Acentra HEALTH

Hospice

Provider Education 2023-2024

Hospice Overview

“Hospice is a comprehensive, holistic program of care and support for terminally ill patients and their families. Hospice care changes the focus to comfort care (palliate care) for pain relief and symptom management instead of care to cure the patient’s illness. “ – CMS

Hospice

To be eligible for hospice services under Medicaid, the member must be certified by a physician as being terminally ill. An individual is considered terminally ill when the prognosis is life expectancy is six months or less if the disease runs its normal course.

Home Hospice coverage for South Carolina Medicaid members is available for an unspecified number of days, subdivided into election periods as follows:

- Two periods of 90-days each
- An unlimited number of subsequent periods of 60-days each

The benefit periods can be used consecutively or at different times during the member's life span.

At the beginning of each benefit period, a physician must certify (or re-certify) the member as terminally ill with a life expectancy of six months or less.

Hospice

ELECTION:

- Individuals elect to receive hospice care and must file Medicaid Hospice Election Form, SCDHHS Form 149 with selected Hospice.
- An election will continue through initial election period and subsequent periods unless the individual revokes or is discharged.

REVOCATION:

- An individual may revoke hospice services at any time. The member must file a Medicaid Hospice Revocation Form (DHHS Form 153) with the hospice agency along with a signed statement acknowledging revocation and the reason for the revocation.
- The Revocation Form must be submitted to SCDHHS within 5 working days of revocation.

Hospice

DISCHARGE:

A Hospice may discharge a member for the following reasons:

- The member dies
- The member is non-compliant
- The member is determined to have a prognosis greater than 6 months
- The member moves out of the hospice's geographically defined service area
- The safety of the patient or hospice staff is compromised

When discharging a member, the Medicaid provider must submit a Medicaid Hospice Discharge Form, DHHS Form 154 to SCDHHS within 5 working days of the discharge.

*Dual eligible members must elect and revoke hospice benefits simultaneously under both programs (Medicare and Medicaid).

Hospice Forms

Hospice forms can be found on the Acentra Health website https://scdhhs.acentra.com

- Medicaid Hospice Election form (DHHS Form 149)
- Medicaid Hospice Physician Certification/Recertification Form (DHHS Form 151)
- Medicaid Hospice Change Request Form (DHHS form 152)
- Medicaid Hospice Revocation Form (DHHS form 153)
- Medicaid Hospice Discharge Form (DHHS Form 154)

Hospice for Members under Age 21

- Supported by section 2302 of the Affordable Care Act, “Concurrent Care for Children,” members under age 21 may receive curative treatment while enrolled in hospice services

- This provision does not change the criteria for hospice and a physician must certify the minor as terminally ill.

Authorization Types

❑ Prior Authorization

Should be submitted on or before the service begins but must be approved within the 15 days of the first day of service.

❑ Retrospective Authorization “Retro”

Needed when services were performed before the member was eligible for Medicaid and the member has since been granted retrospective eligibility covering the date of service.

- A Retro case is NOT one that is submitted late for any reason other than eligibility.
- Untimely requests will be administratively denied.
- Providers must identify a request as RETRO on the fax request form or by request type in Atrezzo.

Submitting a Request for Authorization

Fax

- Providers may use the Prior Authorization Request form.
  - fax to 1-855-300-0082
- Prior Authorization request forms can be found at https://scdhhs.acentra.com/forms
  - Be sure to use the correct form for service type
- Must submit with required clinical information or case will be pended as insufficient.

Customer Service

- Call 1-855-326-5219.
- **Least preferred method.**
- Calling to “start a case” only delays your request. Case will be pended for insufficient information and/or required clinical information before a proper review can begin.
- Once clinical information is received, the case will be reviewed for medical necessity.

Requesting Prior Authorization

When requesting Prior Authorization for Hospice, providers must submit the following:

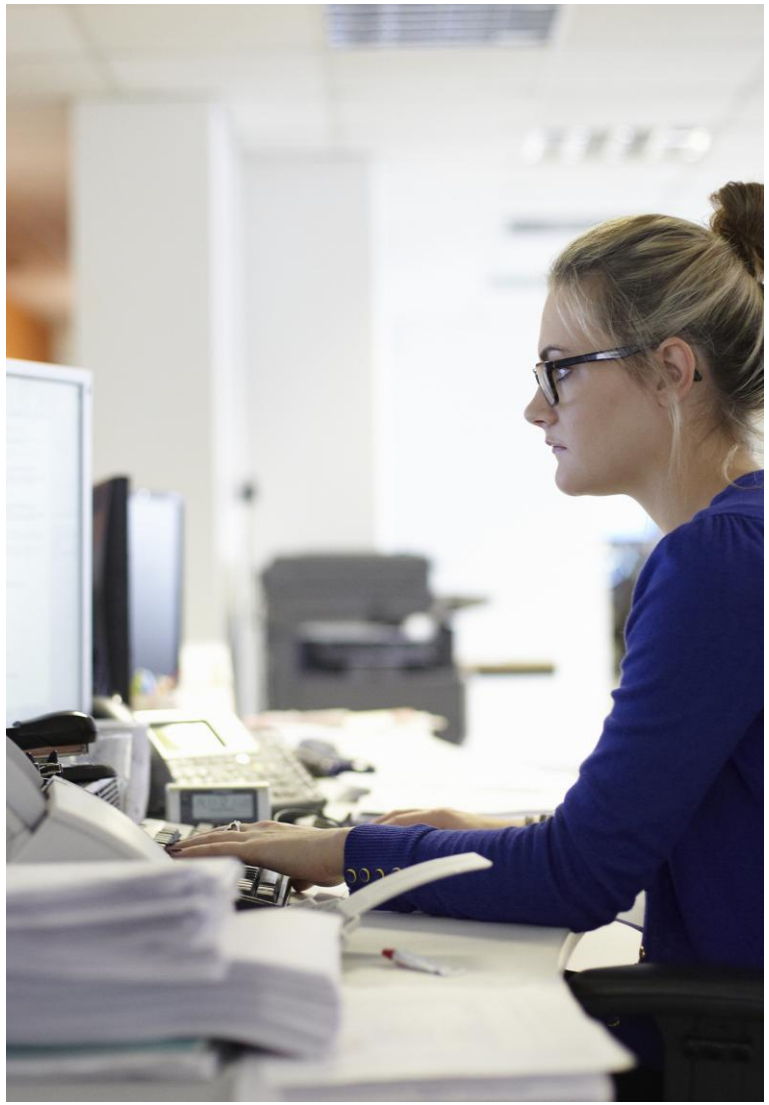
- Acentra Health Prior Authorization Hospice Request form (unless using the web portal)
- Hospice Election Form (DHHS Form 149)
- Hospice Physician Certification/Recertification Form (SCDHHS Form 151)
- Hospice Plan of Care (POC)
- Clinical Information and other documentation that supports the medical prognosis and shows degree of impairment

*Members with **primary other health** insurance do not need prior authorization unless the primary insurance does not cover hospice benefits.

*For **dual eligible** members (members with Medicare), prior authorization is not required; however, the SCDHHS Hospice forms must be submitted to SCDHHS. This includes:

*Medicaid Hospice Election Form (DHHS Form 149)
*Medicaid Hospice Physician Certification/Recertification form (SCDHHS Form 151)
*Medicaid Hospice Discharge Form (SCDHHS Form 154)

Prior Authorization tips



- Services are approved for up to 6 months for each request, except General Inpatient.
- Subsequent requests require an updated SCDHHS Form 151 and updated Plan of Care and should be received within 15 days of the current prior authorization expiration, no later than 2 days after the expiration date.
- T2046 does not require a PA.

General Inpatient Hospice (GIP)

- Upon admission into GIP, Prior Authorization requests must be submitted within 5 business days
- Documentation required for direct admission into GIP upon election of hospice benefits includes the Hospice Election Form (SCDHHS Form 149), Hospice Physician Certification/Recertification Form (SCDHHS Form 151), physician order, initial care plan and supporting documentation.
- GIP may be authorized up to 30 days. Clinical documentation will need to be submitted to support a request for more than 30 days.

Processing Timelines

Acentra Health completes requests for services expeditiously and within contractual timeframes. The review completion timeframe is measured from the date Acentra Health receives a request.

- New Request/Admission review – 5 business days
- Retrospective Reviews – 5 business days

Review Process

Administrative Requirements

- Member eligibility verified
- Provider eligibility verified
- Medicaid Guidelines applied

Nurse Review

- InterQual® or State defined criteria applied
- May pend for additional clinical information
- Approve if criteria met
- Refer to physician reviewer if documentation does not support medical necessity.

Physician Review

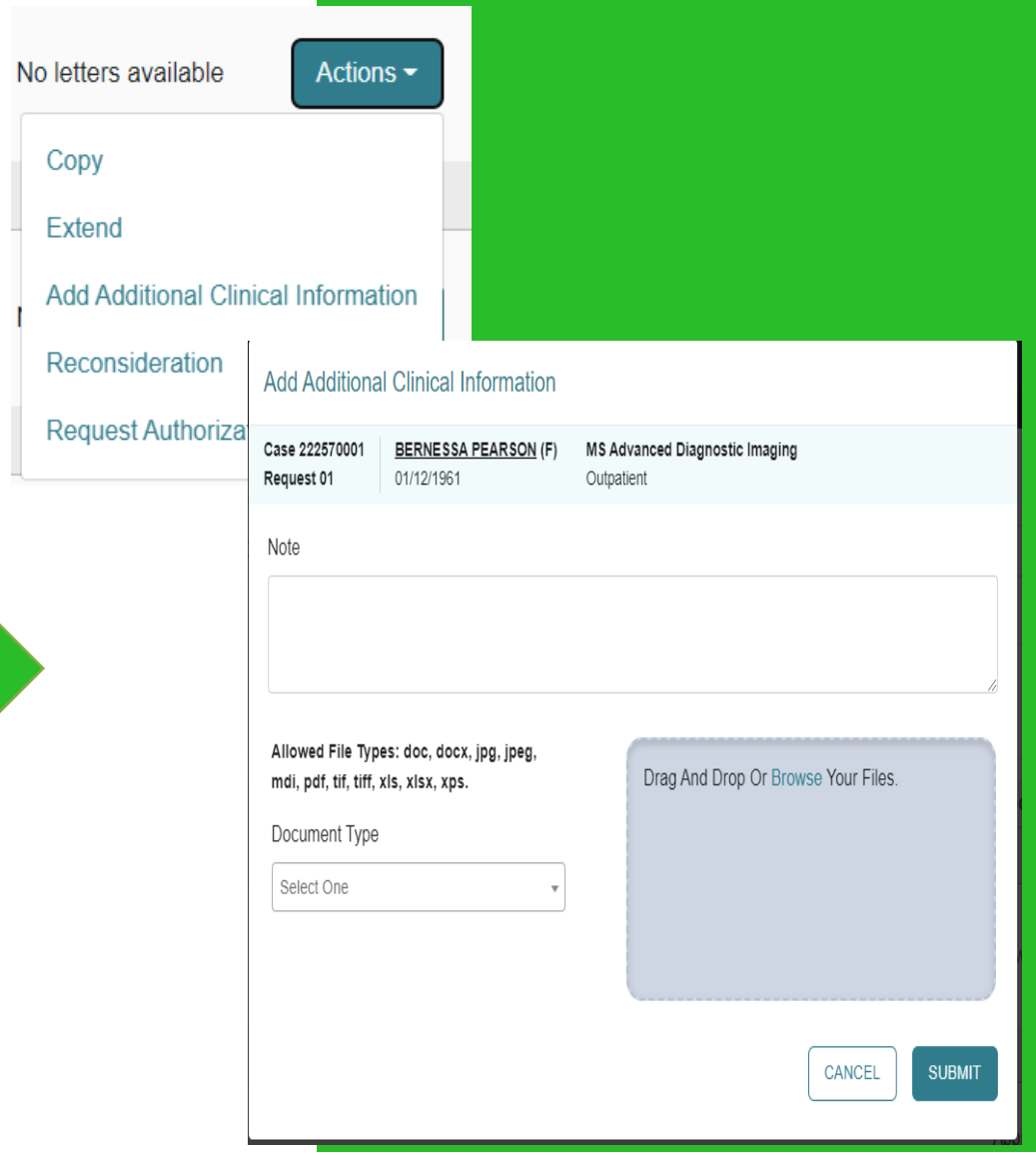
- The medical director, or another qualified physician reviewer will review the case against InterQual® or State defined criteria and national standards to provide a decision
- The physician or qualified practitioner may approve or deny the review

Pended Reviews

- A review may be pended for one of the following reasons:
  - Missing required information such as plan of care or provider number
  - Additional information or clarification is needed before a decision can be made
- Notifications are sent via fax or web portal
- A provider has 2 business days to respond to the additional information request
  - If the case contains no clinical information, the case will be administratively denied.
  - If the case has insufficient clinical information and there is no response to the pended, the case will move to the physician reviewer for a determination.
- If a review is administratively denied, the provider may submit a new request once they have all the necessary information.

Responding to Pended Reviews

- If you submitted the request online thru the Portal:
  - Log into the Portal and open the pended case
  - ACTION TAB – additional Clinical Information
  - Upload the requested documents or type the information in the note section.



Denials and Reconsiderations

Administrative Denial

- When any portion of the review is denied because it does not comply with Medicaid regulations
- Example: untimely, insufficient information
- Provider may submit a new case for the service if an administrative denial is received. This does not apply to those cases that were denied for untimely submission.

Clinical Denial

- Occurs when any portion of the requested service is denied by a physician reviewer due to medical necessity
- Does not meet state Medicaid criteria with information submitted or does not meet other national evidence-based criteria

Reconsideration

- May only be requested for clinically denied cases
- Not used for Administrative Denials

Reconsiderations

- May be submitted within 30 days of the **clinical** denial date
  - This is your opportunity to provide more detailed clinicals
- May be submitted via
  - Web portal *preferred
  - Fax
  - phone *least preferred (will still require additional information to be faxed)
- A clinical reviewer will review any additional information submitted. If unable to meet InterQual® or State approved criteria, it will be referred to the physician reviewer.
- A physician reviewer – a different physician from the one who originally reviewed the case - will look at the case and any new information submitted to support the reconsideration
- The physician reviewer may
  - Uphold original decision (no change made)
  - Overturn the original decision (approve the case)
- If original decision is upheld, provider may appeal the decision to SCDHHS.

Appeals

- If a reconsideration is upheld, an appeal may be requested. Specific instructions will be included in the reconsideration determination letter.
- SCDHHS will review the provider's request and conduct a Fair hearing.
- Members may request an appeal within 30 calendar days from the reconsideration determination notice:
  - online at www.scdhhs.gov/appeals,
  - Fax 803 255 8206
  - Email appeals@scdhhs.gov
  - Mail Office of Appeals and Hearings

    PO BOX 8206

    Columbia, SC 29202

Resources and Education

- SCDHHS Hospice Services Provider Manual
- Provider Training Resources | SCDHHS
- SC Acentra Health website
- Acentra Health Customer Service
  - 1-855-326-5219
  - scproviderissues@kepro.com generic questions please, do not include PHI