Connecticut interChange MMIS

Provider Manual

Chapter 7 - Hospice

October 1, 2020

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CONNECTICUT MEDICAL ASSISTANCE PROGRAM
Hospice Regulation/Policy
Chapter 7

This section of the Provider Manual contains the Medical Services Policy sections that pertain to hospice providers.

Policy updates, additions, and revisions are approved in accordance with the Connecticut Uniform Administrative Procedure Act. Should this occur, providers are notified through the Provider Bulletin process and sent policy update pages to place in Chapter 7 of their manuals.

Hospice

Requirements for Payment of Hospice

Department of Social Services
Requirements for Payment of Hospice

Section 17b-262-829. Scope

Sections 17b-262-829 to 17b-262-848, inclusive, of the Regulations of Connecticut State Agencies set forth the Department of Social Services requirements for the payment of hospice services on behalf of clients who are determined eligible to receive services under the Connecticut Medicaid program pursuant to section 17b-262 of the Connecticut General Statutes.

Sec. 17b-262-830. Definitions

As used in section 17b-262-829 to section 17b-262-848, inclusive, of the Regulations of Connecticut State Agencies:

(1) “Advanced practice registered nurse” or “APRN” means an advanced practice registered nurse as defined in section 20-87a of the Connecticut General Statutes;

(2) “Applied income” means the amount of income that each client receiving hospice care is expected to pay each month toward the cost of care, calculated according to the department’s Uniform Policy Manual, section 5045.20;

(3) “Attending physician” means a physician who is identified by the client at the time he or she elected to receive hospice care as having the most significant role in the determination and delivery of the individual’s medical care;

(4) “Bereavement counseling” means emotional, psychosocial, and spiritual support and services provided before and after the client’s death to the client and the client’s family to assist with issues related to grief, loss and adjustment;

(5) "Client" means a person eligible for goods or services under Medicaid;

(6) "Commissioner" means the Commissioner of Social Services or his or her designee;

(7) “Concurrent" means in the same time period covered by the care plan;

(8) “Counseling” means services, including dietary counseling, provided for the purpose of helping the client and caregivers to adjust to the client’s approaching death;

(9) “Date of terminal diagnosis” means the date on which a physician first diagnoses the client as terminally ill;

(10) "Department" means the Department of Social Services or its agent;

(11) “Election period” means one of three or more periods of care a client may choose to receive the hospice benefit. The periods consist of an initial 90-day period, a subsequent 90 day period and an unlimited number of subsequent 60-day periods;

(12) "Home" means the client's place of residence, including, but not limited to, a boarding home, residential care home or community living arrangement. “Home” does not include facilities such as hospitals, nursing facilities, chronic disease hospitals, intermediate care facilities for the mentally retarded (ICF/MR) or other facilities that are paid an all-inclusive rate directly by Medicaid for the care of the client;

(13) "Home health aide" means an individual who has completed the homemaker-home health aide services training and competency evaluation program in accordance with Sec.19-13-D69 of the Regulations of Connecticut State Agencies;

(14) "Home health care agency" means "home health care agency" as defined in section 19a-490 of the Connecticut General Statutes and licensed pursuant to sections 19-13-D66 to 19-13-D79, inclusive, of the Regulations of Connecticut State Agencies;

(15) "Hospice" means an agency that is primarily engaged in providing care to terminally ill individuals and meets the requirements of section 19-13-D72(b)(2) of the Regulations of Connecticut State Agencies. The hospice model of care is based on a coordinated program of home and inpatient care, employing an interdisciplinary team to meet the special needs of terminally ill individuals;

(16) “Hospice aide and homemaker” means a “hospice aide and homemaker” as defined in 42 CFR 418.76;

(17) "Hospital" means "general hospital” as defined in section 19-13-D1(b)(1) of the Regulations of Connecticut State Agencies;

(18) "Interdisciplinary team” means a group of hospice personnel to include, but not be limited to, a physician, a registered nurse, a pharmacist, a social worker and a counselor that is responsible for providing services to meet the physical, psychosocial, spiritual and emotional needs of a terminally ill client or family members, as delineated in a specific plan of care. The interdisciplinary team is responsible for participating in the establishment of a plan of care for each client, supervising hospice services and reviewing and updating the plan of care as necessary;

(19) “Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for persons with mental retardation licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified to participate in Medicaid

as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(20) “Legal representative” means an individual who has been authorized under Connecticut state law to direct medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated;

(21) "Licensed practical nurse" or "LPN" means "licensed practical nurse" as defined in section 20-87a of the Connecticut General Statutes;

(22) "Medicaid" means the program operated by the department pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act, as amended from time to time;

(23) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective alternative treatments or diagnostic modalities;

(24) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; to prevent a medical condition from occurring; or to alleviate suffering through the palliation of symptoms at the end of life;

(25) "Medical record" means "medical record" as defined in section 19a-14-40 of the Regulations of Connecticut State Agencies;

(26) "Nursing care " means the services provided by a registered nurse or a licensed practical nurse;

(27) "Nursing facility" means “nursing facility” as defined in 42 USC 1396r(a), as amended from time to time, and licensed pursuant to section 19-13-D8t of the Regulations of Connecticut State Agencies;

(28) "Occupational therapy" means the services provided by an occupational therapist or an occupational therapy assistant as set forth in section 20-74a of the Connecticut General Statutes;

(29) “Palliative care” means care that addresses physical, intellectual, emotional, social and spiritual needs and facilitating patient autonomy, access to information and choice;

(30) "Physical therapy" means the services provided by a physical therapist or a physical therapy assistant as set forth in section 20-66 of the Connecticut General Statutes;

(31) "Physician" means a physician or surgeon licensed pursuant to section 20-10 or 20-12, inclusive, of the Connecticut General Statutes;

(32) “Plan of care” means a comprehensive assessment of the client’s needs that identifies the types and frequency of services necessary to manage the client’s discomfort and relieve the symptoms of the terminal illness as well as to identify any services necessary to meet the needs of the family that meet the requirements of 42 CFR 418.54;

(33) "Prior authorization" or "PA" means the approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods;

(34) "Provider" means a hospice that is certified by Medicare as a hospice, is licensed by the Connecticut Department of Public Health as a hospice and is enrolled with Medicaid;

(35) “Registered nurse” means “registered nurse” as defined in section 20-87a of the Connecticut General Statutes;

(36) “Social worker” means an individual licensed pursuant to section 20-195n of the Connecticut General Statutes;

(37) "Speech therapy" or "speech pathology" means the services provided by a speech pathologist as set forth in section 20-408 of the Connecticut General Statutes; and

(38) “Terminally ill” means a condition in which the patient has a medical prognosis of a life expectancy of six months or less if the illness runs its normal course.

Sec. 17b-262-831. Provider participation

To enroll in Medicaid and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies, shall be certified as a provider of hospice services under the Medicare program as described in 42 CFR 418.50 through 418.100, inclusive, and shall be licensed as a hospice by the State Department of Public Health in accordance with section 19a-122b of the Connecticut General Statutes and section 19-13D72(b)(2) of Regulations of Connecticut State Agencies.

Sec. 17b-262-832. Eligibility

Payment for hospice services is provided to persons who meet all of the following conditions:

(1) the individual is eligible for Medicaid; and

(2) the individual is certified by a physician as being terminally ill.

Sec. 17b-262-833. Refusal to serve

No hospice enrolled as a Medicaid provider shall select a service area or refuse to serve any person, based on the geographical location of the service to be provided unless the hospice has a legitimate, non-discriminatory reason for its choice of service area or its refusal to serve as provided in section 17b-262-5 to 17b-262-8, inclusive, of the Regulations of Connecticut State Agencies.. Providers shall designate service areas, document any refusals to serve and be subject to the sanctions in section 17b-262-9 of the Regulations of Connecticut State Agencies.

Sec. 17b-262-834. Certification of Terminal Illness

(a) The provider shall obtain an initial certification of the client's terminal illness jointly from the medical director of the hospice or a physician member of the hospice interdisciplinary group and the client's attending physician, if an attending physician is identified, prior to the beginning of hospice services.

(b) The initial certification shall state that the client's life expectancy is six months or less and shall include clinical information to support this medical prognosis. The initial certification is valid for the first 90 days of hospice care.

(c) At the end of the first 90-day period, a second 90-day period may be certified by the medical director of the hospice or the physician member of the hospice interdisciplinary group. The certification shall include clinical information to support this medical prognosis;

(d) An unlimited number of 60-day periods may be certified following the first two 90-day periods by the medical director of the hospice or the physician member of the hospice interdisciplinary group. The certification shall include clinical information to support this medical prognosis

(e) An APRN may not certify or recertify a terminally ill diagnosis.

Sec. 17b-262-835. Plan of care

(a) The interdisciplinary team in conjunction with the attending physician shall establish an initial written plan of care for each client within 48 hours of the client's election of hospice. Services may not be billed until the plan is established.

(b) The interdisciplinary team, in collaboration with the individual's attending physician, if any, must review, revise and document the individualized plan as

frequently as the client's condition requires, but no less frequently than every 14 calendar days.

(c) The plan of care shall specify the care and services necessary to meet the client's and family's needs identified in the comprehensive assessment.

Sec. 17b-262-836. Election of Hospice

(a) A client who meets the eligibility requirement of 42 CFR 418.20 may file an election statement with a particular hospice. If the individual is physically or mentally incapacitated, his or her legal representative may file the election statement. The election statement must indicate;

(1) that the individual is electing a hospice benefit and identify which hospice he has chosen;

(2) the effective date of the election;

(3) that the individual understands that hospice services are palliative rather than curative and waives all rights to Medicaid payment for services to cure the terminal illness and related condition. Medicaid shall continue to pay for covered benefits that are not related to the terminal illness; and

(4) that the individual is eligible to receive hospice services only through the provider he has designated.

(b) The election statement shall include the following information:

(1) name of client;

(2) address and telephone number of client;

(3) client's Medicaid number and Medicare number, if applicable;

(4) primary terminal diagnosis;

(5) client's date of birth;

(6) name of parent, guardian or legal representative, if applicable;

(7) sex of client;

(8) name, telephone number and Medicaid number of provider;

(9) name and Medicaid number of attending physician;

(10) date of physician's certification of terminal illness;

(11) date the diagnosis is terminal; and

(12) name and Medicaid number of the nursing facility or ICF/MR, if applicable.

(c) A client may revoke election of hospice services at any time during the election period by signing and dating a statement to this effect. The revocation shall be in writing and shall not be retroactive. When a client revokes the hospice benefit, he resumes coverage for any services waived when he elected hospice. The client may re-elect hospice at any time for the next 60 or 90 day election period.

(d) A client may change hospice agencies once during any election period by signing and dating a statement to this effect.

(e) A client who is eligible for Medicare in addition to Medicaid shall elect the hospice benefit in both the Medicare and Medicaid programs simultaneously.

Sec. 17b-262-837. Discharge from hospice

(a) The provider may discharge a client if:

(1) the client moves out of the provider's service area or transfers to another hospice;

(2) the client is no longer terminally ill;

(3) the client revokes the hospice benefit;

(4) the client dies; or

(5) the provider determines that there is just cause because the client or other person living with the client is disruptive, abusive or uncooperative to the extent that delivery of care to the client or the ability of the hospice to operate effectively is seriously impaired. A discharge for just cause shall meet the criteria and follow the process described in 42 CFR 418.26(a)(3).

(b) No client shall be discharged for just cause or if he or she is considered no longer terminally ill without a review by the department. When the hospice advises the client that discharge is being considered either for good cause or because the physician believes the client is no longer terminally ill, a copy of that written communication shall be sent to the department and the attending physician.

(c) The hospice shall obtain a written physician discharge order consistent with 42 CFR 418(b) before discharging a client for any reason other than death.

(d) Upon discharge the client is no longer covered for hospice care for that election period and resumes the Medicaid benefit that had been waived unless the client is immediately transferred to another hospice. As long as the client is still eligible, he or she may re-elect the hospice benefit immediately and by so doing shall enter the next election period.

(e) The provider shall have a discharge planning process in place that is consistent with 42 CFR 418.26(d).

Sec. 17b-262-838. Services covered

(a) The following documents shall be in place prior to the provision of hospice services:

(1) certification of terminal illness for the applicable election period. The certification may be in writing, electronically transmitted or verbal. A facsimile is acceptable provided the original is available on request. Verbal orders are acceptable provided a written order is received within 48 hours of the verbal order.

(2) a statement signed by the client or his or her legal representative electing the hospice benefit; and

(3) an initial plan of care within 48 hours following election of the hospice benefit.

(b) Subject to the limitations and exclusions identified in sections 17b-262-829 to 17b-262-848, inclusive, of the Regulations of Connecticut State Agencies, the department shall pay an all-inclusive per diem rate to the provider for each Medicaid client. This rate represents payment for the provision of the following goods and services:

(1) Physician services to include: the general supervisory duties of the medical director, participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care and establishment of governing policies by the interdisciplinary group;

(2) nursing service provided by or under the supervision of a registered nurse;

(3) home health aide and hospice aide and homemaker services under the supervision of a registered nurse, as ordered by the physician-led interdisciplinary group;

(4) physical therapy, occupational therapy and speech-language pathology to control symptoms or to enable the client to maintain activities of daily living and basic functional skills;

(5) medical equipment, supplies, biologicals and appliances that are a part of the written plan of care and not included in the payment to facilities for room & board;

(6) drugs which are used primarily for the relief of pain and symptom control related to the client's terminal illness and that are included in the provider's formulary, subject to review and approval by the department;

(7) social work services based on the client's psychosocial assessment and the client's and family's needs and acceptance of these services;

(8) dietary counseling, when identified in the plan of care and performed by a qualified individual, including dietitians as well as nutritionists and registered nurses, who are able to address and assure that the dietary needs of the client are met;

(9) spiritual counseling in accordance with the client's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires;

(10) bereavement, grief and loss counseling, to reflect the needs of the bereaved;

(11) short term care inpatient care according to 42 CFR 418.108 for pain control and symptom management;

(12) respite care;

(13) supervision of volunteers; and

(14) any covered medically necessary and reasonable services related to the terminal illness as identified by the interdisciplinary team.

(c) The professional component of physician and APRN services reasonable and necessary for the treatment and management of the hospice client's terminal illness not described in subsection (b)(1) of this section shall be paid in addition to the per diem amount according to the department's fee schedule for physician services.

(d) Hospice services are provided at one of the following four levels of care:

(1) Routine home care is furnished to a client who is at home, in a nursing facility, or ICF/MR; is under the care of a hospice; and is not receiving continuous care.

(2) Continuous home care is furnished during brief periods of crisis as described in 42 CFR 418.204(a) in order to maintain a client at home. A minimum of eight hours of care, of which at least half is direct licensed nursing care, shall be provided in a 24-hour period to qualify for continuous home care to be billed on a hourly basis. The care does not need to be provided in successive blocks of time so long as a need for an aggregate of eight hours is required in a 24-hour period. All direct service hours shall be clearly documented. Services provided by other disciplines, such as social workers or counselors, are expected during periods of crisis but are not counted towards the total hours of continuous care. In addition, documentation of care, modification of the plan of care and supervision of home health aides by a nurse shall not qualify as direct client care.

(3) General inpatient care is furnished in an inpatient facility that meets the requirements in 42 CFR 418.108 when pain control or acute or chronic symptom management cannot be managed in other settings.

(4) Respite care is furnished for each day the client is in an approved inpatient facility in order to give the caregiver a rest. It is available for a maximum of five days in a 60-day period.

(e) The department shall pay a nursing facility or ICF/MR to hold the bed of a client who is hospitalized when the requirements of section 19a-537 of the Connecticut General Statutes are met.

(f) The provider shall routinely provide all nursing services, medical social work services and counseling. The provider may contract for physician services and the services of other personnel consistent with the requirements of 42 CFR 418.64.

Sec. 17b-262-839. Coordination of hospice and waiver services

(a) For clients who receive waiver services prior to electing the hospice benefit under Medicaid, waiver services shall continue to be available.

(b) It is the responsibility of hospice to develop a plan of care that coordinates the hospice and waiver services. It is the responsibility of the hospice to initiate coordination with the waiver program case manager so that the client receives all of the care and services necessary. The waiver program's case manger is responsible for adjusting the waiver services so there is no duplication of services provider by the hospice or the waiver. These objectives should be accomplished according to the following principles:

(1) The best interest of the client is the key consideration. In circumstances when the hospice and waiver program case managers cannot agree on what

is best for the client they shall ask the department for assistance in this determination.

(2) Each program shall provide services consistent with the goals of their respective programs. The goal of hospice care is to keep the client as comfortable as possible while maintaining his or her dignity and quality of life; the goal of the waiver program is to keep clients out of institutions.

(3) Services related to the terminal diagnosis are the responsibility of the hospice.

(4) Services provided prior to the date of terminal diagnosis are generally considered to be unrelated to the terminal diagnosis.

(5) Services unrelated to the terminal diagnosis may be billed in addition to the hospice reimbursement by the provider rendering the service.

(6) For the purpose of developing a plan of care, the presumption is that waiver services provided prior to the date of the terminal diagnosis should continue to be provided as waiver services. It is presumed that services initiated after the date of the terminal diagnosis are the responsibility of the hospice although this is subject to review and reconsideration by the hospice as approved by the department.

Sec. 17b-262-840. Volunteers

The provider shall maintain a volunteer program consistent with 42 CFR 418.78.

Sec. 17b-262-841. Service Limitations

(a) The department shall pay only for services listed in its fee schedule.

(b) The department shall not pay separately for any services that are related to the treatment of the terminal condition for which hospice services were elected.

(c) Hospice services are covered in a nursing facility only if the nursing facility has a written agreement with the provider such that the provider takes full responsibility for the professional management of the client's hospice care and the nursing facility agrees to provide room and board to the client. The agreement shall meet the requirements of 42 CFR 418.112.

(d) For a client eligible for both Medicare and Medicaid, the only service payable by Medicaid is the room and board charge for a client in a nursing facility. Room and board means the facility's per diem rate that includes the services described in section 17b-262-705 of the Regulations of Connecticut State Agencies.

(e) The department shall pay for only one level of care on any day.

(f) Respite care is not available for a client who resides in a nursing facility, hospital or ICF/MR.

(g) Bereavement counseling shall be available for the family for up to 13 months following the client's death but is not separately reimbursable.

(h) Home health agency services are not covered unless they are unrelated to the terminal illness and prior authorized by the department.

Sec. 17b-262-842. Services not covered

(a) When a client elects the hospice benefit, the client waives his or her right to receive the following services under Medicaid:

(1) treatment intended to cure the terminal illness;

(2) treatment related to the terminal illness except for the treatment provided by the designated hospice;

(3) hospice services provided by a provider other than the one designated by the client on the hospice form submitted to the department. However, the provider may subcontract with another hospice for services as described is section. 17b-262-838(f); and

(4) any services that are duplicative of any service provided by the hospice provider with the exception of services of the client's attending physician.

(b) In order for charges to be billed separately, the provider shall first demonstrate that the service is not related to the terminal illness.

(c) The department shall not pay for services that are not medically necessary and medically appropriate.

Sec. 17b-262-843. Prior authorization

(a) Prior authorization, on forms and in the manner specified by the department shall be required for:

(1) general inpatient days beyond the fifth day; and

(2) any service which the department indicates on its fee schedule requires prior authorization.

(b) The department, in its sole discretion, shall determine what information is necessary to approve a prior authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

Sec. 17b-262-844. Billing procedures

(a) Claims from providers shall be submitted on the department's designated form or electronically transmitted to the department, in a form and manner as specified by the department and shall include all information required by the department to process the claim for payment.

(b) The provider is responsible for:

(1) completing any admission and discharge forms consistent with the department's instructions; and

(2) exhausting other payment sources of which the provider is aware before billing the department.

Sec. 17b-262-845. Payment

(a) The Commissioner shall establish fees that are consistent with section 1902(a)(13)(B) of the Social Security Act.

(b) the Commissioner may increase any fee payable to a hospice upon the application of such an agency evidencing extraordinary costs related to providing escort services. In no case shall any rate or fee exceed the charge to the general public for similar services.

(c) The department shall reimburse the provider at the per diem rate for the appropriate level of care .

(d) The department shall reimburse a provider when all of the requirements of sections 17b-262-829 to 17b-262-848, inclusive, of the Regulations of Connecticut State Agencies have been met.

(e) The fee for routine, inpatient or respite services represents the per diem reimbursement for the client and is payment for all services provided by the provider on that day. Only one level of care may be billed on any day.

(f) The fee for continuous hospice care is paid on an hourly basis. A minimum of eight hours must be medically necessary in a 24-hour period to qualify for continuous hospice care.

(g) The department shall pay the fee for the routine, inpatient or respite level of care for each day the client is within an election period, regardless of the volume or intensity of services provided on that day.

(h) The department shall pay the same fee for border providers as for in-state providers.

(i) When a client who has elected hospice resides in a nursing facility or ICF/MR, the department shall make a payment equal to the department's rate for the nursing facility or ICF/MR. This payment represents payment for room and board services and is payable to the provider. It is the responsibility of the provider to reimburse the nursing facility or ICF/MR for room and board expenses. Applied income shall be deducted from the room and board payment.

Sec. 17b-262-846. Payment Limitations

(a) It is expected that the provider shall provide bereavement counseling to the client's family after the client's death; however the department shall not pay the provider for such bereavement counseling.

(b) For a twelve month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days, both general inpatient and respite, shall not exceed twenty percent of the aggregate number of days of hospice care provided to all hospice clients during that same period. At the department's discretion, the days of inpatient care provided to individuals with AIDS may be excluded from the days counted toward the twenty percent limitation.

(c) Payment for inpatient care is limited as follows:

(1) The total payment to the provider for inpatient care, general and respite, is subject to a limitation that total inpatient care days for Medicaid clients not exceed 20 percent of the total days for which these clients had elected hospice care.

(2) At the end of a twelve-month period specified in subsection (b) of this section, the department calculates a limitation on payment for inpatient care to ensure that Medicaid payment is not made for days of inpatient care in excess of 20 percent of the total number of days of hospice care furnished to Medicaid clients. Payments to nursing facilities and ICF/MRs where Medicaid is the secondary payer to Medicare shall be excluded from the calculation.

(3) If the number of days of inpatient care furnished to Medicaid clients is equal to or less than 20 percent of the total days of hospice care to Medicaid clients, no adjustment is necessary. Overall payments to a provider are subject to the cap amount specified in 42 CFR 418.309. Any provider that has received an exemption as specified in 42 CFR 418.108(e) shall be

exempt from this provision.

(4) If the number of days of inpatient care furnished to Medicaid clients exceeds 20 percent of the total days of hospice care to Medicaid clients, the total payment for inpatient care is determined in accordance with subsection (c)(5) of this section. That amount is compared to actual payments for inpatient care and any excess reimbursement shall be refunded by the provider or recouped from subsequent claims. Overall payments to the provider are subject to the cap amount specified in 42 CFR 418.309.

(5) If a provider exceeds the number of inpatient care days described in subsection (c)(4) of this section, the total payment for inpatient care is determined as follows:

(A) calculate the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the provider to Medicaid clients;

(B) multiply this ratio by the total reimbursement for inpatient care made by the department;

(C) multiply the number of actual inpatient days in excess of the limitation by the routine home care rate;

(D) add the amounts calculated in subsections (c)(5)(B) and (C) of this section.

(E) compare the amount in section 5(D) of this section with the total reimbursement to the hospice provider for inpatient care during that period. The amount that total reimbursement to the hospice exceeds the amount calculated in section 5(D) of this section is the amount due from the hospice provider.

(d) Applied income shall be calculated and deducted from the department's payment to the provider for a client living in a nursing facility or a hospice facility as follows:

(1) Clients who receive hospice services while residing in a hospice facility or in a nursing facility pursuant to a room and board arrangement with a hospice are responsible for paying applied income to the hospice provider.

(2) The department shall calculate the applied income liability and shall inform the client and the provider of the amount that the client is required to contribute towards the cost of care each month. The client's applied income liability shall be deducted from the amount that the department would otherwise pay to the hospice provider each month.

(3) The provider and the nursing facility may assign responsibility for collecting the client's applied income and may assign the risk of loss for nonpayment in their agreement, depending on the result of their negotiations. In no event shall the department be liable to a hospice or to a nursing facility in the event that a client fails to pay his or her applied income obligation.

(4) The provider shall notify the department's caseworker of any errors in the amount of applied income processed against the claim using the form specified by the department. Payment adjustments resulting from retroactive applied income corrections shall be processed periodically.

(5) In any month that a resident returns to the community or dies, and the cost of care is less than the applied income, the department shall adjust the applied income as follows: the applied income shall equal the number of days that the resident was in the hospice multiplied by the per diem rate.

(6) Applied income is not pro rated. It is used to cover the cost of care until it is expended.

(e) A nursing facility that enters into an agreement with a hospice to provide room and board services for clients shall accept the amount paid by the hospice, if any, pursuant to the contractual agreement between the hospice and the nursing facility as payment in full. In no event may a nursing facility assert a claim against a client, or against the department, in the event that the hospice fails to pay the nursing facility in accordance with their agreement, except that a nursing facility may assert a claim against a client for nonpayment of the client's applied income amount only when the agreement between the hospice and the nursing facility assigns responsibility for collecting the client's applied income liability to the nursing facility.

Sec. 17b-262-847. Review process

(a) A client or client representative may request a review with the hospice whenever a requested good or service is denied.

(b) Review Process:

(1) The hospice shall have a timely and organized review process. The review process shall be available whenever:

(A) the hospice denies a requested good or service; or

(B) the hospice fails to respond to a client's request for goods and services within five working days of such request.

(2) The results of the review shall be in writing and shall include a brief statement of the reasons for the decision and shall state that the client may request review by the department and how to obtain such review.

(3) The hospice's review process shall allow for an expedited review within one business day when the standard time frames for determining a review could jeopardize the comfort of the client.

(c) Department review:

(1) A client who is denied a good or service by the hospice provider may request a review by the department in accordance with the following procedures:

(A) The client shall file a written or verbal request for a review within fifteen days from the date of the hospice denial of the good or service.

(B) The request shall state the reasons the client believes he or she should receive the goods or services and include any additional documentation in support of his or her case.

(C) Within five days of the request, the department shall make a finding based on an evaluation of the evidence submitted and shall notify the client in writing.

(2) If the standard timeframe for the department's review could jeopardize the comfort of the client, an expedited review shall be completed by the department within one business day of the request.

Sec. 17b-262-848. Documentation

(a) All required documentation shall be maintained for at least five years, or longer, by the provider in accordance with statute or regulation, subject to review by the department. In the event of a dispute concerning a service provided, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation, whichever is longest.

(b) Failure to maintain and provide all required documentation to the department upon request shall result in the disallowance and recovery by the department of any future or past payments made to the provider for which the required documentation is not maintained and not provided to the department upon request.

(c) The following information shall be documented in writing or electronically, consistent with the requirements described in the Provider Enrollment Agreement and maintained on file with the provider for each Medicaid client:

(1) signed and dated physician orders;

(2) initial and subsequent plans of care signed and dated by the licensed practitioner or interdisciplinary team;

(3) Medicaid identification number;

(4) pertinent diagnostic information;

(5) documentation of each service provided and its duration;

(6) dates of services provided;

(7) all election forms signed by the client indicating that he has elected the hospice benefit and which hospice he has elected to provide services;

(8) the initial certification of terminal illness signed by the attending physician and the medical director of the hospice;

(9) subsequent certifications of terminal illness signed by the medical director of the hospice or the physician member of the interdisciplinary team;

(10) forms signed and dated by the client indicating any change in the designation of the hospice, if applicable; and

(11) revocation statements signed and dated by the client, if applicable.

(d) All clinical records shall be maintained in accordance with 42 CFR 418.104.

(e) Each provider shall maintain fiscal and medical records that fully disclose services and goods rendered or delivered to Medicaid clients.

(f) Providers shall maintain documentation supporting all prior authorization requests.