Utilization Review and Control (Hospice)

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Under the provisions of federal regulations, the Medical Assistance Program must continually review and evaluate the care and services paid through Medicaid, including the utilization of services by providers and individuals enrolled in the Program. These reviews are mandated by Title 42 *Code of Federal Regulations*, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic utilization reviews on all programs. In addition, DMAS conducts compliance reviews on providers found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or authorized representatives, and authorized federal personnel, upon reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by DMAS.

Individuals Enrolled IN CCC Plus Managed Care (Hospice)

Many individuals enrolled in the Medicaid program have their services furnished through contracted managed care organizations (MCOs) and their network of providers. All providers should check eligibility (refer to Chapter 3) prior to rendering services to confirm in which health plan the individual is enrolled. The MCO may require a referral or prior authorization in order for the individual to receive services. All MCO network hospice providers are responsible for adhering to their MCO provider contract, as well as state and federal regulations. Some providers may choose not to enroll in the MCO network; the individual's choice of provider is limited to those in the MCO network.

For those individuals enrolled in Medicaid receiving care under Medicaid fee-for-service, the provider is responsible for adhering to this manual, as well as state and federal regulations.

Financial Review and Verification (Podiatry)

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 (Hospice)

The Department of Medical Assistance Services routinely conducts compliance reviews to ensure services provided to individuals enrolled in Medicaid are medically necessary, appropriate, and are provided by the appropriate provider. These reviews are mandated by Title 42 of the *Code of Federal Regulations,* Part 455. Providers and enrollees are identified for review by:

- Systems-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. An exception profile report is generated for each provider exceeding peer group averages.

- Referrals and complaints from agencies or individuals. Referrals and complaints of inappropriate utilization of Medicaid services are investigated to determine if a Quality Management Review is necessary. The case may be referred to the DMAS Provider Review Unit or the Attorney General's Office for further review.

Reviews are conducted by:

- The reviewer, who is either a Health Care Compliance Specialist (HCCS), a trained professional employed by DMAS, or a contractor of DMAS, reviews all cases using available resources, including appropriate consultants, and makes on-site reviews of medical records, as necessary.

On-site review process:

- Upon arrival at the facility, the reviewer will supply the provider with a list of records to be reviewed. The provider must supply the reviewer with the requested records.

The reviewer will begin the review at the facility.

- Upon completion of the on-site portion of the review, the reviewer will conduct an exit conference. This conference is a brief summary of the onsite findings.
- Upon return to DMAS, the reviewer will complete the review. Completion of this review includes a summary letter to the provider. This letter includes technical assistance, areas of citation, and, if applicable, documentation of overpayment.
- If overpayment occurs, a copy of the letter will be forwarded to the Fiscal Division of DMAS. The provider will receive another letter outlining the repayment requirements and appeals process from this Division.

Desk review process:

- The reviewer will mail, via United States Post Office certified mail, a list of records to be reviewed. The provider must supply the reviewer with the requested records. The records must be received by DMAS by the date instructed. Upon receipt of the documents, the reviewer will review the records. The reviewer may contact the provider for clarification of any documents received, if needed.
- Upon completion of the review, the reviewer will send a summary letter to the provider via certified mail. This letter includes technical assistance, areas of citation, and, if applicable, documentation of overpayment.
- If overpayment occurs, a copy of the letter will be forwarded to the DMAS Fiscal Division. A letter outlining the repayment requirements will be received from this Division.

NOTE: These processes may be different for providers who participate in the CCC Plus network. Refer to your provider contract or guidance from the MCO for compliance audit specifications.

Overpayments:

- Overpayments may also be calculated based on a review of all claims submitted during a specified time period.
- Providers will be required to refund payments made by Medicaid, or its contractor, if they are found to have billed Medicaid contrary to law or regulation, failed to maintain records or adequate documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or any of the above problems, Medicaid may restrict or terminate the provider's participation in the program.

Fraudulent Claims (Hospice)

Fraud means an intentional deception or misrepresentation made by a person with knowledge the deception could result in some unauthorized benefit to him or 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, documents, or 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 and adhering to applicable state and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring all employees are informed of these regulations. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to the Department of Medical Assistance Services, or its contractor, is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will 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:

Program Integrity Division

Department of Medical Assistance Services

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:

Director, Medicaid Fraud Control Unit

Office of the Attorney General

900 E. Main Street, 5th Floor

Richmond, Virginia 23219

Recipient Fraud

Allegations of fraud or abuse by individuals enrolled in Medicaid are investigated by the Division of Program Integrity of the Department of Medical Assistance Services. The Division 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 Division also investigates incidences of card sharing and prescription forgeries.

If it is determined benefits to which the individual was not entitled were approved, 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. Referrals should be made to:

Program Integrity Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, Virginia 23219

Referrals to the Client Medical Management Program (Hospice)

DMAS providers may refer individuals enrolled in Medicaid who are suspected of inappropriate use or abuse of Medicaid services to the Division of Program Integrity (PI) of the Department of Medical Assistance Services. Referred individuals will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. If CMM enrollment is not indicated, Recipient Monitoring Unit (RMU) staff may educate these individuals on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, fax, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voicemail receives after hours referrals. Written referrals should be mailed to:

Program Integrity Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the individual and a brief statement about the nature of the utilization problems. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

Hospice Admission Process

Admission Package

Hospice will be responsible for completing the *Request for Hospice Benefits* form (DMAS 420, pages 1 and 2). *(NOTE: For information on how to access DMAS hospice forms, please reference the "Accessing DMAS Forms" section of this chapter.)* 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.

If the hospice provider cannot obtain written certification within two (2) calendar days after a period begins, it must obtain an oral certification within two (2) calendar days and written certification prior to submission of a claim for payment. Documentation must be in the 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. *(NOTE: For information on how to access DMAS hospice forms, please reference the "Accessing DMAS Forms" section of this chapter.)*

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. *(NOTE: For information on how to access DMAS hospice forms, please reference the "Accessing DMAS Forms" section of this chapter.)*

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 individuals enrolled in a managed care organization, please refer to and follow that particular MCO's hospice procedures for admission. *(NOTE: For information on how to access DMAS hospice forms, please reference the "Accessing DMAS Forms" section of this chapter.)*

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 Portal located online at: www.virginiamedicaid.dmas.virginia.gov. To access the forms, visit the portal and click on the "Provider Services" tab highlighted in blue on the right side of the page. Once on the Provider Services page, click on "Provider Forms Search" in the center of the page. On the page that generates, select "Long Term Care Facility and Home Based Services" in the "Type" dropdown box, while selecting "Hospice" in the "Category" dropdown box. Finally, click the "Search" button at the bottom. The current versions of all DMAS hospice forms will populate on the next page. The provider must not alter any DMAS forms. In addition to the aforementioned portal, forms may be obtained through Commonwealth Martin at 804-780-0076.

NOTE: These forms and processes may be different for providers who participate in the CCC Plus network. Refer to your provider contract or guidance from the MCO for

compliance audit specifications.

Documentation Requirements (Hospice)

The hospice provider is responsible for coordinating an individual's care as long as he or she is enrolled under the hospice benefit. Medical record documentation must be kept on each individual and will 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 and 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 the changes in each 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 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 (Hospice)

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. *(NOTE: For information on how to access DMAS hospice forms, please reference the "Accessing DMAS Forms" section of this chapter.)* 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. *(NOTE: For information on how to access DMAS hospice forms, please reference the "Accessing DMAS Forms" section of this chapter.)* 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. 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.

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 (Hospice)

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.

Use of Electronic Signatures (Hospice)

Use of electronic signatures for clinical documentation purposes shall be deemed to constitute a signature and will have the same effect as a written signature on a document. An electronic signature meeting the following criteria is acceptable for clinical documentation:

- Identifies the individual signing the document by name and title;
- Assures the documentation cannot be altered after the signature has been affixed by limiting access to the code or key sequence; and
- Provides for nonrepudiation; that is, strong and substantial evidence making it difficult for the signer to claim the electronic representation is not valid.

Providers must have written policies and procedures in effect regarding use of electronic signatures. In addition to complying with security policies and procedures, providers who use computer keys or electronic signatures must sign a statement assuring they alone will have access to and use of the key or computer password. The policies and procedures and statements of exclusive use must be maintained and available at the provider's location.

Additionally, the use of electronic signatures must be consistent with the applicable accrediting and licensing authorities and the provider's own internal policies. These requirements for clinical documentation apply only to Medicaid claims and do not preclude other state and federal requirements.

An original written signature is still required on provider enrollment forms and medical consents. This clarification does not apply to electronic claims submission or the electronic sharing or transmission of clinical records. For guidance on billing, see Chapter V in this manual.