A Performance Audit of the Utah Medicaid Hospice Services Payment Policies and Procedures

Report Number 2014-16

October 8, 2014

STATE OF UTAH

LEE WYCKOFF

Inspector General

Utah Office of Inspector General

October 8, 2014

To: Utah Department of Health

Please see the attached report, **A Performance Audit of the Utah Medicaid Hospice Services Payment Policies and Procedures,** (Report 2014-16). An Executive Summary is included at the inception of this report. The objectives and scope of the audit are explained on page 2 of this report.

Sincerely,

Lee Wyckoff, CPA, CISA, CFE
Inspector General
Utah Office of Inspector General

cc: David Patton, Michael Hales, Shari Watkins, Gail Rapp, Tonya Hales, Shandi Wanlass, Travis Lansing, Darin Dennis

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EXECUTIVE SUMMARY

Hospice care benefits terminally ill, eligible recipients by certified and licensed hospice providers.

Hospice providers must be Medicare certified and approved as a Medicaid provider. Medicare certification must happen before Medicaid approval can happen. Medicaid approval is required for payment from Medicaid.

Hospice care benefits "terminally ill" clients with "Palliative" care versus "Curative" care. The care categories covered by Medicaid are, routine home care, continuous home care, inpatient respite care, general inpatient care, and room and board. Medicaid reimburses the hospice agency for only one of these five categories each day, with the exception of room and board. Reimbursement of room and board is permissible with one other code if the client is a resident of a long-term care facility.

Hospice services require prior authorization from Medicaid for reimbursement. To obtain prior authorization, the request requires the enrollment documentation signed by the client or their personal representative, as well as the medical certification of the terminal illness signed by a physician based on a face-to-face evaluation of the client.

Audit Objectives:

- Determine if Medicaid paid hospice correctly, and if Medicaid appropriately excluded payment of other claims on behalf of hospice recipients.
- Determine if medical records support the time-line for each recipient. Determine if the time-line agrees with operational dates, including prior authorization dates, enrollment dates, respite and general inpatient (GIP) dates, certification dates, annual independent assessment dates, and death dates.
- Determine if Medicaid followed rules and regulations for hospice providers.
- Determine if hospice agencies ownership declarations appropriately list practicing professional members. Determine if practicing professional members self-referred clients in violation of federal regulations.
- Determine if Medicaid correctly enrolled and maintained hospice recipients.
- Determine if care given is palliative or curative.

Audit Findings:

- Medicaid did not perform an annual assessment of hospice recipients.
- Medicaid did not have complete records on file to support hospice prior authorizations.
- Medicaid's evaluation of prior authorization requests inappropriately omitted a medical review.
- Medicaid did not have ownership declarations in provider enrollment records.

State Agency Comments:
In written comments on the draft report, the State agency agreed with all recommendations.

INTRODUCTION

BACKGROUND

The hospice care program provides support and care for persons with limited life expectancy that allows them to live as fully and comfortably as possible. Hospice care comes from recognition that a recipient's terminal condition warrants a change in focus from curative care to palliative care. Hospice care does not hasten or postpone death. Hospice agencies believe that, through appropriate care, the recipient and their families can attain a satisfying degree of mental and spiritual preparation for death. Hospice care is provided by an agency that offers palliative services providing physical, psychosocial, spiritual, and bereavement care for dying persons and their families.

Section 95905 of Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), permits states to provide hospice care under their Medicaid State Plan. COBRA requires the State to provide hospice services in the same amount, duration, and scope as Medicare services and at the same payment rate.

The Utah Medicaid program added hospice care as a covered service effective March 1, 1989. Hospice care is available to categorically and medically needy individuals under Medicaid.

Hospice services must meet the requirements relating to certification of terminal illness and the recipient's election of hospice care. The certification requires that the hospice provider obtain written certification by a licensed physician that a recipient is terminally ill. To enroll in hospice care, a recipient files an election statement with a hospice agency. The recipient also acknowledges a full understanding of the palliative care nature of hospice care, acknowledges that the recipient waives certain Medicaid services and acknowledges that they may revoke the election at any time in the future.

All hospice care requires prior authorization. Documentation submitted with the prior authorization request must support the reasons for the request.

Hospice providers are required to give notice to Medicaid with any change in status of a hospice recipient. Changes in hospice services, retroactive eligibility, revocation of hospice, enrollment with a different hospice agency, and discharge from hospice all require notice in the form of prior authorization with the proper documentation.

If a recipient is eligible for both Medicare and Medicaid, the recipient must elect hospice care for both. The recipient then must receive hospice coverage under the Medicare benefit. If Medicare determines that a recipient is no longer eligible for Medicare reimbursement for hospice services, the recipient will no longer be eligible for Medicaid reimbursement for hospice services.

OBJECTIVES AND SCOPE

Audit Objectives:

- Determine if Medicaid paid hospice correctly, and if Medicaid appropriately excluded payment of other claims on behalf of hospice recipients.
- Determine if medical records support the time-line for each recipient. Determine if the time-line agrees with operational dates, including prior authorization dates, enrollment dates,

respite and general inpatient (GIP) dates, certification dates, annual independent assessment dates, and death dates.

- Determine if Medicaid followed rules and regulations for hospice providers.
- Determine if hospice agencies ownership declarations appropriately list practicing professional members. Determine if practicing professional members self-referred clients in violation of federal regulations.
- Determine if Medicaid correctly enrolled and maintained hospice recipients.
- Determine if care given is palliative or curative.

Audit Scope:

The scope of this audit covers all reimbursements by Medicaid for the five CPT4 codes defined in the administrative rule and Medicaid manual for fiscal year 2013. (July 2012 to June 2013).

METHODOLOGY

The Utah Office of Inspector General (Utah OIG) reviewed three documents to learn the regulations and policies concerning hospice care: the Utah State Plan Attachment 4.19-B pages 28 and 28a, Rule R414-14A (Rule), and the provider manual, Hospice Care[1] (Manual). Utah OIG developed two lists of questions, one for Medicaid and one for Medicare.

The Utah OIG requested a list of all paid claims referencing the five CPT4 hospice care codes from the Utah OIG data team. This request yielded a file with 14,103 unique claim lines for 1,277 recipients and 82 providers. Table 1 displays the breakdown of payments.

Table 1: Breakdown of Hospice reimbursement by CPT4 codes

CPT4 Code	Code Description	Reimbursed Amount	Percentage
T2042	Routine Home Care	$ 3,116,061.10	15.85500%
T2043	Continuous Home Care	$ 35.84	0.00018%
T2044	Inpatient Respite Care	$ 6,389.35	0.03331%
T2045	General Inpatient Care	$ 116,439.47	0.59181%
T2046	Room and Board	$ 16,415,241.06	83.51970%
	Total	$ 19,654,166.82	100.00000%

The Utah OIG created a statistically valid sample to use for requests for information from Medicare, Medicaid, and select providers for ownership information and medical records. This sample yielded 31 recipients from 19 providers for record requests from prior authorization and provider medical records, and 124 recipients and 25 providers for record requests from provider enrollment and licensing and certification.

The Utah OIG developed a timeline for each recipient from the sample file. This timeline detailed the diagnosis, date of death, service dates, covered CPT4 codes, general inpatient and respite days billed, and claim status fields, all from the MMIS System.

The Utah OIG compared the ownership detail from Medicare and ownership detail from the Medicaid provider enrollment certifications in an ownership comparison worksheet. The Utah OIG created a

[1] Utah Medicaid Provider Manual Section 2 Hospice Care Provider Manual, updated January 2012.

medical records review worksheet from the medical records received from select providers. This worksheet details observations from the record review. The Utah OIG created a prior authorization review worksheet from the documentation received from Medicaid. This detailed the observations made from the prior authorization record review.

FINDING 1 Medicaid Did Not Perform an Annual Assessment of Hospice Recipients

Rule R414-14A-13, Extended Hospice Care, reads, "Clients who accumulate 12 or more months of hospice benefits are subject to an independent utilization review by a physician with expertise in end-of-life and hospice care selected by the Department."

Medicaid could not show evidence to substantiate that an annual assessment existed on those recipients that accumulated twelve months of service.

The Subject Matter Expert (SME) designated by Medicaid's Bureau of Authorization and Community Based Service (BACBS), explained that the interpretation of the term "Subject To" included in the rule citation above, was an optional process rather than a required process. The SME also explained that there was not a means in place to solicit or pay for an independent utilization review.

This process is an important control point in hospice care. The purpose is to ensure that the diagnosis and certification process used by the physicians in hospice agencies follow the rules and regulations and protect hospice care reimbursement by Medicaid.

Recommendation

1.1 Medicaid should perform independent medical utilization reviews of hospice care recipients that have accumulated benefits in excess of 12 months.

FINDING 2 — Medicaid Did Not Have Complete Records on File to Support Hospice Prior Authorizations

In the Utah State Plan,[2] hospice program is one of several programs that require prior authorization. The Hospice Provider Manual[3] states, "...All Medicaid hospice services (including room and board in a nursing facility for Medicare hospice clients) must be prior authorized in accordance with R414-14A." In section 1.3 I, the Hospice Care provider manual defines six situations that require a prior authorization request form: (1) with the signed election statement, (2) a change to a different hospice service, (3) if the client becomes retroactively eligible for Medicaid and hospice care, (4) a copy with a revocation statement, (5) when a client changes hospice providers, and (6) upon discharge.

The Utah OIG requested documentation from Medicaid for 41 unique prior authorization numbers issued during the scope period for hospice services. In review of these prior authorization records, the Utah OIG observed several recurring results: the authorization period-of-time did not meet the certification periods; eligibility for Medicaid and Medicare notation was not checked on all requests; and, there was no evidence of a tracking method to know who evaluated the request and authorized the service.

The analysis of 41 sample prior authorization numbers shows 15 instances of questionable eligibility, 6 instances of a second authorization granted using the same initial documentation as the first, 5 instances with incorrect effective dates, 7 instances lacking complete documentation, and 6 instances where the recipient was discharged, changed hospice coverage or revoked service with no additional documentation. Of 41 sampled authorization numbers 30 failed in having adequate documentation.

When reviewing the same 41 sample prior authorization numbers for information on which employee in BACBS issued the authorization number, there was no accountability evident in the records.

Several providers documented that Medicaid had contacted them and requested the missing documentation necessary after the Utah OIG made the request for documentation. Medicaid did not have the required documents for all of the numbers in the sample.

Recommendations

2.1 Medicaid should develop a mechanism to ensure that all of the steps required in the request and granting of prior authorizations are satisfied with accountability built in for those authorizing the services.

2.2 Medicaid should ensure that the required documentation is complete before archiving.

2.3 Medicaid should review the policy of issuing prior authorizations that cover a six-month period in relationship to the frequency of 2 90-day periods and an unlimited number of 60-day periods where certification of terminal illness is required for each period. Certification periods could cover either two or three periods within the six-months currently authorized.

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[2] Utah State Plan Section 4 – GENERAL PROGRAM ADMINISTRATION, citation 4.13 paragraph € - (1).
[3] Utah Medicaid Provider Manual Section 2 Hospice Care Provider Manual, updated January 2012.

FINDING 3 Medicaid's Evaluation of Prior Authorization Requests Inappropriately Omitted Medical Review

By definition, hospice care is care provided to terminally ill clients by hospice providers. Further by definition, terminally ill means that the client has a medical prognosis to live no more than six months if the illness runs its normal course[4]. In the hospice care provider manual paragraph 1-2 (1) it says; "Hospice care is available to categorically and medically needy individuals under Medicaid." Therefore, all requests for prior authorization require review for medical validation that the diagnosis, in part or in whole, is sufficient to classify the illness as a terminal illness. That requires a certain level of medical knowledge and training.

The persons reviewing the request for prior authorization for hospice services lacked medical training or certifications until June of 2013, or the last month of the scope period for this audit. Although Medicaid can prior authorize any service requested and the person who authorizes the service is not required to have medical training or certifications, since hospice is a benefit for the medically needy, medical training and/or certification should be required.

The SME said Medicaid did not use a nurse to review hospice care requests for prior authorization until June of 2013.

Recommendations

3.1 Medicaid should review the medical training and certification of those who grant prior authorization for hospice service to ensure proper administration under the rule and manual cited.

3.2 Medicaid should review the universe of the prior authorization functions to ensure that reviews with a significant medical component have appropriate review procedures in place.

[4] Administrative Rule R414-14A-2 (4) and (8).

FINDING 4 — Medicaid Did Not Have Ownership Declarations in Provider Enrollment Records

The 42 CFR 455.104, updated Feb. 2, 2011, defines when providers must disclose ownership information. The disclosure is required at the following times: 1) upon submitting the provider application, 2) upon the provider executing the provider agreement, 3) upon request of the Medicaid agency during the re-validation of enrollment process, and 4) within 35 days after any change in ownership. Prior to this Feb. 2011 revision, 42 CFR 455.104 stated that providers must disclose financial information. In both periods, federal financial participation is withheld if this disclosure is not met.

The Utah OIG requested provider agreements, which included ownership declaration documentation for 25 providers, from Medicaid Provider Enrollment for review. The review of these documents showed that six provider records did not include ownership documents. Six providers included ownership documents that showed receiving dates in June or July of 2014, after the request for records date of May 2014; indicating that provider enrollment failed to have these records on file in May 2014. Thirteen providers had appropriate ownership documents on file when the Utah OIG made the request.

The six providers who did not have ownership documents on file showed enrollment dates in years of 2001 through 2007. Of the six providers, three had ceased operation, so no ownership documentation was available. The other three did not respond to requests within the time allotted. In discussion with the Bureau of Medicaid Operations (BMO) they agreed that prior to 2011 the requirement to disclose ownership documentation was not enforced. The Affordable Care Act (ACA) introduced stricter provider enrollment requirements. Medicaid has changed their enrollment processes to comply with ACA. The requirement that all providers must reenroll by March 2016 will eliminate this concern.

Medicaid securing ownership declarations on all required providers is a control point that is necessary to protect Medicaid funds from overpayment due to self-referral abuse.

Recommendation

4.1 Medicaid should obtain ownership documents for all Hospice Providers lacking ownership declaration documentation if applicable.

OBSERVATION — Providers Inappropriately Using Debility and Failure to Thrive as Primary Diagnosis for Enrollment

Medicaid's provider manual states that hospice care comes from the recognition that a client's terminal condition warrants a change in focus from curative to palliative care. The Center for Medicare & Medicaid Services (CMS) finalized the FY 2014 Hospice Wage Index and Payment Rate Update in August of 2013. CMS finalized the rule to give clarification on principal diagnosis of hospice claims:

> Therefore, in the proposed rule, we clarified that "debility" and "failure to thrive" should not be used as principal hospice diagnoses on the hospice claim form. When reported as a principal diagnosis, these would be considered questionable encounters for hospice care, and the claim would be returned to the provider for a more definitive principal diagnosis. "Debility" and "adult failure to thrive" could be reported on the hospice claim as other, additional or coexisting diagnoses.

The Utah OIG reviewed three record sources. Hospice providers used debility and adult failure to thrive as the principal diagnosis on 42% of claims (See table 2).

Table 2. Primary Diagnosis From Record Review.

Record Source	# Recipients	Diagnosis	Number	Percentage
Provider	31	Debility	9	29%
		Failure to Thrive	3	10%
Prior Authorization	29	Debility	11	38%
		Failure to Thrive	2	7%
MMIS Claim History	31	Debility	9	29%
		Failure to Thrive	4	13%

By definition, hospice recipients have a life expectancy of six months or less. The Utah OIG reviewed a sample of 31 recipients. The average length of stay (LOS) for recipients with a death date and a principal diagnosis of debility or adult failure to thrive was 294 days. The average LOS decreased to 270 days for all recipients, including those without death dates, using debility or adult failure to thrive as the principal diagnosis because many recipients improved to a point that they did not require hospice services.

Recommendations

5.1 Medicaid should evaluate the use of the two diagnoses, debility and failure to thrive, in requests for prior authorization. If there are no other diagnoses that could be defined as terminal illness, the prior authorization should not be granted, resulting in the claim not being paid.

5.2 Medicaid should train hospice care providers on the newly defined CMS rule.

OBSERVATION — Utah Bureau of Licensing and Certification Did Not Have Complete Documentation on File

Rule R414-14A-4 (1) says: "A hospice provider must be certified by Medicare and licensed as a Medicaid provider to provide hospice care". Therefore, Medicare certification must be accomplished before approval as a Medicaid hospice provider. A fiscal intermediary reviews the applications along with the CMS 855 form. The CMS 855 form shows the ownership information, as well as information on managers and key employees. CMS receives the results of the fiscal intermediary review along with the Utah State Licensing and Certification agency. Not all of these communications include the CMS 855 report. The Utah Bureau of Licensing and Certification (Licensing and Certification) agency receives a copy of the approval letter from the fiscal intermediary. They cannot certify a hospice provider without the approval letter from the fiscal intermediary.

The Utah OIG requested copies of documentation to support certification by Medicare from Licensing and Certification. Included in this request was the information on the CMS 855 form referring to ownership. The request covered 25 providers from the sample file extracted for testing. Of the 25 providers selected, Licensing and Certification did not have records for 4 of the 25 providers, and Licensing and Certification did not have the CMS 855 form for 2 of the 25 providers. In the sample of Medicare certified providers, Licensing and Certification did not have complete records for 24% of the providers.

The Licensing and Certification agency does not always receive the total document package for a provider from the fiscal intermediary. If they receive the approval letter only, the site verification process for that provider begins.

CMS sends an acceptance letter to the provider with a provider number. A copy of this acceptance letter is also sent to the Licensing and Certification agency. This copy of the acceptance letter does not have a copy of the CMS 855 report. The Licensing and Certification agency does not have authority to require the CMS 855 form, if that form does not accompany the approval letter. Licensing and Certification should continue to work with the fiscal intermediary and CMS to obtain the CMS 855 form. This form would be useful in identifying ownership and key employees and managers.

GLOSSARY OF TERMS

The first use of each term is described in the report. The glossary is included to help ensure easier reading.

Term	Description
CMS	Centers for Medicare & Medicaid Services
DOH	Utah Department of Health
MMIS	Medicaid Management Information System
BACBS	Utah Medicaid Bureau of Authorization and Community Based Services
LOS	Length of Stay
NAHC	National Association of Hospice Care
Utah OIG	Utah Office of Inspector General
SME	Subject Matter Expert

MANAGEMENT RESPONSE

State of Utah

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Governor

SPENCER J. COX
Lieutenant Governor

Utah Department of Health

W. David Patton, Ph.D.
Executive Director

Division of Medicaid and Health Financing

Michael Hales
Deputy Director, Utah Department of Health
Director, Division of Medicaid and Health Financing

October 7, 2014

Lee Wyckoff, CPA
Inspector General
Office of the Inspector General of Medicaid Services
P.O. Box 14103
Salt Lake City, Utah 84114

Dear Mr. Wyckoff:

Thank you for the opportunity to respond to the audit entitled "A Performance Audit of the Utah Medicaid Hospice Services Payment Policies and Procedures" (Report Number 2014-16). We appreciate the effort and professionalism of you and your staff in this review. Likewise, our staff has spent time collecting information for your review, answering questions, and planning changes to improve the program. We believe that the results of our combined efforts will make a better, more efficient program.

We concur with the recommendations in this report. Our response describes the actions the Department plans to take to implement the recommendations.

The Department of Health is committed to the efficient and effective use of taxpayer funds and values the insight this report provides on areas that need to be improved.

Sincerely,

Michael Hales
Deputy Director, Department of Health
Division Director, Medicaid and Health Financing

UTAH DEPARTMENT OF HEALTH

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Response to Recommendations

Recommendation 1.1

> *Medicaid should perform independent medical utilization review of hospice care recipients that have accumulated benefits in excess of 12 months.*

Department response:

We concur that a thorough medical utilization review of adult hospice care clients should be performed when the person has received hospice care for 12 consecutive months. Because federal regulations require that children are eligible to receive palliative and curative care simultaneously, Medicaid does not believe utilization review needs to be performed for children receiving hospice services.

The proposed review process will include:

- Developing a *hospice utilization review form*. Medicaid will require that the client's primary care physician (not by a physician associated with the hospice agency) complete the form. The form will include verbiage that hospice services are intended to provide palliative care for a terminal illness with a medical prognosis that life expectancy is six months or less. The form will notify the primary care physician that the client has received hospice care for greater than 12 consecutive months and will require the physician to describe and validate the diagnosis that qualifies the person to continue to receive hospice care.
- The form will be required to accompany all prior authorization requests for adults who have received services for greater than 12 consecutive months. Requests that do not include the form will be denied and will include a notice of agency action and appeal rights information.

To implement this recommendation, Medicaid will update the hospice provider manual, draft an article for the Medicaid Information Bulletin, inform hospice clients and Accountable Care Organizations of the new requirements and train internal prior authorization nurses, hospice providers and nursing facilities.

Contact: Tonya Hales, Director, Bureau of Authorization & Community Based Services, 801-538-9136
Anticipated Implementation Date: April 1, 2015

Recommendation 2.1

Medicaid should develop a mechanism to ensure that all of the steps required in the request and granting of prior authorizations are satisfied with accountability built in for those authorizing the services.

Department response:

We concur with this recommendation.

As of June 2013, a registered nurse within the Prior Authorization Unit is assigned to complete the prior authorization of hospice services. The steps required to issue prior authorizations are well-established within the Prior Authorization Unit. Accordingly, this recommendation has been implemented.

Contact: Tonya Hales, Director, Bureau of Authorization & Community Based Services, 801-538-9136
Implementation Date: June 2013

Recommendation 2.2

Medicaid should ensure that the required documentation is complete before archiving.

Department response:

We concur with this recommendation.

As of June 2013, a registered nurse within the Prior Authorization Unit is assigned to complete the prior authorization of hospice services. Archiving prior authorization request documentation is a well-established component of completing prior authorization requests. Accordingly, this recommendation has been implemented.

Contact: Tonya Hales, Director, Bureau of Authorization & Community Based Services, 801-538-9136
Implementation Date: June 2013

Recommendation 2.3

Medicaid should review the policy of issuing prior authorizations that cover a six-month period in relationship to the frequency of election periods where certification is required. Certification periods could cover either two or three periods within the six months currently authorized.

Department response:

We concur with this recommendation.

Training will be provided to the hospice prior authorization nurse and Medicaid will begin issuing prior authorization with date ranges that are in alignment with hospice election periods (initial 90-day, a subsequent 90-day, and an unlimited number of subsequent 60-day election periods). Physician certification of the patient's terminal illness with a life expectancy of six months or less will be required with each prior authorization submission.

To implement this recommendation, Medicaid will update the hospice provider manual, draft an article for the Medicaid Information Bulletin, inform hospice clients and Accountable Care Organizations of the new requirements, and train internal prior authorization staff, hospice providers, and nursing facilities.

Contact: Tonya Hales, Director, Bureau of Authorization & Community Based Services, 801-538-9136
Anticipated Implementation Date: April 1, 2015

Recommendation 3.1

Medicaid should review the medical training and certification of those who grant prior authorization for hospice service to ensure proper administration under the rule and manual cited.

Department response:

We concur with this recommendation.

As of June 2013, a registered nurse within the Prior Authorization Unit is assigned to complete the prior authorization of hospice services.

Contact: Tonya Hales, Director, Bureau of Authorization & Community Based Services, 801-538-9136
Implementation Date: June 2013

Recommendation 3.2

Medicaid should review the universe of prior authorization functions to ensure that reviews with a significant medical component have appropriate review procedures in place.

Department response:

We concur with this recommendation.

Medicaid has completed a review of the universe of prior authorizations to ensure that reviews with a significant medical component have appropriate review procedures in place.

Contact: Tonya Hales, Director, Bureau of Authorization & Community Based Services, 801-538-9136
Implementation Date: June 2013

Recommendation 4.1

Medicaid should obtain ownership documents for all Hospice Providers lacking ownership declaration documentation if applicable

Department response:

We concur with this recommendation.

All providers enrolling on or after March 25, 2011, have been required to submit a completed ownership disclosure form. Federal Regulation 455.410 of The Affordable Care Act (ACA) mandates that states re-enroll all providers regardless of provider type at least every five years. Those providers who are classified as high risk will be re-enrolled every three years, and those providers who are moderate/ low risk will be re-enrolled every five years.

Based on this schedule, all states will complete the re-enrollment process for all providers by March 25, 2016. As stated previously, to comply with the new ACA requirements all providers will submit a completed ownership disclosure form to become enrolled. Providers that do not comply with this request will be terminated at the time of re-enrollment. Likewise, those who are submitting a new application will be denied if they do not provide the completed ownership disclosure form. The Bureau of Medicaid Operations expects to be fully compliant with 455.410 by March 25, 2016.

Contact: Shandi Adamson, Director, Bureau of Medicaid Operations, 801-538-6308
Anticipated Implementation Date: April 1, 2016

Recommendation 5.1

Medicaid should evaluate the use of the two diagnoses, debility and failure to thrive in requests for prior authorization. If there are no other diagnoses that could be defined as terminal illness, the prior authorization should not be granted which would result in the claim not being paid.

Department response:

We concur with this recommendation.

Medicaid will update the Hospice Provider Manual to include the CMS guidance with regard to "debility" and "failure to thrive" diagnoses not being used as principal hospice diagnoses and will describe that prior authorization requests submitted with debility or failure to thrive as principal diagnoses will be returned to the provider with a request for a more definitive diagnosis. If a more definitive diagnosis cannot be provided, the prior authorization nurse will deny the prior authorization request and will include a notice of agency action and appeal rights information.

To implement this recommendation, Medicaid will update the hospice provider manual, draft an article for the Medicaid Information Bulletin, inform hospice clients and Accountable Care Organizations of the new requirements and train internal prior authorization staff, hospice providers, and nursing facilities.

Contact: Tonya Hales, Director, Bureau of Authorization & Community Based Services, 801-538-9136
Anticipated Implementation Date: April 1, 2015

Recommendation 5.2

Medicaid should train hospice care providers on the newly defined CMS rule.

Department response:

We concur with this recommendation. Please see response to Recommendation 5.1.

Contact: Tonya Hales, Director, Bureau of Authorization & Community Based Services, 801-538-9136
Anticipated Implementation Date: April 1, 2015

EVALUATION OF MANAGEMENT RESPONSE

Management concurs with the findings and recommendations of this report. Management has designated a responsible person to implement changes within a reasonable deadline. Management's response is adequate.

UTAH OIG CONTACTS AND STAFF ACKNOWLEDGEMENT

UTAH OIG CONTACT

David P. Stoddard
Lead Auditor

Kevin Anderson
Audit Manager

UTAH OIG AUDIT SERVICES MISSION

We conduct audits to reduce or eliminate waste, abuse and fraud in the Utah Medicaid Programs for the benefit of taxpayers, Medicaid providers and recipients.

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