ACTION: REFILED	DATE: 08/14/2002 12:21 PM

5101:3-56-05 **Requirements for coverage ~~for~~of medicaid hospice services.**

For hospice services to be reimbursed by ~~ODHS~~ODJFS, the services must be reasonable and necessary for the palliation or management of the individual's terminal illness as well as related conditions and all of the following criteria must be met:

(A) The hospice ~~agency~~ must have:

(1) ~~Establish~~Established a written plan of care for the individual before services ~~are~~were provided ~~and services must be consistent with the plan of care~~and must have provided services in accordance with the individual's plan of care. The plan of care must be ~~established~~:

(a) ~~In~~Established and maintained in accordance with 42 CFR 418.58, October 1, 2001; ~~and~~that is

(b) By ~~a member of~~ the attending physician, the medical director or physician designee and the ~~basic~~ interdisciplinary group, as enumerated in 42 CFR 418.68, October 1, 2001~~. The member who assesses the client's needs must meet or call at least one other group member (nurse, physician, medical social worker or counselor) before writing the initial plan of care. At least one of the persons involved in developing the initial plan must be a nurse or physician~~, which shall include a physician, a registered nurse, a social worker, and a spiritual or other counselor; and

(c) ~~On the same day as the assessment if the day of assessment is to be a covered day of hospice care under the medicaid hospice program~~Reviewed and updated, at intervals specified in the plan, by the attending physician, the medical director or physician designee and interdisciplinary group. These reviews must be documented; and

(d) ~~For the review of the other members of the basic interdisciplinary group. The other two members of the basic interdisciplinary group must review and provide input to the process of establishing the plan of care within two calendar days following the day of assessment~~The plan must include an assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the individual's and family's needs; and

(e) The hospice must designate a registered nurse to coordinate the implementation of the plan of care for each individual.

(2) Provide the following services in accordance with 42 CFR 418 subpart (F), October 1, 2001.

(a) Nursing care.

(b) Medical social services.

(c) Physicians' services.

(d) Counseling services, provided to the ~~client~~individual and the family members or other persons caring for the ~~client~~individual at home, including but not limited to:

(i) Dietary

(ii) Bereavement~~.~~

(iii) Spiritual

(e) Short-term inpatient care.

(f) Medical appliances and supplies, including drugs and biologicals.

(g) Home health aide and homemaker services.

(h) Therapies, including:

(i) Physical

(ii) Occupational

(iii) Speech-language pathology.

(i) All other medical treatment and diagnostic procedures provided in relation to the terminal condition, when medically indicated.

Nursing care, ~~physicians' services~~, medical social services and

counseling are core hospice services and must routinely be provided directly by hospice employees. These core hospice services must be available as needed on a twenty-four-hour basis. Supplemental services may be contracted for during periods of peak patient loads and to obtain physician services and physician specialty services.

(3) Provide or arrange for transportation services if they are needed in order for the ~~client~~individual to receive medical care for the terminal condition. If the hospice determines that the ~~client's~~individual's need for transportation is for other than receiving care related to the terminal illness, the hospice ~~agency~~ may make arrangements for the appropriate level or type of transportation and the service may be covered under medicaid in accordance with Chapter 5101:3-24 of the Administrative Code.

(4) Not discontinue or diminish the hospice care it provides to ~~a client~~an individual because of the inability of the ~~client~~individual to pay or receive medicaid reimbursement for such care pursuant to section 1861 (dd)(2)(D) of the Social Security Act, January 1, 2001.

(B) The ~~client~~individual ~~of hospice services~~ must elect the medicaid hospice benefit in accordance with rule 5101:3-56-03 of the Administrative Code.

(C) All services must be performed by appropriately qualified personnel in accordance with current licensure rules, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the level of reimbursement of the service.

(D) When ~~a client~~an individual ~~has no family member or caregiver, who voluntarily provides gratuitous assistance to the client, and must reside~~resides in a NF, or when general inpatient or inpatient respite care is provided, the hospice ~~agency~~ and the facility must have a written, signed agreement which remains on file at the hospice. This agreement must contain, at a minimum, the following:

(1) A stipulation that the hospice agency maintain responsibility for the professional management of the ~~client's~~individual's hospice care; and

(2) In the case of ~~a client~~an individual residing in a NF, a stipulation that the NF provide room and board to the ~~client~~individual in accordance with rule 5101:3-56-06 of the Administrative Code; and

(3) The delineation of the manner in which contracted services are coordinated and supervised by the hospice ~~agency~~; and

(4) The delineation of the role(s) of the hospice ~~agency~~ and the facility in the admissions process, patient/family assessments, and the interdisciplinary team care conferences.

(5) A stipulation that the facility must have a valid medicaid provider agreement in accordance with rule 5101:3-1-172 of the Administrative Code and accept the payment from the hospice ~~agency~~ as payment in full.

The terms of the agreement must not violate the medicaid provider agreement as set forth in rule 5101:3-1-172 of the Administrative Code and must not violate the ~~client's~~individual's freedom of choice of NF providers.

Effective:

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Certification

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