Policy Name:	Inpatient and Home Hospice and Respite	Page:	**1** of **6**
Department:	Medical Management	Policy Number:	UM 05
Subsection:	Utilization Management	Original Effective Date:	06/01/2023
Applies to:	Medicaid Health Plans		

PURPOSE:
The purpose of this policy is to define Maryland Care, Inc., dba Maryland Physicians Care's (MPC's) business guidelines for the utilization management of inpatient (IP), home ospice, and respite care for members.

OBJECTIVE:
The objectives of this policy are to:

- Establish guidelines to provide authorization for IP, home hospice and respite requests.
- Identify a mechanism to confirm that hospice coverage is provided locally, and/or in conjunction with a hospice provider.

POLICY:
Hospice care can be approved for up to six months in any setting (home or IP). A Certificate of Terminal Illness (CTI) is required and must be signed by the attending physician on, or within 2 calendar days (CDs) to the start of hospice services.

The member may move periodically from home hospice to IP hospice care. Each IP admission for hospice care requires a new authorization, however a home hospice segment is approved for 180 days and does not require a new authorization when the member is discharged home.

Respite care provides short-term relief for primary caregivers and is provided only if the guidelines outlined in this policy are met.

MPC Responsibilities Regarding IP, Home Hospice, and Respite Care

- Review of all clinical information for medical necessity for IP hospice and respite services (completed by the Concurrent Review Team).
- Review of all clinical information for medical necessity home hospice services (completed by the Discharge Planning or Prior Authorization Team).
- Referral of all potential denials of IP, home hospice, and respite services to the Medical Director for review.
- Documentation of all decisions within the business operating system and notification of the hospice or respite provider timely.

IP, Home Hospice, and Respite Care Provider Responsibilities

- Meet all medical necessity criteria for IP, home hospice, and respite care.
- Communicate any relevant changes to the member's condition or place of service within one business day.
- Communicate any relevant changes to practitioner's, providers, and/or business partners' demographic information including but not limited to new phone numbers, address, or call options.

Timeliness of Decisions and Notifications

Please refer to the following policies for the timeliness of decisions and notification standards: 7100.05 Prior Authorization Policy; 7200.05 Concurrent Review Policy; and 7600.07 Pharmacy Prior Authorization Policy.

Authorization of IP Hospice Process

- Authorization for IP hospice is built using the INPATIENT Authorization Template in Identifi.
  - Line 1 should reflect the admit day with a 7-day length of stay (LOS) at HOSPICE LOC.
  - If the provider submits the request with a CPT/HCPCS code, the authorization may reflect 30 days for that code as well – hospice providers only bill revenue codes so the IP bed day line will pay claims.
- Authorization is assigned to the Care Coordinator Team Lead:
  - If the CTI is not included, fax and call the hospice provider to request CTI be sent as soon as possible.
  - Authorization is pended for CTI which gives a 14-calendar day turnaround time.
- Once CTI is received and noted to be signed on/or prior to start of service, 7 days are approved per the MPC Utilization Management Directive.
- The Care Coordinator Team Lead follows up with the hospice provider weekly until a member is discharged to home hospice or expires.
- If a member expires, the Care Coordinator Team Lead sends notice to the EVH Enrollment team with the Date of Expiration.
- If a member stays more than 180 days, day 181+ requires a medical necessity review with the Concurrent Review manager(s) and the Medical Director.

Home Hospice Care Guidelines

- Prior Authorization for home hospice is required.
    - Initial request to be reviewed for 180 days with a participating hospice provider
        - Required CTI signed within 2 CDs of Hospice Evaluation for Care.
        - Signed acceptance of understanding the nature of hospice care by the member or proxy.
    - Additional request to be reviewed for 180 days with a participating hospice provider
        - Required updated CTI signed within 2 CDs of recertification for continued home hospice.
        - Requests that exceed 12 months from start of home hospice are to be sent to the Medical Director for final review.

Respite Care Guidelines

- Prior authorization for respite care is required in addition to the original hospice authorization.
- The member must be enrolled for hospice for at least one month prior to approving respite care.
- No respite care is to be approved between days 1-30 of hospice.
- Respite care can be approved for up to 5 days between days 31-90 of hospice.
- Respite care can be approved for up to 5 days between days 91-180 of hospice.

OPERATING PROTOCOL:

Systems

- Business operating system
- Codes/Devices/Services:

Code	Description
Q5005	Hospice care provided in inpatient hospital
Q5006	Hospice care provided in inpatient hospice facility
Q5001	Hospice or home health care provided in patient's home/residence
T2045	Hospice General inpatient care; per diem
T2044	Hospice inpatient respite care; per diem
T2046	Hospice long term care, room and board only, per diem
T2042	Hospice Routine Home Care; Per Diem
T2042	Hospice continuous home care; per hour

Measures

- Utilization tracking and trending

Reporting

- *NA*

INTER-/INTRADEPENDENCIES:

Internal

- Medical Management
- Enrollment

External

- Members
- Hospice Providers
- State Regulatory agency

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Legal/Contract References:
NA

ATTACHMENTS:
None

DEFINITIONS:
Hospice Care: Hospice is provided for a person with a terminal illness whose doctor believes he or she has six months or less to live if the illness runs its natural course.

Respite Care: Care that provides short-term relief for primary caregivers.

Certificate of Terminal Illness (CTI): Legal medical document that certifies a person's terminal diagnosis and life expectancy of six months or less.

Normal Business Hours: The period of the organization's stated hours of operation.

Affiliate: Medicaid business conducted by the direct and indirect subsidiaries of the management company.

Board of Directors (BOD): MPC governing body that has ultimate accountability for the health plan processes, activities, and systems. This includes responsibility for implementing systems and processes for monitoring and evaluating the care and services members receive through the health delivery network.

Code of Federal Regulations (CFR): This codification of rules and regulations published in the Federal Register by the Federal Government of the United States.

COMAR: Code of Maryland Regulations

Contractor and Agent: Any entity or person, including a subcontractor, that, on behalf of MPC or its affiliates, furnishes administrative and/or operational services.

Member: Person enrolled by the Maryland Department of Health to MPC, a Medicaid managed care organization.

Personnel: Employees of MPC management company, its affiliates, consultants, temporary or seasonal employees, student interns, volunteers, and any other class or type of full or part time employee who participate in MPC administrative operations.

REVISION LOG:

REVISION	***DATE***
Policy Created	04/12/2023
Effective Date	06/01/2023
Addition of Home Hospice Guidelines	11/10/2023

POLICY AND PROCEDURE APPROVAL:

The electronic approval retained in P&P management software is considered equivalent to a signature.