CHAPTER VI

UTILIZATION REVIEW AND CONTROL

Table of Contents

INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by individuals. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) or its designated contractor(s) conducts periodic utilization reviews on all programs. In addition, DMAS or its designated contractor(s) conducts compliance reviews on providers that are found to provide services that are not within the established Federal or State codes, DMAS guidelines, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that Participation Agreement, contracts, state and federal regulations, Medicaid Memos and Provider Manual requirements for services rendered are met in order to receive payment from DMAS and its contractors. Under the Participation Agreement/contract with DMAS, Magellan of Virginia and the Medicaid Managed Care Organizations (MCOs) the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives or its designated contractor(s), the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control procedures conducted by DMAS. The MCOs conduct audits for services provided to Members enrolled in Managed Care. Providers shall contact the specific MCO for information about the utilization review and control procedures conducted by the MCO.

FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction.

COMPLIANCE REVIEWS

DMAS or its designated contractor(s) routinely conduct compliance reviews to ensure that the services provided to Medicaid individuals are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455.

Providers and individuals are identified for review by system-generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group.

To ensure a thorough and fair review, trained professionals review all cases using available resources, including appropriate consultants, and perform on-site or desk reviews.

Overpayments will be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by DMAS, the BHSA or the MCOs if they are found to have billed these entities contrary to law or manual requirements, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, DMAS, the BHSA or the MCOs may restrict or terminate the provider's participation in the program.

DMAS contracts with Health Management Systems, Inc. (HMS) to perform audits of FFS Mental Health Services in-state and out-of-state providers that participate in the Virginia Medicaid program. DMAS will also continue to audit mental health services as well. Providers that have been audited by HMS and have questions directly pertaining to their audit may contact HMS at: VABH@HMS.com

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading, understanding, and adhering to applicable state and federal regulations, Medicaid Memos, their provider agreement with DMAS or its contractor, and to the requirements set forth in this manual. The provider is also

responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his/her signature or the signature of his/her authorized agent on each invoice that all information provided to DMAS and its contractors is true, accurate, and complete. If provider attests to having all required licensed as required they must be able to furnish such documentation. Although claims may be prepared and submitted by an employee or contracted business partner, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Department of Medical Assistance Services
Division of Program Integrity
Supervisor, Provider Review Unit
600 East Broad Street
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Office of the Attorney General
Director, Medicaid Fraud Control Unit
202 North Ninth Street
Richmond, Virginia 23219

Member Fraud

Allegations about fraud or abuse by Medicaid enrolled individuals are investigated by the Recipient Audit Unit of the DMAS. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries and other acts of drug diversion.

If it is determined that benefits to which the individual was not entitled were received, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction. The sanction period may only be revoked or shortened by court order.

Suspected cases of Medicaid fraud and abuse should be reported to the local Department of Social Services (LDSS) or to the DMAS Recipient Audit Unit via the RAU Fraud Hotline: local at (804) 786-1066 and toll free at (866) 486-1971. Written referrals can also be made at the RAU email address: recipientfraud@dmas.virginia.gov or forwarded to:

Department of Medical Assistance Services
Division of Program Integrity
Recipient Audit Unit
600 East Broad Street
Richmond, Virginia 23219

PATIENT UTILIZATION AND MANAGEMENT SAFETY PROGRAMS (PUMS)

The DMAS contracted MCOs must have a Patient Utilization Management & Safety Program (PUMS) for MCO enrolled members which is intended to coordinate care and ensure that members are accessing and utilizing services in an appropriate manner in accordance with all applicable rule and regulations. The PUMS Program is a utilization control and care coordination program designed to promote proper medical management of essential health care. Upon the member's placement in the PUMS, the MCO must refer members to appropriate services based upon the member's unique situation.

Once a Member meets the placement requirements for PUMS, the MCO may limit a member to a single pharmacy, primary care provider, controlled substances prescriber, hospital (for non-emergency hospital services only) and/or, on a case-by-case basis, other qualified provider types as determined by the MCO and the circumstances of the member. The MCO may limit a member to providers and pharmacies that are credentialed in their network.

If the member changes MCOs while the member is enrolled in a PUMS, the receiving MCO must re-evaluate the member within thirty (30) calendar days to ensure the member meets the minimum criteria above for continued placement in the health plan's PUMS. More information about the PUMS process is located in Chapter IV of this provider manual.

UTILIZATION REVIEW – GENERAL REQUIREMENTS

Utilization reviews of enrolled providers are conducted by DMAS, the designated contractor or the MCOs. These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the provider's Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified.

Utilization reviews are comprised of desk audits, on-site record review, and may include observation of service delivery and review of all provider policies and procedures and human resource files. Dependent upon the setting, the utilization review may also include a tour of the program. Staff will visit on-site or contact the provider to request records. Utilization Review may also include face-to-face or telephone interviews with the individual, family, or significant other(s), or all. In order to conduct an on-site review, providers may also be asked to bring program and billing records to a central location within their organization. The facility shall make all requested records available and shall provide an appropriate place for the auditors to conduct the review if conducted on-site.

DMAS and the MCOs shall recover expenditures made for covered services when providers' documentation does not conform to standards specified in all applicable regulations. Providers who are determined not to be in compliance with DMAS requirements shall be subject to 12VAC30-80-130 for the repayment of those overpayments to DMAS.

Providers shall be required to maintain documentation detailing all relevant information about the Medicaid individuals who are in the provider's care. Such documentation shall fully disclose the extent of services provided in order to support provider's claims for reimbursement for services rendered. This documentation shall be written and dated at the time the services are rendered or within one business day from the time the services were rendered. Claims that are not adequately supported by appropriate up-to-date documentation may be subject to recovery of expenditures.

The review will include, but is not limited to, the examination of the following areas / items:

- If a provider lacks a full or conditional license or a provider enrollment agreement does not list each of the services provided and the locations where the provider is offering services, then during a utilization review the provider will be subject to retraction for all unlisted service and/or locations.
- Health care entities with provisional licenses shall not be reimbursed by Medicaid.
- An assessment of whether the provider is following The U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) procedures w/ regard to excluded individuals (See the Medicaid Memo dated 4/7/2009).
- An assessment of whether the provider is following DRA 2005 procedures, if appropriate (See CMS Memo SMDL 06-025.).
- The appropriateness of the admission to service and for the level of care, and medical or clinical necessity of the delivered service.

- A copy of the provider's license/certification, staff licenses, and qualifications to ensure that the services were provided by appropriately qualified individuals and licensed facilities.
- Verification that the delivered services as documented are consistent with the documentation in the individual's record, invoices submitted, and specified service limitations.
- The reviewer determines that all documentation is specific to the individual and their unique treatment needs. Checklists and boilerplate or repeated language are not appropriate. Electronic records and commercial recordkeeping products offer canned language. The provider must still individualize their records to reflect the services they actually provided. Most commercial recordkeeping products are designed for outpatient services and may not be adequate recordkeeping mechanisms for these services.
- The reviewer determines whether all required aspects of treatment (as set forth in the service definitions) are being provided, and also determines whether there is any inappropriate overlap or duplication of services.
- The reviewer determines whether all required activities (as set forth in the appropriate sections of this manual and related regulations) have been performed.
- The reviewer determines whether inappropriate items have been billed.
- The reviewer determines whether the amount billed matches the documented amount of time provided to the individual.

Services must meet the requirements set forth in the Virginia Administrative Code (12 VAC 30) and in the Virginia State Plan for Medical Assistance Services and as set forth in this manual. If the required components are not present, reimbursement will be retracted.

Upon completion of on-site activities for a routine utilization review, the MCO, DMAS, or its designated contractor(s) may be available to meet with provider staff for an Exit Conference. The purpose of the Exit Conference is to provide a general overview of the utilization review procedures and expected timetables.

Following the review, a written report of preliminary findings is sent to the provider. Any discrepancies will be noted. The provider will have 30 days from receipt of the preliminary report to respond to the discrepancies outlined in the report. The provider must detail the discrepancy in question and may include any additional supporting medical record documentation that was written at the time the services were rendered. The provider must submit their written request within thirty (30) days from the receipt of the preliminary findings letter. The provider's response and any additional information provided will be reviewed. At the conclusion of the review, DMAS or its designated contractor(s) will

contact the provider to conduct an Exit Conference to review the procedures that have taken place and further steps in the review process. A final report will then be mailed to the provider.

If a billing adjustment is needed, it will be specified in the final audit findings report.

If the provider disagrees with the final audit findings report, they may appeal the findings. Refer to Chapter II for information on the provider appeal process.

MEDICAL RECORDS AND RETENTION

The provider must recognize the confidentiality of recipient medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern medical record use and removal and the conditions for the release of information. The recipient's written consent is required for the release of information not authorized by law. Current recipient medical records and those of discharged recipients must be completed promptly. All clinical information pertaining to a recipient must be centralized in the recipient's clinical/medical record.

Records of Medicaid covered services must be retained for not less than five years after the date of service or discharge. Records must be indexed at least according to the name of the recipient to facilitate the acquisition of statistical medical information and the retrieval of records for research or administrative action. The provider must maintain adequate facilities and equipment, conveniently located, to provide efficient processing of the clinical records (reviewing, indexing, filing, and prompt retrieval). Refer to 42 CFR 482.24 for additional requirements.

The provider must maintain medical records on all recipients in accordance with accepted professional standards and practice. The records must be completely and accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information. All medical record entries must be fully signed, and dated (month, day, and year) including the title (professional designation) of the author. Documentation should be clear and legible.

ACCESSING DMAS FORMS

There are four hospice DMAS forms, including: (1) the *Request for Hospice Benefits* (DMAS 420); (2) the *Physician Recertification* (DMAS 420A); (3) the *Hospice Benefits Change/Revocation/Termination Statement* (DMAS 421); and (4) the *Hospice Enrollment/Disenrollment Authorization Request* (DMAS 421A). The current versions of these forms are available on the Virginia Medicaid Website located online at: https://vamedicaid.dmas.virginia.gov/provider/forms.

NOTE: These forms and processes may be different for members enrolled in the Cardinal

Care managed care program. Refer to your provider contract or guidance from the MCO for compliance audit specifications.

HOSPICE ADMISSION PROCESS

Admission Package

Hospice shall complete the *Request for Hospice Benefits* form (DMAS 420, pages 1 and 2). A copy of this completed form must be kept in the individual's medical record. The written certification statement must be signed and dated by the hospice medical director, or the physician member of the hospice interdisciplinary team, and the individual's attending physician (if he or she has an attending physician), at the beginning of the first 90-day period of hospice coverage.

Hospice providers who cannot obtain written certification within two (2) calendar days after a period begins, must obtain verbal certification within two (2) calendar days and written certification prior to submission of a claim for payment. Documentation of the verbal certification and the date it was received must be in the maintained in the member's medical record chart that the provider received oral certification and the date the certification was received.

Hospice must ensure the individual choosing hospice services is eligible for the Medicaid hospice benefit. The first page (Section I) of the *Request for Hospice Benefits* form (DMAS 420) is the election statement for hospice services and must be signed and dated by the individual, or his or her representative, prior to the initiation of hospice services. Section II, located on page 2 of the DMAS 420, contains hospice provider information, which also must be completed.

Section III is the required physician member certification and must be completed by the hospice medical director, or physician member of the hospice interdisciplinary team, and the individual's attending physician (if he or she has an attending physician).

If the individual is not dually eligible (Medicare and Medicaid eligible), the DMAS *Request for Hospice Benefit* form (DMAS 420) is the only acceptable form for Medicaid hospice enrollment.

Hospice Providers must enter hospice admissions and disenrollments directly into the AE&D portal for FFS individuals enrolled in Hospice. This allows the Hospice FFS providers to complete the process of electronic submission for all individuals who are enrolled in Hospice. FFS Hospice providers will no longer FAX the DMAS 421A to DMAS. The Hospice provider will maintain the DMAS 420, 420A and 421A in the individual's record. Hospice enrollment cannot be completed without an active Medicaid number.

For those enrolled in a managed care organization, please refer to and follow that particular MCO's hospice admission procedures.

CHANGE OR REVOCATION/TERMINATION OF HOSPICE BENEFITS

An individual, or his or her representative, may change the designation of the particular hospice provider from which hospice care is received once each election period by signing the *Hospice Benefits Change/Revocation/Termination Statement* (DMAS 421). The new provider must maintain the signed DMAS 421 in the individual's medical record.

Changing the designated hospice provider is not a revocation of the election period for which it is made. The new hospice provider must obtain a new *Request for Hospice Benefits* form (DMAS 420). The new provider must enter the admission in the AE&D portal for FFS individuals. For ~~those~~ individuals enrolled in a managed care organization, please refer to and follow that particular MCO's hospice procedures for a new provider.

An individual, or his or her representative, may revoke the election of hospice care at any time during an election period using the *Hospice Benefits Change/Revocation/Termination Statement* (DMAS 421). The DMAS 421 must be maintained in the individual's medical record. Hospice providers must enter the discharge date into the AE&D portal, within five (5) business days, using the DMAS 421A, of ~~this~~ a change/revocation/termination. For those enrolled in a managed care organization, please refer to and follow that particular MCO's hospice revocation/termination notification procedures. The DMAS 421 must be maintained in the individual's medical record. Upon the revocation of the election of Medicaid hospice services, the individual is no longer covered by Medicaid for hospice care, but, if eligible, may resume Medicaid coverage under the regular scope of benefits. The individual may, at any time, elect to receive hospice coverage for any other benefit period(s) that he or she is still eligible to receive.

An election to receive hospice care will continue without a break as long as the individual remains in the care of a hospice, does not revoke the election of hospice services, and remains eligible for Medicaid. If an individual revokes hospice benefits during a benefit period, he or she is not eligible for the remainder of days in that benefit period. The individual may elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

RE-ELECTION OF HOSPICE BENEFITS

If an individual revokes the hospice benefit and subsequently re-elects the hospice benefit, a new *Request for Hospice Services* form (DMAS 420) must be signed and dated. The hospice medical director must also sign and date the certification of the appropriate benefit period and this form must be maintained in the individual's medical record. Hospice must obtain written certification within two calendar days of the beginning of the re-election benefit period. The provider must enter the admission into the AE&D portal for FFS hospice individuals. For ~~those~~ individuals enrolled in a managed care organization, please refer to and follow that particular MCO's hospice procedures for admission.

DOCUMENTATION REQUIREMENTS

The hospice provider is responsible for coordinating and documenting an individual's care as long as he or she is enrolled under the hospice benefit. The individual's medical record documentation must include, in addition to the necessary identifying information, the physician's progress notes (if applicable); the physician's certification and recertification of the need for hospice services; and the physician's plan of care, which includes the orders, treatments, medications, services to be rendered, diagnostic studies, therapies, activities, social services, special procedures, diet, diagnoses, and a general statement of the prognosis.

Documentation of hospice services shall, at a minimum:

a. Describe the clinical signs and symptoms of the individual's terminal illness;

b. Document an accurate and complete chronological picture of the individual's clinical course and treatments;

c. Document an interdisciplinary plan of care specifically designed for the individual has been developed, updated as necessary, and is in compliance with physician orders;

d. Document all treatment rendered to the individual in accordance with the plan of care, with specific attention to the frequency, duration, modality, and response. The identity of who provided care (include the full name, title, and date) will also be provided;

e. Document changes in the individual's condition;

f. Identify the category of care as described in Chapter IV; and

g. Document that waiver services, if applicable, are being provided and how these services interact with the hospice plan of care.

All categories of services and coordination of care must be documented in the individual's medical record. Services not specifically documented in the individual's medical record as having been rendered will be deemed not to have been rendered and reimbursement will not be provided. Reimbursement for services based upon missing, incomplete, or outdated documentation will be retracted upon post payment utilization review.

UTILIZATION REVIEW VISITS

Utilization Review will be conducted by DMAS or its designated contractor. Unannounced on- site visits will be made. Desk reviews will be conducted periodically of any Medicaid participating hospice provider. Reviews will include:

- Care being provided to those who are enrolled;
- Adequacy of the services available to meet current health needs and to provide the maximum physical and emotional well-being of each individual;
- Necessity and desirability of the continued participation in hospice services by

the individual;

- Feasibility of meeting the individual's health needs in alternate care arrangements;

- Verification of the existence of all documentation required by Medicaid; and

- Services not documented in the individual's record will be determined not to have been performed and reimbursement will be retracted.

Subsequent visits may be made to follow-up on deficiencies or problems, complaint investigation, or technical assistance.

SPECIFIC MEDICAL RECORD DOCUMENTATION REQUIREMENTS

Physician Certification and Plan of Care

For the initial 90-day benefit period of hospice coverage, a written certification documented on page 2 of the *Request for Hospice Benefits* form (DMAS 420), must be signed and dated by the attending physician and hospice medical director. This initial certification must be obtained prior to the request for authorization of enrollment. For individuals who are dually eligible (Medicare/Medicaid), Medicaid will accept the Medicare certification period(s) signed by both physicians (the attending physician and the hospice medical director) within the required Medicare time frames. This will apply even when the individual becomes Medicare eligible after a period when Medicaid was the primary payer for hospice services. Hospice services cannot begin prior to the individual's election of the hospice benefit. This certification must be maintained in the individual's medical record.

DMAS will accept the Medicare definition and regulations regarding the "Certification of Terminal Illness" as cited in the *Code of Federal Regulations* at §418.22(a)(2) and (3), which reads as follows:

"a) *Timing of certification* -- (1) *General rule*. The Hospice must obtain written certification of terminal illness for each of the periods listed in §418.21, even if a single election continues in effect for an unlimited number of periods, as provided in §418.24(c).

(2) *Basic requirement*. Except as provided in paragraph (a)(3) of this section, the Hospice must obtain the written certification before it submits a claim for payment.

(3) *Exception*s. (i) If the Hospice cannot obtain the written certification within 2 calendar days, after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment."

For any subsequent 90-day or 60-day hospice period, a written physician recertification must be signed and dated by the hospice medical director, or the physician member of the hospice interdisciplinary team, before or on the beginning day of the 90-day or 60-day hospice period. A *Physician Recertification* form (DMAS 420A) is provided for provider use. This certification must include a statement that the individual's medical prognosis (his or her life expectancy) is six months or less, if the illness runs its normal course.

If the hospice provider cannot obtain the written certification within 2 calendar days after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment. Documentation must be in the chart that the provider received oral certification and date this certification was received.

The hospice medical director, or physician member of the interdisciplinary team, must review and renew the physician plan of care as often as the severity of the individual's condition requires, but not less than once every 60 days. The review must be conducted by the attending physician, hospice medical director, or the physician member of the interdisciplinary team, in consultation with the interdisciplinary team. The professional staff involved in the care of the individual shall promptly alert the attending physician or the hospice medical director of any changes in the individual's condition which indicate a need to alter the plan of care or to terminate the service. The plan must include the medication orders with dosages, frequencies, and routes of administration; the treatment orders; the diet order; and any orders for activities, social services, rehabilitative therapies, durable medical equipment and supplies, and ancillary services. The information may be incorporated in the interdisciplinary team plan of care. The attending physician, hospice medical director, or physician member of the interdisciplinary team sign and date the interdisciplinary team care plan as changes are made.

Physician progress notes should record the individual's status at the time of visits, as well as any significant changes between visits. The physician is responsible for signing (name, title) and dating (month, day, year) this required documentation.

All physician documentation must be signed with initials, last name, and title and dated with the month, day, and year. A required physician signature for Medicaid purposes may include signatures, written initials, computer entry, or rubber stamp initialed by the physician. These methods do not preclude other requirements that are not for Medicaid purposes. If a physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide hospice administration with a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. The physician must initial and completely date (with month, day, and year) all rubber-stamped signatures.

Nursing Documentation

The following components are required for nursing documentation:

Nursing Assessment - A thorough evaluation must be made by a registered nurse at the time of admission to hospice services. The evaluation must include, but not be limited to, history of the individual's medical condition as it relates to the need for hospice services, a review of the individual's physical systems, and identification of the physical problems/disabilities. During the nursing evaluation, a determination may be made for further assessment and need for social services. The nursing evaluation must also include a pain assessment and management plan. This initial evaluation must be maintained in the individual's record.

Nursing Care Plan - Nursing care plans based on an admission assessment are required for all individuals and should indicate realistic individual/family needs, measurable goals and objectives, and specifically state the method by which they are to be accomplished.

The nursing care plan is an integral part of the interdisciplinary team care plan and is not required as a separate document. If home health or homemaker aides are to be utilized, the care plan will reflect their duties and frequency.

Nursing Summaries/Progress Notes - Nursing summaries/progress notes, in addition to PRN (as needed) notes, are required at least every two weeks for individuals enrolled in hospice. They must give a current, written picture of the individual, his or her nursing needs, the care being provided, and the individual's response to treatment. They shall address the medical status, functional status in activities of daily living, emotional/mental status, any special therapies, nutritional status, any special nursing procedures, spiritual needs, potential referrals for other services, and identification and resolution of acute episodes.

All nursing documentation must be signed with the initial, last name, and title and dated completely with the month, day, and year. A rubber stamp or initial(s) is never acceptable on any portion of the required nursing documentation. Computer entry signatures and dates are acceptable as agency policy dictates.

Home Health Aide Documentation

Documentation of all services, including the time the aide was in the home on behalf of the individual enrolled in hospice, must be maintained in the individual's record. All aide notes must be signed and dated. Computer entry signatures and dates are acceptable as agency policy dictates.

Coordination between aide services provided under the hospice benefit and those provided under the CCC Plus Waiver must be documented by the hospice nurse in the individual's record. If the individual receives aide services under any other programs or providers, the hospice nurse must document coordination of these services with the hospice benefit. This documentation shall include the hours the individual is receiving aide services from any other agency or program. It is not necessary to have the care plan in the medical record. Documentation of waiver services is maintained separately from hospice services.

Social Services Documentation

Social services must be provided as a part of the interdisciplinary care plan developed for each individual. The social worker assists the interdisciplinary team in understanding the significant social and emotional factors related to terminal illness. The social worker will assist the interdisciplinary team in achievement of maximum social function of each individual enrolled in hospice and the coping capacity of the individual's family. In fostering the human dignity and personal worth of each person, the social worker will assist in preparing the individual for changes in his or her living situation and the family in developing constructive and personally meaningful ways to provide support.

Social service documentation must include an initial psychosocial assessment of the individual and family, a social services plan of care as part of the interdisciplinary team plan of care, and progress notes. The care plan must include measurable goals with realistic time frames and must be updated as often as necessary, but at least every 60 days. Progress notes must be written, signed, and dated at the time of each contact with an individual and/or family member. Computer entry signatures and dates are acceptable

as agency policy dictates. The social worker must participate in the development and periodic review of the interdisciplinary team care plan.

Counseling Services Documentation

Hospice must ensure individuals and their families receive visits, upon their request, from clergy or other members of religious organizations of their choice. Spiritual counseling may be provided through a working arrangement with individual clergy, clergy associations and other religious organizations in the community, or by a clergy person employed by the hospice provider. There must be at least one individual, employed by hospice, who coordinates counseling services if a variety of individuals are providing these services. Counseling services must be available to both the individual and family. Spiritual counseling must include notice to individuals as to the availability of clergy. Dietary counseling, when required, must be provided by a qualified professional. Counseling may be provided by other members of the interdisciplinary team, as well as by other qualified professionals or trained volunteers, as determined by the hospice provider.

Required documentation includes an initial assessment and a plan of care. The plan of care should be a part of the interdisciplinary team care plan; a separate care plan is not required. The plan of care for counseling services must reflect family needs and may include dietary, spiritual, and any other counseling required and must be reviewed and updated at intervals specified in the plan, but no less than once every 60 days. Progress notes for counseling services must be written, signed, and dated at the time of any contact with an individual and/or family member. Computer entry signatures and dates are acceptable as agency policy dictates. The counselor must participate in the development and periodic review of the interdisciplinary care plan.

Bereavement Services Documentation

There must also be an organized program for the provision of bereavement services under the supervision of a qualified professional. The plan of care for bereavement services shall clearly delineate the services to be provided, the individual(s) who will provide the services, the length of time the services will be provided, and the frequency of service delivery (up to one year following the death of the individual enrolled in hospice). Bereavement services must be documented by all persons involved in providing these services.

Interdisciplinary Care Plan and Interdisciplinary Team (IDT)

The IDT shall be comprised of a nurse, physician, and social worker or counselor. The member of the basic interdisciplinary team (IDT) who assesses the individual must consult with one other member of the IDT to establish the initial plan of care, in person or by telephone. At least one member of the IDT establishing the initial plan of care must be either a nurse or a physician. The hospice nurse or physician, in consultation with the individual's independent attending physician, if there is one, must develop the initial plan of care. Two other members of the IDT must review the plan of care and provide input within two calendar days following the day of the assessment. If the date of the initial assessment is a Medicaid covered day of hospice care, the plan of care must be established on the initial assessment date.

The plan of care must be reviewed and updated at intervals specified in the plan, but at

least once every 60 days.

The plan of care must be developed, reviewed, and updated using a coordinated interdisciplinary team approach with the participation of each core service, as well as any other disciplines providing services. The plan of care should be updated as the individual's condition improves or deteriorates. The plan must also include the assessment of the individual's needs and identification of services related to the management of pain and discomfort and symptom relief. The plan of care must state in detail the scope and frequency of services needed to meet the needs of the individual and his or her family. Reviews of all plans of care with signatures and dates must be maintained in the individual's medical record.

The plan of care must also include identification of any other services, regardless of the payer source, that may impact the coordination of the hospice plan of care, including, but not limited to, waiver services. It is not necessary to include another provider's plan of care; however, the hospice interdisciplinary plan of care must reflect the hospice provider's awareness and coordination of the individual's care and needs.

OTHER SERVICES - DOCUMENTATION

Rehabilitative Therapies

Physical therapy, occupational therapy, and speech-language pathology services must be ordered by a physician. The order must include a specific plan of treatment and frequency and duration of services to be provided. For each service provided, there must be an initial assessment and a plan of care, which includes measurable goals and objectives. Each plan of care must be reviewed by each therapist involved in providing care, at least every two weeks. Progress notes must be written, signed, and dated in the individual's medical record at the time of each visit. Computer signatures and dates are acceptable as agency policy dictates.

Other Services

Consultations with any other ancillary health care professionals, such as dietary services, pharmacist, etc., must include an assessment and plan of care. Any documentation in the individual's record must include the name and title of the individual providing the consultation, as well as a complete date (month, day, and year). Each visit or consultation must be documented in the individual's medical record.

Volunteers

Hospice must provide appropriate orientation and training to volunteers consistent with acceptable standards of hospice practice. Volunteers must be used in administrative or direct recipient care roles and be under the supervision of a designated hospice employee. Hospice must document active and ongoing efforts to recruit and retain volunteers.

Hospice must have written policies and procedures regarding the training and use of volunteers. Hospice must document the cost savings achieved through the use of volunteers. Documentation must include identification of necessary positions which are

occupied by volunteers; the work time spent by volunteers occupying these positions; and estimates of the dollar costs the hospice provider would have incurred had paid employees occupied the positions for the time the volunteers occupied the positions.

Hospice must document and maintain a volunteer staff sufficient to provide administrative or direct individual care in an amount that, at a minimum, equals five percent of the total individual care hours of all paid hospice employees and contract staff. Hospice must document a continuing level of volunteer activity. Expansion of care and services achieved through the use of volunteers, including the type of services and the time worked, must be recorded.

Hospice must make reasonable efforts to arrange for visits of clergy and other members of religious organizations in the community to individuals enrolled in hospice who request such visits and must advise them of this opportunity.

All services to individuals enrolled in hospice, including those performed by volunteers, must be documented in the individual's medical record.