

HealthSystems



HealthSystems  
OF MISSISSIPPI

A blue silhouette of the state of Mississippi is positioned behind the title text.

# Hospice Provider Manual

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Of Mississippi

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## *I. Introduction*

HealthSystems of Mississippi (HSM) is the Utilization Management and Quality Improvement Organization contracted by the Division of Medicaid (DOM) to perform precertification for Hospice care rendered to Mississippi Medicaid clients with full Medicaid Benefits.

We have been contracted with DOM providing utilization and quality of care review since 1997. Review is performed for the following types of services:

- Inpatient Acute Hospitals
- Free Standing Psychiatric Inpatient Hospitals
- Psychiatric Residential Treatment Facilities
- MYPAC - Mississippi Youth Programs Around the Clock
- Hospital Outpatient Mental Health Services
- Community Mental Health Post Payment Review
- Day Treatment Services (5 Years of Age and Younger)
- Outpatient Physical, Occupational and Speech Therapy
- School Health Related Outpatient Physical, Occupational and Speech Therapy
- Home Health
- Durable Medical Equipment, Orthotics, Prosthetics and Supplies
- Private Duty Nursing
- Large Organ Transplant
- Hospice

The purpose of this manual is to assist providers in successfully navigating through HSM's review requirements and processes.

## *II. Frequently Used Terms*

**Admit Date** - HSM adopts the Centers of Medicare and Medicaid Services' definition of the admit date as the date when the plan of care is established.

**Admission Review** -The review performed by HSM when a new or existing patient's information is entered into the HSM Web portal for the first time or is new to the precertification process. Admission Review is interchangeable with Precertification Review. This review determines if the patient meets medical justification for hospice services.

**Precertification** - The process by which HSM determines the hospice patient meets eligibility and medical justification for Medicaid coverage. Precertification includes an identified enrollment period.

**Continued Stay/Recertification** - Subsequent reviews performed by HSM to determine if continuation of a hospice benefit period and services are medically necessary. Recertification must be requested seven business days prior to the certification end date for the current enrollment period.

**Enrollment Period** - The hospice benefit is divided into distinct periods. Each period stands alone and once used, is never again available. A period is used when the beneficiary enrolls in that period and subsequently dis-enrolls, or when the maximum number of days available in that period is used. The maximum number of days in each election period is as follows:

- 1<sup>st</sup> - 90 days
- 2<sup>nd</sup> - 90 days
- 3<sup>rd</sup> - 60 days - unlimited increments

**Benefit/certification Period** - Begins on the admit date and ends on the date the maximum number of days available in that period is used or when the beneficiary dis-enrolls.

**Bar Coded Fax Coversheet** - Web utility option that allows the provider to print a specialized cover sheet encrypted with bar code technology that links required documents directly to a specific review. The coversheet is designed for one use and may not be altered in any way.

**Upload** - Web utility option that allows providers to link required documents in the form of .tif, .jpeg, or pdf files directly from their computer to a specific review.

**Treatment Authorization Number (TAN)** - The acronym for "Treatment Authorization Number" is the number issued by HSM to providers verifying certification of a benefit period. The TAN number drives the "lock- in" which allows payment of claims.

**Pend** - Refers to the process of placing a review certification review request on hold until additional information has been received. HSM will notify the provider of the information needed along with a time frame for submission

**Suspended** - Status assigned to a review when a provider fails to provide the requested information within the time frame. Suspended reviews can be reactivated upon receipt of the requested information.

**Denial** - Occurs when requested services are not approved. Only a physician reviewer can clinically deny a request.

**Reconsideration** - Following a clinical denial of an enrollment period, either the beneficiary/legal representative, provider and/or attending physician can request reconsideration by a HSM physician, (different from the initial physician) to review the request and any additional information submitted.

**Appeal** - If the reconsideration outcome was to uphold the denial and there is a disagreement with this decision, the beneficiary/legal representative may request an administrative appeal from the Division of Medicaid.

**Face To Face Encounter** - A hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient, no more than 30 calendar days prior to the 180th day recertification, and each 60-day recertification period. The physician or nurse practitioner who performs the face-to-face encounter with the patient must attest that he or she had a face-to-face hospice encounter with the patient, including the date of the visit. The attestation of the nurse practitioner shall state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. 42 CFR Part 418.

**Lock -In Segment**-Describes a series of start and end dates to assist in claims payment when a beneficiary meets the requirements for hospice admission.

**Disenrollment**- When a beneficiary/legal representative revokes the election of hospice care at any time by completing a Disenrollment form (DOM 1166).

**First Level Reviewers** - HSM first level reviewers (Registered Nurses):

- Applies DOM policy.
- Applies DOM approved medical necessity clinical guidelines.
- Request additional information.
- Refer requests that cannot be approved for physician determination.
- Authorize care.

**Second Level Reviewers** - HSM second level reviewers (Physicians):

- Make certification, denial or reconsideration determinations. That decision is:
  - Based on documentation that supports prognosis and medical appropriateness of setting.\*
  - Based on evidenced based guidelines.

- Patient-centered and takes into consideration the unique factors associated with each patient care episode.
- Sensitive to the local healthcare delivery system infrastructure.
- Based on his or her clinical experience, judgment and accepted standards of healthcare.
- Request additional information.
- Clinically deny certification.

\*The physician reviewer may contact the attending physician or the hospice medical director to obtain additional information when the documentation submitted does not clearly support medical necessity.

### ***III. Getting Started - Helpful Tips***

#### ***Before submitting a hospice review request to HSM:***

1. Discuss the services available to meet the beneficiary's needs.
2. Discuss the limits of hospice services with the beneficiary/legal representative.
3. Check beneficiary Medicaid eligibility to ensure they are eligible for election.

#### ***Verification of Eligibility***

The plastic Medicaid card is not a guarantee of Medicaid eligibility. Providers must access the beneficiary's eligibility and service limit information through the eligibility verification channels that are provided.

The provider is responsible for verifying a Medicaid beneficiary's eligibility each time the beneficiary appears for service. The provider is also responsible for confirming that the person presenting the card is the person to whom the card is issued. Providers can receive information such as verification of client eligibility, other health insurance, and benefits remaining using the Medicaid ID number or social security number.

Providers can verify eligibility by using either of the following services:

- Website verification at <https://msmedicaid.acs-inc.com/msenvision/index.do>
- Automated Voice Response System (AVRS) at 1-866-597-2675
- Provider/Beneficiary Services Call Center at 1-800-884-3222
- Medicaid Eligibility Verification Services (MEVS) transaction using personal computer (PC) software or point of service (POS) swipe card verification device.

#### ***DOM Hospice Policies and Procedures***

Providers must read and be familiar with DOM's policies and procedures located at <http://www.medicaid.ms.gov>. Medicaid hospice policy may be found in the DOM Provider Policy Manual, Section 14.

In order to qualify for hospice services, the beneficiary/legal representative must:

- Be Medicaid eligible. See Page 14 of this manual regarding dual eligibles & Medicare.
- Be certified by two physicians as being terminally ill with a life expectancy of six months or less. The physicians must be the hospice medical director or the physician member of the hospice interdisciplinary team **and** the beneficiary's attending physician.
- Have a documented diagnosis consistent with a terminal stage of six months or less.
- Acknowledge the terminal illness and elect to receive the palliative care of hospice services rather than active treatment of the condition. The exception to this requirement is the patient under 21 years of age who can receive active treatment for a terminal illness while receiving Medicaid coverage for Hospice care.
- Disenroll from Home and Community Based (HCBS) waiver, if applicable. To disenroll a beneficiary from a HCBS waiver please contact the Long Term Care Bureau, Mississippi Division of Medicaid, for assistance.

### *Hospice Care for Children in Medicaid*

According to the Patient Protection and Affordable Care Act of 2009 for Hospice, **children under the age of 21** may receive hospice benefits including curative treatment upon the election of the hospice benefit without foregoing any other service to which the child is entitled to under Medicaid.

### *Hospice Enrollment Periods*

Hospice benefit periods must be precertified with HSM. Requests for precertification are submitted to HSM prior to admission and before the end of an existing enrollment period. See page 12 for submission timelines. Prior to submitting a request for certification/recertification, the hospice provider must:

- Obtain written certification signed by the hospice medical director and beneficiary's attending/certifying physician. (If the written certification is not obtained prior to initiation of hospice care, a verbal certification must have been made. If the written order has not been received within 30 days of the verbal certification, no precertification will be issued and the case is closed)
- Discuss the limits of hospice services with the beneficiary/legal representative,
- If hospice services are selected, the following forms must be completed and submitted to HSM electronically:
  - Beneficiary Election Statement (DOM 1165-A).
  - Enrollment Form (DOM 1165-B).
  - Physician Certification/Recertification (DOM 1165-C).
  - History and Physical (H&P) not older than 30 days from start of care date. This must be submitted with each review.

**Face -To- Face Encounter** - A hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient, no more than 30 calendar days prior to the 180th day recertification, and each 60-day recertification period. The physician or nurse practitioner who performs the face-to-face encounter with the patient must attest that he or she had a face-to-face hospice encounter with the patient, including the date of the visit. The attestation of the nurse practitioner shall state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. 42 CFR Part 418.

#### **IV. Access and Submission to HSM**

To submit the information covered in Section III, providers must have a user name and password to access the Web portal at [www.hsom.org](http://www.hsom.org). HSM's HIPAA secure Web-based system provides 24 hours a day, 7 days a week access to for real-time submission of:

- Review requests.
- Additional information for specific reviews when requested by HSM.
- Helpline inquiries.

If you do not have a HSM Web portal user name and password, contact HSM's education department at [education@hsom.org](mailto:education@hsom.org) or by phone at (601) 360-4949 or toll-free at 1-866-740-2221 to request enrollment and training.

The table below lists important phone numbers and hours of operation.

Purpose	Description	Hours of Operation and Number(s)
Hospice Precertification Review Request Submission	Used by providers to submit review request and additional information requested by HSM.	<p><b>Web reviews:</b> <a href="http://www.hsom.org">www.hsom.org</a>. Click on "Submit Review Requests" link.</p> <p>Web: 24 hours, 7 days a week.</p> <p>The system will direct the user to upload any required documents or provide instruction on generating a bar coded technology fax cover sheet with a secure fax number to send required information.</p> <p>Fax: 1-877-272-8727</p> <p><i>Reviews received after 5:00 p.m. or over the weekend or holidays are considered received the next working day.</i></p>
Helpline	Used by providers for questions regarding the precertification process and to obtain assistance.	<p><b>Web Helpline:</b> <a href="http://www.hsom.org">www.hsom.org</a>. Click on "Reports and Communications" link.</p> <p>Web: 24 hours, 7-days a week.</p> <p>Local: (601) 360-4949</p> <p>Toll Free: 1-866-740-2221</p> <p>Hours of availability: 8:00 a.m. - 5:00 p.m. (business days)</p>
Hot Line	Used by providers/beneficiaries to report quality concerns and/or complaints.	<p>Toll Free: 1-888-204-0221</p> <p>Hours of availability: 8:00 a.m. - 5:00 p.m. (business days)</p>

### ***Electronic Helpline Inquiries***

Providers are encouraged to use HSM's HIPAA secure Web-based system to electronically submit helpline inquiries and to check the status of reviews at any time. The reporting module is provider-specific and available 24 hours a day, 7 days a week.

In addition to Internet access, minimum computer specifications are:

- PC 1GHz+ processor, 512 MB+ RAM, 500MB of free space.
- Super VGA (1024x768) or higher resolution video card and monitor.
- Broadband internet connection with a speed of at least 512Kbps.
- Internet Explorer Version 7.

### *V. Hospice Review Exclusions*

Medicaid policy exempts certain encounters from HSM review. HSM will not process requests that meet these policy conditions. The following are reasons for review exclusion.

<b>Reason</b>	<b>Description</b>
No Medicaid Eligibility	If the beneficiary is not eligible for Medicaid at the time of request, no HSM review is required.
Duplication of Services	No HSM review is allowed if a review determination has already been rendered for the requested services for a different provider.
Category of Eligibility	If the beneficiary's category of eligibility does not include hospice benefits, no HSM review is required. For example, those persons whose eligibility limits their benefits to Medicare cost sharing only.
Mississippi Coordinated Care Program	If the beneficiary's category of eligibility & lock-in are part of Mississippi Coordinated Care Program, no HSM review is required.

Dual eligible beneficiaries:

- The following applies to all beneficiaries:
  - Providers who participate with Mississippi Medicaid are required by law to determine if a beneficiary is covered by a third party source, including Medicare.
  - Medicare A is the primary coverage for dual eligible beneficiaries, when combined with a Medicaid category of eligibility that has hospice as a service option.
  - The hospice benefit is used simultaneously under both programs.
  - You must have a lock-in for each enrollment period. The lock-in is created when abbreviated enrollment information is submitted through the HSM Web portal. A reference number called a TAN is generated to assist in any future questions. However, information related to the enrollment period (the lock-in) is transmitted to the fiscal intermediary (FI) daily. The lock-in facilitates claims payment once a claim is submitted to the FI.

When a hospice provider successfully submits a Web review request for a dual eligible (Medicare/Medicaid) beneficiary; HSM will create an administrative TAN. Medicare B, C, & D coverage or any other third party insurance must follow precertification rules for Medicaid only if pursuing Medicaid reimbursement for hospice.

## *VI. Precertification Review Process*

### *A. Requests for Precertification Review*

Providers submit requests for review directly to HSM via the Web at [www.hsom.org](http://www.hsom.org).

A review for initiation of an enrollment period is referred to as a precertification or admission review. Subsequent reviews are performed to determine if continuation of a hospice benefit period is medically necessary. These reviews are called continued stay or recertification reviews.

Hospice enrollment periods are reviewed for medical necessity. The review request must be entered via HSM's Web portal to receive a lock-in. The lock-in provides a start and end date. Once a lock-in is successfully created, a reference number called a TAN is assigned to the lock-in. A lock-in is necessary in order for a claim to pay.

**Medicaid Only Beneficiary**

The following table describes the types of review, timeframes for submission, and required documentation for each type of review.

**Table 1 Hospice Review for Medicaid Only Beneficiaries (see Table 2 for Dual Eligible Beneficiaries)**

Review Type	Timeframe	Required Documentation
Admission/ Precertification request (Medicaid Only Beneficiary)	At least 7 business days prior to initiation of hospice.	<ul style="list-style-type: none"> <li>• Submit the required information to HSM via the Web portal.</li> <li>• Upload the following via .tif, .jpeg or .pdf file:               <ol style="list-style-type: none"> <li>1. Election Statement (DOM 1165-A).</li> <li>2. Enrollment Form (DOM 1165-B).</li> <li>3. Physician Certification/Recertification (DOM 1165-C)</li> <li>4. History and Physical (H&amp;P) not older than 30 days from start of care date.</li> </ol> </li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• Use bar coded coversheet to fax a copy of the completed forms.</li> </ul>
Continued Stay/Recertification request (Medicaid Only Beneficiary)	At least 7 business days prior to the last date certified by HSM. (This is the end date on your TAN)	<ul style="list-style-type: none"> <li>• Submit the required information to HSM via the Web portal.</li> <li>• Upload the following via .tif, .jpeg or .pdf file:               <ol style="list-style-type: none"> <li>1. Enrollment Form (DOM 1165-B).</li> <li>2. Physician Certification/Recertification (DOM 1165-C)</li> <li>3. Clinical Narrative Such as an update to the H&amp;P. (Not older than 30 days from start of the recertification date.)</li> </ol> </li> </ul> <p><b>OR</b></p> <ul style="list-style-type: none"> <li>• Use bar coded coversheet to fax a copy of the completed forms.</li> </ul> <p><b>Note:</b> A hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient, no more than 30 calendar days prior to the 180th day recertification, and each 60-day recertification period, The physician or nurse practitioner who performs the face-to-face encounter with the patient must attest that he or she had a face-to-face encounter with the patient, including the date of the visit.</p>

**Medicare/Medicaid (Dual Eligible) Beneficiary**

The following table describes the required information for administratively creating a “lock-in” for dual eligible Medicare/Medicaid beneficiaries. **NOTE:** All forms are required to be maintained as part of the beneficiaries’ hospice record.

**Table 2 Hospice Review for Dual Eligible (Medicare/Medicaid) Beneficiaries**

Enrollment Period	Timeframe	*Documentation
Admission (Enrollment Period 1)	At least 7 business days prior to initiation of hospice.	Submit the required information to HSM Web portal by completing the Start and DX/Items tabs of the review submission. This includes: <ul style="list-style-type: none"> <li>a) The beneficiary’s Medicaid Identification number</li> <li>b) Physician’s and Healthcare Practitioner Information:                             <ul style="list-style-type: none"> <li>a. Ordering Physician.</li> <li>b. Attending Physician.</li> <li>c. Hospice Medical Director.</li> </ul> </li> <li>c) Case Supervisor (optional)</li> <li>d) Start of Care Date</li> <li>e) # of Days Requested.</li> <li>f) Date of Death (if applicable)</li> <li>g) Enrollment Period.</li> <li>h) Enrollment Period Start and End Dates</li> <li>i) County where hospice service will be performed.</li> <li>j) If hospice care is to be provided in a nursing facility (Yes or No). If yes, the nursing home’s Provider ID.</li> <li>k) Diagnoses Codes</li> <li>l) Indicate which standardized tool/scale was used to assess the functional status: (Include score):                             <ul style="list-style-type: none"> <li>a. Karnofsky Performance Status Scale.</li> <li>b. Functional Assessment Staging Tool (FAST)</li> <li>c. Palliative Performance Scale (PPS)</li> <li>d. NY Heart Association Cardiac Functioning Classification.</li> <li>e. Other as specified.</li> </ul> </li> </ul>
Continued Stay (Enrollment Period 2 or greater)	At least 7 business days prior to the last date certified by HSM. (This is the end date on your TAN)	Submit the required information through the HSM Web portal. For a continued stay review, access the prior review information by inputting the TAN in the corresponding data field. This will import the prior review information, enabling access to modify or edit existing data. Please see items a - l information as noted above.

**Admission Review Helpful Tip:** (*Applicable only to dual eligible Medicare/Medicaid beneficiaries enrolled prior to January 1, 2011*) If a hospice provider determines a dual eligible (Medicare/Medicaid) beneficiary was enrolled with Medicare prior to Jan 1, 2011 but was not enrolled with Medicaid; the provider should submit an admission request to HSM for the corresponding enrollment period for the number of days remaining in the Medicare enrollment as of Jan 1, 2011. This will maintain synchronicity between the two agencies and reduce provider work.

**Example:** A beneficiary is enrolled with Medicare for enrollment period 1 and has 30 days remaining in the period, but has not been enrolled with Medicaid. Provider should submit to HSM an Admission request through the Web portal for enrollment period 1 and days requested equal to 30, the start and end dates of the request should also equal 30 days.

**Continued Stay or Recertification Review Additional Note:** It is the responsibility of the hospice service provider to request a continued stay review seven business days prior to the next review point (Last day certified for the current enrollment period).

### ***B. Determining Enrollment Period and Review Type***

The hospice benefit is divided into distinct periods. Each period stands alone and once used, is never again available. A period is used when the beneficiary enrolls in that period and subsequently dis-enrolls, or when the maximum number of days available in that period is used.

For those beneficiaries who may have been served by different hospices at varying times, it is recommended for Hospice Providers to obtain a written verification or attestation from the beneficiary or legal representative as to the number of prior hospice enrollments. The following table lists the maximum number of days for each enrollment period.

Type of Review	Length of Certification
1 <sup>st</sup> Enrollment and Election Request	90-days.
2 <sup>nd</sup> Enrollment Request	90-days.
3 <sup>rd</sup> and Subsequent Enrollment Requests	Unlimited 60-day increments.

**Example 1** - A beneficiary has been in a hospice for 160 days and the certified enrollment period ends in 20 days, the hospice provider must submit a request to HSM for recertification seven days in advance of the last certified day of the enrollment period listed on the TAN. Prior to submitting the request, the hospice physician or nurse practitioner must have a face-to-face visit with the beneficiary and attest the visit occurred. An updated or addendum to the history and physical (H&P) must be performed and documented and submitted with the re-certification request. See [\*Table 2 Hospice Review for Dual Eligible\*](#) for exceptions that apply only to dual eligible (Medicare/Medicaid) beneficiaries.

**Example 2** - If a beneficiary has been in a hospice for 200 days and the certified enrollment period ends in 40 days, the hospice provider must submit a request to HSM for recertification seven days in advance of the last certified day of the enrollment period listed on the TAN. The hospice physician or nurse practitioner must have a face-to-face visit with the beneficiary and attest the visit occurred. An updated or addendum to the history and physical (H&P) must be performed and documented and submitted with the re-certification request. This must be completed no more than 30 calendar days before the subsequent enrollment period. See *Table 2 Hospice Review for Dual Eligible* for exceptions that apply only to dual eligible (Medicare/Medicaid) beneficiaries.

The table below provides examples of enrollment periods, enrollment period dates, applicability of face-to face rule, and review submission due dates.

**Examples:**

Enrollment Period	Enrollment Period Dates	180 day (face-to-face)/60 day (face-to-face) CMS & DOM requirement*	HSM Review Submission Due Date
Admission Date/First Enrollment Period (90 Days)	2/1/2011 thru 5/1/2011	N/A	1/21/2011
First Continued Stay/Second Enrollment Period (90 Days)	5/2/2011 thru 7/30/2011	H&P must be no more than 30 calendar days prior the subsequent recert period.	4/21/2011
Second Continued Stay/Third Enrollment Period (60 Days)	7/31/2011 thru 9/28/2011	H&P must be no more than 30 calendar days prior the subsequent recert period.	7/21/2011
Third Continued Stay/Fourth Enrollment Period (60 Days)	9/29/2011 thru 11/27/2011	H&P must be no more than 30 calendar days prior the subsequent recert period.	9/20/2011

Reference: 42 CFR, Part 418C. Disenrollment/Transfer or Discharge

The beneficiary/legal representative may revoke the election of hospice care at any time by completing a Disenrollment form (DOM1166). Disenrollment is required for, but not limited to the following:

- Death
- Hospitalization unrelated to terminal illness.
- Beneficiary is seeking treatment other than palliative in nature.
- Beneficiary no longer meets program requirements.
- Direct transfer to another hospice provider.

Use HSM Web portal Disenrollment/Discharge and Transfer utility to report disenrollment, discharges and transfers.

- Must be submitted **within 48 hours** of discharge/disenrollment/transfer.
- The form must be signed if disenrollment is for any reason other than death.

### D. Processing of Review Requests

HSM has a diverse group of professionals that assist at various stages of the review process. These highly qualified professionals make certification review determinations for hospice services; however, only HSM's second level reviewers (physicians) can deny a hospice request. The following table describes our staff's functions.

Staff	Functions
First level reviewers (Registered Nurses)	<ul style="list-style-type: none"> <li>• Apply DOM policy.</li> <li>• Apply DOM approved medical necessity clinical guidelines.</li> <li>• May request additional information.</li> <li>• Refer requests that cannot be approved for physician determination.</li> <li>• Can authorize care.</li> </ul>
Second level reviewers (Physicians)	<ul style="list-style-type: none"> <li>• Make certification, denial or reconsideration determinations. That decision is:               <ul style="list-style-type: none"> <li>- Based on documentation that supports prognosis and medical appropriateness of setting.*</li> <li>- Based on evidenced based guidelines.</li> <li>- Patient-centered and takes into consideration the unique factors associated with each patient care episode.</li> <li>- Sensitive to the local healthcare delivery system infrastructure.</li> <li>- Based on his or her clinical experience, judgment and accepted standards of healthcare.</li> </ul> </li> <li>• May request additional information.</li> <li>• Only physicians may clinically deny a request.</li> </ul> <p>*The physician reviewer may contact the attending physician or the hospice medical director to obtain additional information when the documentation submitted does not clearly support medical necessity.</p> <p><b>Note:</b> See the <i>Reconsideration Process</i> section of this manual for information on the reconsideration process.</p>

**Pended Review:** There are three types of situations that may cause a review to be pended for additional information. The following table describes each situation with its corresponding timeframes for submission of the requested information. If the information is not submitted by the due date then HSM suspends review of the request.

If the review cannot proceed because ...	Then ...	Review Type	Timeframe for submission
1. Administrative information is missing or incomplete.	Non-clinical information necessary to proceed with the review is requested.	All review types/enrollment periods.	One business day.
Clinical information is needed by the: 2. First level reviewer. 3. Second level reviewer.	Clinical information required to complete the review is requested.		

***E. Notification of Review Outcome***

HSM provides notification of review results to the hospice provider via the Web. If an enrollment period is denied, providers and attending physicians are notified by mail, fax, and/or verbally. Beneficiary/legal representative denial notifications will be sent via mail.

The hospice provider/beneficiary/legal representative or ordering physician may request a reconsideration of a denial determination. A second physician, one not involved in the initial decision, will review the request and make a determination. If the decision to deny is upheld the beneficiary/legal representative may appeal the decision directly to the Division of Medicaid. See the *Reconsideration Process* section of this manual for additional information. If a beneficiary is denied hospice services, the hospice provider may contact the Long Term Care Bureau, Mississippi Division of Medicaid to discuss other care options. The following table contains the details of the notification process based on review outcome.

Review Outcome	Details
Certification (Approval)	<ul style="list-style-type: none"> <li>Electronic notification of approval review results is sent to the hospice provider via Web. (<i>See GO Green Manual</i>)</li> </ul>
Denial	<ul style="list-style-type: none"> <li>If HSM determines the documentation submitted does not substantiate the medical necessity of the hospice benefit period, a denial notification will be issued and reconsideration rights will apply.</li> <li>Notification of denial determination is sent to the hospice provider and to beneficiary/legal representative, via regular mail service.</li> <li>Verbal notice is also given to the hospice provider.</li> <li>The beneficiary/legal representative’s notice does not contain the medical basis for the denial.</li> </ul>

<b>Suspended</b>	<ul style="list-style-type: none"> <li>HSM will notify the requester (verbally and via the Web) when additional information is required and the review will be pended. If the requested information is not submitted by the due date, HSM issues a written notice of Review Suspended.</li> </ul>
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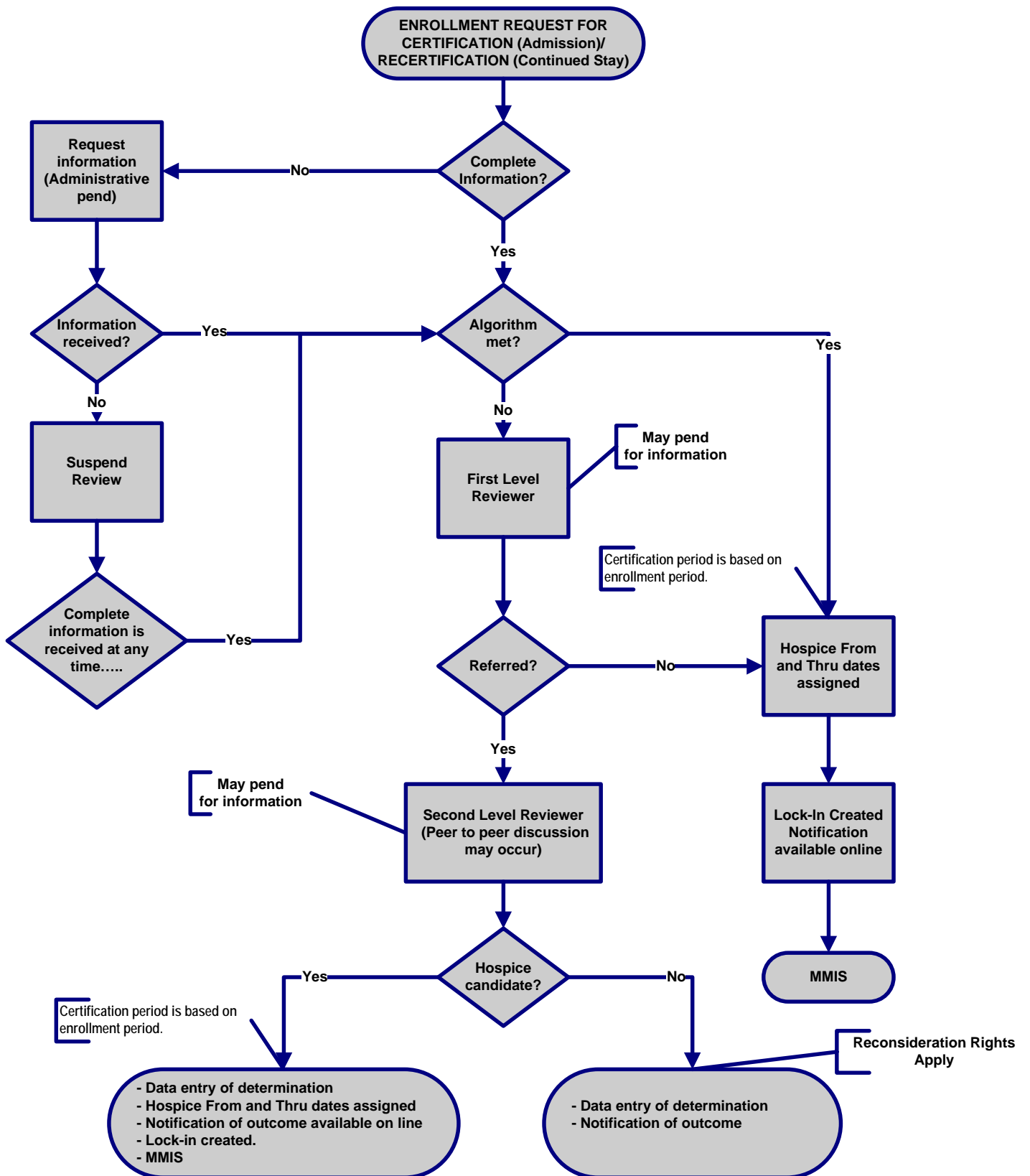
Review determination and notification timeframes are displayed in the following table.

Review Type	Review Determination	Electronic Notification
Admission/ Precertification	Within three business days of receipt of review request and necessary information.	Within one business day of review determination.
Continued Stay/Subsequent Enrollment Period		

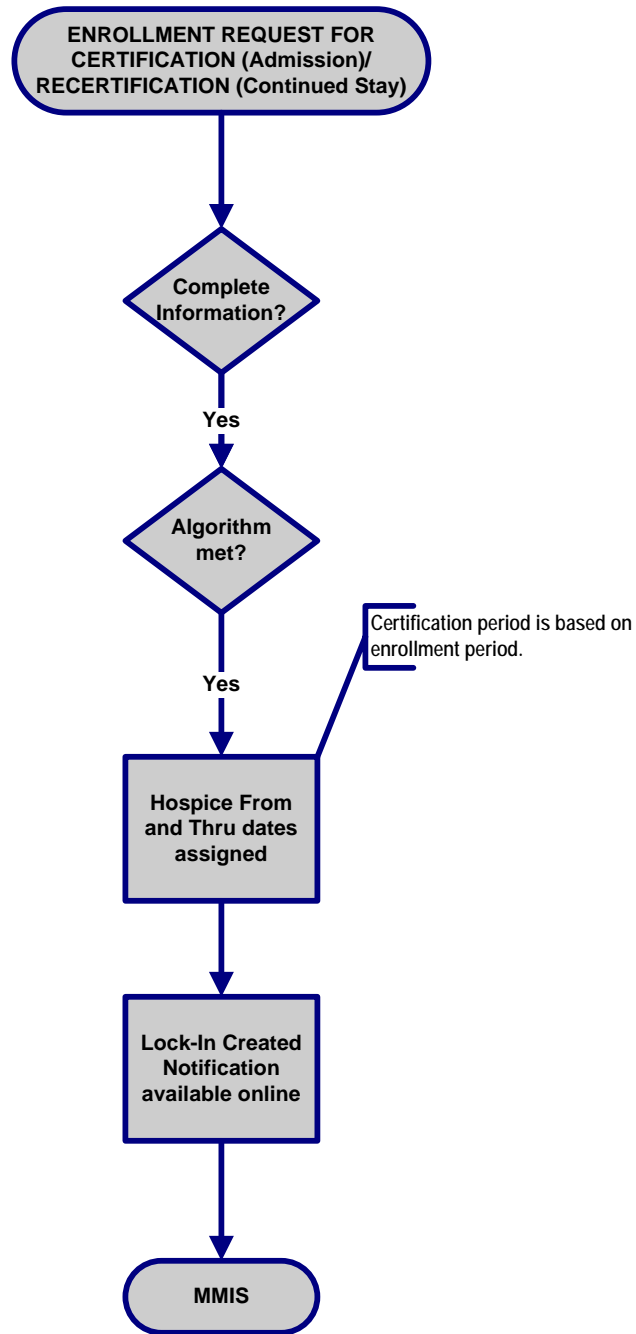
Notices of review outcome include the following information.

Review Outcome	Information	Review Type	
		Admission	Continued Stay/Recertification
Certification (Approval)	Date of notice	✓	✓
	Brief statement of HSM’s authority and responsibility for review	✓	✓
	Reason for determination	✓	✓
	Date(s) of service being approved	✓	✓
	Type service certified	✓	✓
	Number of days certified	✓	✓
	Treatment Authorization Number (TAN)	✓	✓
Denial	Date of notice.	✓	✓
	Brief statement of HSM’s authority and responsibility for review.	✓	✓
	Principal and clinical reason for denial.	✓	✓
	Type of services and dates of services being denied.	✓	✓
	Type of services and dates of services previously certified.		✓
	Process for submitting a reconsideration request.	✓	✓
	Reconsideration timeframes.	✓	✓

**F. Review Process Flow Chart for Medicaid Only Beneficiary**



*G. Review Process Flow Chart for Dual Eligible (Medicare/Medicaid) Beneficiary*



### *VII. Reconsideration Review*

If any of the following parties disagree with the determination made by HSM, a request for reconsideration (a second look) may be requested from HSM. They are:

- Beneficiary/legal representative.
- Hospice provider.
- Attending physician.

A standard reconsideration may be requested by one of the above listed parties within thirty calendar days of the initial denial notice if the patient is currently receiving hospice services.

A second physician, not one involved in the initial decision, will review the reconsideration request, the original request, and any additional information to support the review and make a determination.

Please see the **Reconsideration Manual** for additional details, on how to request reconsideration.

### *VIII. Resources*

Please visit the HSM Website [www.hsom.org](http://www.hsom.org) to access the following resources:

- Provider Quick Reference Guide
- Go Green Information
- DOM Hospice Forms
- Reconsideration Manual
- Hospice Frequently Asked Questions
- Hospice “Breaking News”