hospice for the NF room and board services if the hospice and NF have a written agreement delineating responsibilities for hospice care and room and board services.

(a) For dual-eligible recipients, medicaid pays any coinsurance amounts for drugs, biological and respite care. See 42 CFR Section 418.400.

(b) For dual-eligible recipients, direct medicaid payment for service to the NF is discontinued.

[2/1/95; 8.325.4.18 NMAC - Rn, 8 NMAC 4.MAD.763.9, 3-1-06]

HISTORY OF 325.4 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:

MAD Rule 310.26, Hospice Services, filed 3/20/89.

History of Repealed Material:

MAD Rule 310.26, Hospice Services, filed 3/20/89 - Repealed effective 2/1/95.