

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 to perform precertification for Hospice care rendered to Mississippi Medicaid beneficiaries.

We have been contracted with the Mississippi Division of Medicaid (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 process.

II. Frequently Used Terms

Admit Date – Start of care date, the date the plan of care is established.

Precertification – A request submitted prior to the begin date of a hospice benefit period.

Continued Stay/Recertification - Subsequent reviews performed to determine if continuation of a hospice benefit period is medically indicated and appropriate.

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:

- 1st – 90 days
- 2nd – 90 days
- 3rd – 60 days – unlimited increments

Benefit/certification period - Starts on admit date and ends on the date the maximum number of days available in that period is used or 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) - Number issued by HSM to providers verifying certification of a benefit period.

Pend – HSM will “pend” a review request when additional information must be submitted before a review can be completed. HSM will notify the provider of the information needed and will hold the review until the information is received.

Suspended – Status assigned to a review that had been pended for additional information but the provider failed to provide the requested information within the time frame as defined in the Provider Manual. 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, the beneficiary/legal representative, provider and/or attending physician can request reconsideration, or another look 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.

III. Getting Started – Helpful Tips

Before submitting any request to HSM, providers must verify beneficiary eligibility and available benefits through DOM's fiscal agent at <https://msmedicaid.acs-inc.com/msenvision/index.do> or 1-800-884-3222. The above contact information is also used if you have a billing question. Categories of Medicaid eligibility with hospice benefits requiring prior authorization are listed in the table below.

COE	Description
001	SSI Individual via SDX
002	SSI Retro Eligibility
003	IV-E Foster Care/Adoption Assistance Related
005	SSI in Institution
006	Protected SSI Child
007	Protected Foster Care Child
010	Nursing Home, under 300% FPL
013	NH, Eligible at Home
019	Disabled Child at Home
026	CWS Foster Care/Adoption Assistance Child
045	Healthier MS Waiver Only (No Medicare)
085	Medical Assistance – Intact Family
087	Children up to Age 6
088	Pregnant Women and children under Age 1, under 185% FPL
091	Child Under Age 19, under 100%
094	Disabled Adult Child-DAC

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 DOM Provider Policy Manual, Section 14.

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

- Be Medicaid eligible. See COE tables above with hospice as a benefit.
 - *Refer to page 8 of this manual regarding dual eligible's & Medicare.*
- Be certified by two physicians as being terminally ill with a life expectancy of six months or less.
- 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.
- Disenroll from Home and Community Based (HCBS) waiver, if applicable.

Hospice benefit periods must be pre-certified with HSM. Requests for precertification are submitted to HSM prior to admission and before the end of an existing enrollment period. See page 9 for submission timelines. Prior to submitting a request for certification/recertification the hospice provider must:

- Obtain a written certification statement signed by the hospice medical director and beneficiary's attending/certifying physician. **and**
- Discuss the limits of hospice services with the beneficiary/legal representative, **and**
- 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.
- If the hospice service provider submits recertification after the last date of the treatment authorization number (TAN), a new start date will be required. This will create a gap in the certification period, and forfeiture of days. The earliest new start date will be the date in which all information is submitted to HSM for review of the new period.
 - **Example:** If the last date of the treatment authorization number (TAN end date) is 6/30/2011 but HSM receives the complete information via electronic review submission on 7/4/2011; the start date for the new TAN would be 7/4/2011.

IV. Information You Need to Know

Hospice providers submit review requests and receive HSM certification responses via the Web at 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 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>Web reviews: www.hsom.org. 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>Web Helpline: www.hsom.org. Click on "Reports and Communications" link.</p> <p>Web: 24 hours, 7-days a week.</p> <p>Local: (601) 360-4949 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 and the provider should not submit review requests for these situations. HSM will not process requests that meet these policy conditions. The following are reasons for review exclusion.

Reason	Description
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 offer hospice benefits, no HSM review is required.
MS CAN Care Coordination	If the beneficiary's category of eligibility & lock-in are part of MS CAN – Care Coordination. No HSM review is required.

Notes:

Dual eligible 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.
- A treatment authorization number (TAN) must be obtained from HSM for those dual eligible beneficiaries with Medicare a coverage.

Medicare B, C, & D coverage or any other third party insurance must follow prior authorization rules for Medicaid 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.

A review for initiation of an enrollment period is referred to as a prior authorization or admission review. Subsequent reviews are performed to determine if continuation of a hospice benefit period is medically indicated and appropriate. These are called continued stay reviews.

Hospice benefit periods are reviewed for medical necessity and appropriateness. The review request must be entered via HSM's Web portal to receive a Treatment Authorization Number (TAN). The TAN provides a start and end date. *A TAN is required to receive reimbursement for hospice effective January 1, 2011 going forward.*

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

Review Type	Timeframe	Required Documentation
Admission/ Precertification request (Medicaid Only Beneficiary) Enrollment Period 1	At least 7 business days prior to initiation of hospice.	<ul style="list-style-type: none"> • Web the required information to HSM. • Upload the following via .tif, .jpeg or .pdf file: <ol style="list-style-type: none"> 1. Election Statement (DOM 1165-A). 2. Enrollment Form (DOM 1165-B). 3. Physician Certification/Recertification (DOM 1165-C) 4. History and Physical (H&P) not older than 30 days from start of care date. <p>OR</p> <ul style="list-style-type: none"> • Use bar coded coversheet to fax a copy of the completed forms.
Continued Stay/Recertification request (Medicaid Only Beneficiary) Enrollment Period 2 or more	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"> • Web the required information to HSM. • Upload the following via .tif, .jpeg or .pdf file: <ol style="list-style-type: none"> 1. Enrollment Form (DOM 1165-B). 2. Physician Certification/Recertification (DOM 1165-C) <p>OR</p> <ul style="list-style-type: none"> • Use bar coded coversheet to fax a copy of the completed forms. <p>Note: 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>
Admission/ Precertification request (Medicare/ Medicaid Beneficiary, dual eligible) Enrollment Period 1	At least 7 business days prior to initiation of hospice.	<ul style="list-style-type: none"> • Web the required information to HSM. • Upload the following via .tif, .jpeg or .pdf file: <ol style="list-style-type: none"> 1. Election Statement (DOM 1165-A). 2. Enrollment Form (DOM 1165-B). 3. Physician Certification/Recertification (DOM 1165-C) <p>OR</p> <ul style="list-style-type: none"> • Use bar coded coversheet to fax a copy of the completed forms.
Continued Stay/Recertification request (Medicare/ Medicaid Beneficiary, dual eligible)	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"> • Web the required information to HSM. • Upload the following via .tif, .jpeg or .pdf file: <ol style="list-style-type: none"> 1. Physician Certification/Recertification (DOM 1165-C) <p>OR</p> <ul style="list-style-type: none"> • Use bar coded coversheet to fax a copy of the completed forms.

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). REMEMBER: If the hospice service provider submits after the last certified day of enrollment period listed on the TAN, a new start date will be required. This will create a gap in the certification period, and forfeiture of days. The earliest new start date will be the date in which all information is submitted to HSM for review of the new period.

The following table lists the maximum review segments for each review type.

Type of Review	Length of Certification
1 st Enrollment and Election Request	90-days.
2 nd Enrollment Request	90-days.
3 rd 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 re-certification 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.

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 re-certification 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.

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 418

B. 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. The following table describes our staff's functions.

Staff	Functions
First level reviewers	<ul style="list-style-type: none"> • Apply DOM policy. • Apply DOM approved medical necessity clinical guidelines. • May request additional information. • Refer requests that cannot be approved for physician determination.
Second level reviewers	<ul style="list-style-type: none"> • Make certification, denial or reconsideration determinations. That decision is: <ul style="list-style-type: none"> - 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. • May request additional information. • Only physicians may clinically deny a request. <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>Note: See the <i>Reconsideration Process</i> section of this manual for information on the reconsideration process.</p>

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.		

C. 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 via Web or fax and verbally. Beneficiary/legal representative denial notifications will be sent via mail.

The hospice provider/beneficiary/legal representative/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.

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

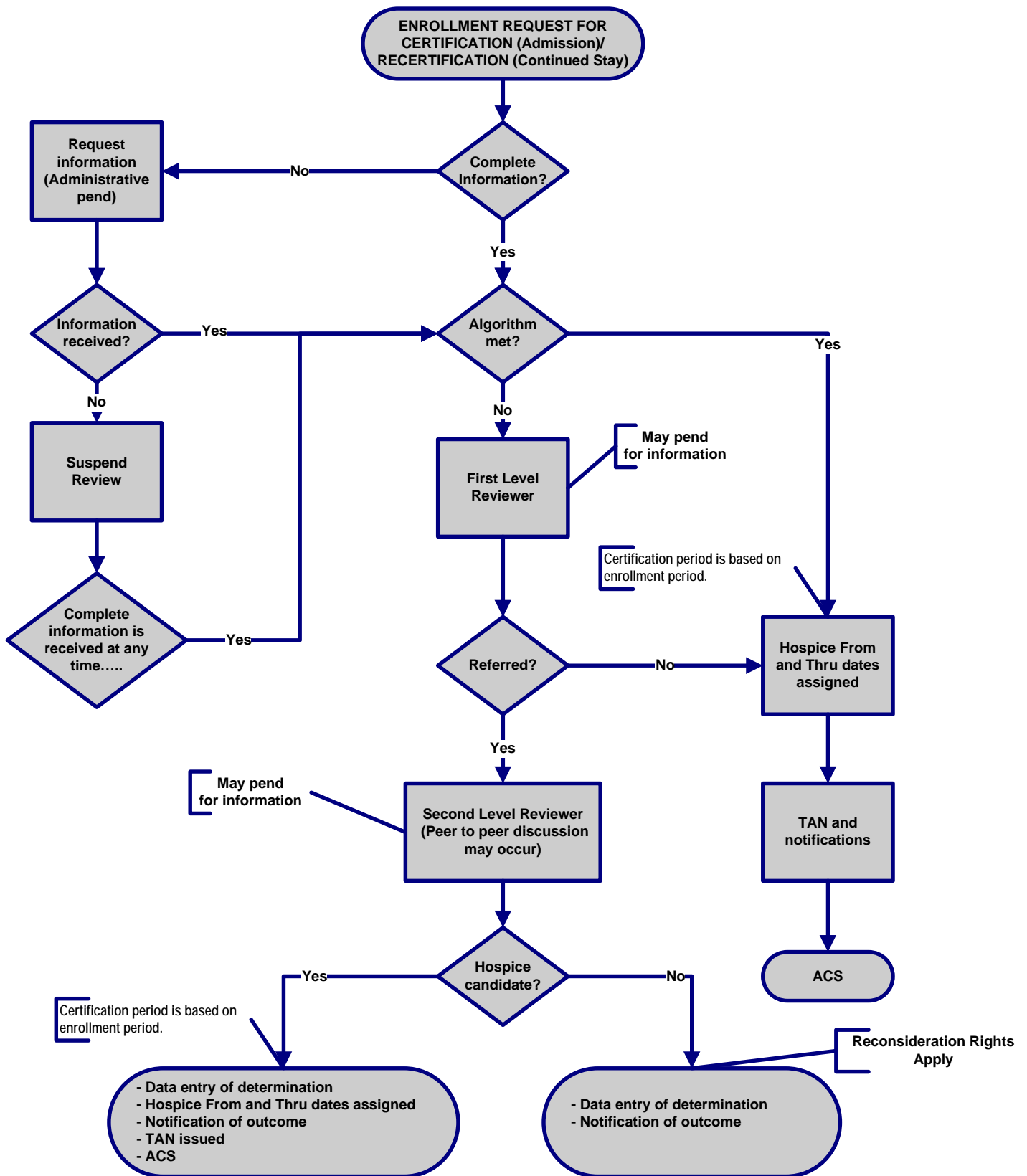
Review determination and notification timeframes are displayed in the following table.

Review Type	Review Determination	Electronic Notification
<ul style="list-style-type: none"> Admission/ Precertification Continued Stay/Subsequent Enrollment Period 	Within three business days of receipt of review request and necessary information.	Within one business day of review determination.

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.	✓	✓

D. Review Process Flow Chart



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.

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

A standard reconsideration may be requested 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.