12VAC30-50-270. Hospice ~~care (~~in accordance with §1905 (o) of the Act).

A. Covered hospice services shall be defined as those services allowed under the provisions of Medicare law and regulations as they relate to hospice benefits and as specified in the Code of Federal Regulations, Title 42, Part 418.

B. Categories of care. As described for Medicare and applicable to Medicaid, hospice services shall entail the following four categories of daily care:

1. Routine home care is at-home care that is not continuous.

2. Continuous home care consists of at-home care that is predominantly nursing care and is provided as short-term crisis care. A registered or licensed practical nurse must provide care for more than half of the period of the care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home care.

3. Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice, hospital, or nursing facility) to relieve the primary caregiver(s) providing at-home care for the recipient. Respite care is limited to not more than 5 consecutive days.

4. General inpatient care may be provided in an approved freestanding hospice, hospital, or nursing facility. This care is usually for pain control or acute or chronic symptom management which cannot

be successfully treated in another setting.

C. Covered services.

1. As required under Medicare and applicable to Medicaid, the hospice itself shall provide all or substantially all of the "core" services applicable for the terminal illness which are nursing care, ~~physician services~~, social work, and counseling (bereavement, dietary, and spiritual).

2. Other services applicable for the terminal illness that shall be available but are not considered "core" services are physician services, drugs and biologicals, home health aide and homemaker services, inpatient care, medical supplies, and occupational and physical therapies and speech-language/pathology services.

3. These other services may be arranged, such as by contractual agreement, or provided directly by the hospice.

4. To be covered, a certification that the individual is terminally ill shall have been completed by the physician and hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a plan of care must be established before services are provided. To be covered, services shall be consistent with the plan of care. Services not specifically documented in the patient's medical record as having been rendered will be deemed not to have been rendered and no coverage will be provided.

5. All services shall be performed by appropriately qualified personnel, but it is the nature of the

service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

a. Nursing care. Nursing care shall be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse.

b. Medical social services. Medical social services shall be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

c. Physician services. Physician services shall be performed by a professional who is licensed to practice, who is acting within the scope of his or her license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team shall be a licensed doctor of medicine or osteopathy.

d. Counseling services. Counseling services shall be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

e. Short-term inpatient care. Short-term inpatient care may be provided in a participating hospice

inpatient unit, or a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

f. Durable medical equipment and supplies. Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness is covered. Medical supplies include those that are part of the written plan of care.

g. Drugs and biologicals. Only drugs used which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

h. Home health aide and homemaker services. Home health aides providing services to hospice recipients must meet the qualifications specified for home health aides by ~~42 CFR 484.36~~ Medicare and the Department of Health . Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the ~~patient~~ recipient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the ~~patient~~ recipient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse.

i. Rehabilitation services. Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the

individual to maintain activities of daily living and basic functional skills.

D. Eligible groups.

To be eligible for hospice coverage under Medicare or Medicaid, the recipient must have a life expectancy of six months or less, have knowledge of the illness and life expectancy, and elect to receive hospice services rather than active treatment for the illness. Both the attending physician and the hospice medical director must certify the life expectancy. The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures:

1. For the first 90-day period of hospice coverage, the hospice must obtain, within two calendar days after the period begins, a written certification statement signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician if the individual has an attending physician. For the initial 90-day period, if the hospice cannot obtain written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.

2. For any subsequent 90-day or 30-day period or a subsequent extension period during the individual's lifetime, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six months or less and the signature(s) of the physician(s). The hospice must maintain the certification statements.

12VAC30-60-130. Hospice services.

A. Admission criteria. 1. Service election. To be eligible for hospice coverage under Medicare or Medicaid, the recipient must be "terminally ill," defined as having a life expectancy of six months or less, and elect to receive hospice services rather than active treatment for the illness. Both the attending physician (if the individual has an attending physician) and the hospice medical director, or the physician member of the interdisciplinary team, must certify the life expectancy.

2. Service revocation. The recipient shall have the right to revoke his election of hospice services at any time during the above mentioned hospice periods. DMAS must be contacted if the recipient revokes his hospices services. If the recipient re-elects the hospice services, the hospice periods will begin as an initial time frame. Therefore, the above certification and time requirements will apply. The recipient cannot retroactively receive hospice benefits from previously unused hospice periods. The recipient's written revocation statement must be maintained in the recipient's medical chart.

B. General Conditions. The following general conditions apply to nursing care, medical social services, physician services, counseling services, short-term in-patient care, durable medical equipment and supplies, drugs and biologicals, home health aide and homemaker services and rehabilitation services.

The recipient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his or her license. The hospice medical director or the physician member of the interdisciplinary

team must be a licensed doctor of medicine or osteopathy. Hospice services may be provided in the recipient's home, or in a freestanding hospice, hospital or nursing facility.

The hospice must obtain the written certification that an individual is terminally ill in accordance with the following procedures:

1. For the initial 90-day benefit period of hospice coverage, a Medicaid written certification (DMAS 420) must be signed and dated by the medical director of the hospice or physician member of the hospice interdisciplinary group and attending physician, at the beginning of the certification period. This initial certification must be submitted for preauthorization within 14 days from the physician's signature date. This certification must be maintained in the recipient's medical record.

2. For the subsequent 90-day hospice period, a Medicaid written certification (DMAS 420) must be signed and dated before or on the begin day of the 90 day hospice period by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the statement that the recipient's medical prognosis is that his life expectancy is six months or less. This certification of continued need for hospice services must be maintained in the recipient's medical record.

3. After the second 90 day hospice period and until the recipient is no longer in the Medicaid

hospice program, a Medicaid written certification must be signed and dated every 60 days on or before the begin date of the 60 day period. This certification statement must be signed and dated by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the statement that the recipient's medical prognosis is that his life expectancy is six months or less. This certification must be maintained in the recipient's medical chart.

~~B.~~ C. Utilization review. Authorization for hospice services requires an initial preauthorization by DMAS and physician certification of life expectancy. Utilization review will be conducted to determine if services were provided by the appropriate provider and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. Services not specifically documented in the ~~patients'~~ recipients' medical records as having been rendered shall be deemed not to have been rendered and no coverage shall be provided. All hospice services shall be provided in accordance with guidelines established in the Virginia Medicaid Hospice Manual.

~~C.~~ D. Hospice services are a medically directed, interdisciplinary program of palliative services for terminally ill people and their families, emphasizing pain and symptom control. The rules pertaining to them are:

1. Nursing care. Nursing care must be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is

licensed as a registered nurse.

2. Medical social services. Medical social services must be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

3. Physician services. Physician services must be performed by a professional who is licensed to practice, who is acting within the scope of his license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team must be a licensed doctor of medicine or osteopathy.

4. Counseling services. Counseling services must be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him to adjust to the individual's approaching death. Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. Bereavement counseling is a required hospice service, but it is not reimbursable.

5. Short-term inpatient care. Short-term inpatient care may be provided in a participating hospice

inpatient unit, or a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

6. Durable medical equipment and supplies. Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness is covered. Medical supplies include those that are part of the written plan of care.

7. Drugs and biologicals. Only drugs which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

8. Home health aide and homemaker services. Home health aides providing services to hospice recipients must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse.

9. Rehabilitation services. Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

10. Documentation of hospice services must be maintained in the recipient's medical chart. Coordination of patient care between all health care professionals should be maintained in the recipient's medical chart.

12VAC30-80-30. Fee-for-service providers.

A. Payment for the following services, except for physician services, shall be the lower of the state agency fee schedule (12VAC30-80-190 has information about the state agency fee schedule) or actual charge (charge to the general public):

1. Physicians' services (12VAC30-80-160 has obstetric/pediatric fees). Payment for physician services shall be the lower of the state agency fee schedule or actual charge (charge to the general public), except that reimbursement rates for designated physician services when performed in hospital outpatient settings shall be 50% of the reimbursement rate established for those services when performed in a physician's office. The following limitations shall apply to emergency physician services.

a. Definitions. The following words and terms, when used in this subdivision 1, shall have the following meanings when applied to emergency services unless the context clearly indicates otherwise:

"All-inclusive" means all emergency service and ancillary service charges claimed in association with the emergency department visit, with the exception of laboratory services.

"DMAS" means the Department of Medical Assistance Services consistent with Chapter 10

(§32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

"Emergency physician services" means services that are necessary to prevent the death or serious impairment of the health of the recipient. The threat to the life or health of the recipient necessitates the use of the most accessible hospital available that is equipped to furnish the services.

"Recent injury" means an injury which has occurred less than 72 hours prior to the emergency department visit.

b. Scope. DMAS shall differentiate, as determined by the attending physician's diagnosis, the kinds of care routinely rendered in emergency departments and reimburse physicians for nonemergency care rendered in emergency departments at a reduced rate.

(1)DMAS shall reimburse at a reduced and all-inclusive reimbursement rate for all physician services, including those obstetric and pediatric procedures contained in 12VAC30-80-160, rendered in emergency departments which DMAS determines are nonemergency care.

(2)Services determined by the attending physician to be emergencies shall be reimbursed under the existing methodologies and at the existing rates.

(3)Services determined by the attending physician which may be emergencies shall be manually

reviewed. If such services meet certain criteria, they shall be paid under the methodology in subdivision 1 b (2) of this subsection. Services not meeting certain criteria shall be paid under the methodology in subdivision 1 b (1) of this subsection. Such criteria shall include, but not be limited to:

(a)The initial treatment following a recent obvious injury.

(b)Treatment related to an injury sustained more than 72 hours prior to the visit with the deterioration of the symptoms to the point of requiring medical treatment for stabilization.

(c)The initial treatment for medical emergencies including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered life threatening.

(d)A visit in which the recipient's condition requires immediate hospital admission or the transfer to another facility for further treatment or a visit in which the recipient dies.

(e)Services provided for acute vital sign changes as specified in the provider manual.

(f)Services provided for severe pain when combined with one or more of the other guidelines.

(4)Payment shall be determined based on ICD-9-CM diagnosis codes and necessary supporting documentation.

(5)DMAS shall review on an ongoing basis the effectiveness of this program in achieving its objectives and for its effect on recipients, physicians, and hospitals. Program components may be revised subject to achieving program intent objectives, the accuracy and effectiveness of the ICD-9-CM code designations, and the impact on recipients and providers.

2. Dentists' services.

3. Mental health services including: (i) community mental health services; (ii) services of a licensed clinical psychologist; or (iii) mental health services provided by a physician.

a. Services provided by licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists.

b. Services provided by independently enrolled licensed clinical social workers and licensed professional counselors shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

4. Podiatry.

5. Nurse-midwife services.

6. Durable medical equipment.

a. The rate paid for all items of durable medical equipment except nutritional supplements shall be the lower of the state agency fee schedule that existed prior to July 1, 1996, less 4.5%, or the actual charge.

b. The rate paid for nutritional supplements shall be the lower of the state agency fee schedule or the actual charge.

7. Local health services.

8. Laboratory services (other than inpatient hospital).

9. Payments to physicians who handle laboratory specimens, but do not perform laboratory analysis (limited to payment for handling).

10. X-ray services.

11. Optometry services.

12. Medical supplies and equipment.

13. Home health services. Effective June 30, 1991, cost reimbursement for home health services is eliminated. A rate per visit by discipline shall be established as set forth by 12VAC30-80-180.

14. Physical therapy; occupational therapy; and speech, hearing, language disorders services when rendered to noninstitutionalized recipients.

15. Clinic services, as defined under 42 CFR 440.90.

B. Hospice services payments must be no lower than the amounts using the same methodology used under Part A of Title XVIII, ~~adjusted to disregard offsets attributable to Medicare coinsurance amounts~~ take into-account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual. Hospice services shall be paid according to the location of the service delivery and not the location of the agency's home office.

12VAC30-130-480. Covered hospice services.

A. "Hospice" means a medically directed, interdisciplinary program of palliative services for terminally ill people and their families, emphasizing pain and symptom control provided by a team of professionals including physicians, nurses, counselors, social workers, therapists, aides and volunteers. Hospice is primarily a concept of care, rather than a specific place, with the majority of hospice services being delivered in the home with inpatient care available as needed.

B. "Terminally ill" means an individual has a medical prognosis that his or her life expectancy is six months or less. ~~This prognosis must be certified by written statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician.~~ This prognosis must initially be certified by written statements signed and dated by the medical director of the hospice or the physician member of the hospice interdisciplinary team, and the individual's attending physician. For subsequent periods, the written statement must be signed and dated by the medical director or the physician member of the hospice interdisciplinary team.

C. As required under Medicare and applicable to Medicaid, the hospice itself must provide the "core" services applicable for the terminal illness which are nursing care, ~~physician services~~, social work, and counseling (bereavement, dietary, and spiritual). However, the hospice may use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the

hospice shall maintain professional, financial, and administrative responsibility for the services.

Other services applicable to the terminal illness that must be available but are not considered "core" services are physician services, drugs and biologicals, home health aide and homemaker services, inpatient care, medical supplies, and occupational and physical therapies and speech-language pathology services, and any other item or service which is specified under the plan and which is reasonable and necessary for the palliation and management of terminal illness and for which payment may otherwise be made under Title XIX. These other services may be arranged, such as by contractual agreement, or provided directly by the hospice.

D. As described for Medicare and applicable to Medicaid, hospice services shall include the following four categories of daily care: routine home care, continuous home care, inpatient respite care, and general inpatient care.

12VAC30-130-490. Admission criteria for covered services.

A. To be eligible for hospice care under Medicaid, an individual must be certified as terminally ill. An individual is considered to be terminally ill if he has a medical prognosis that his life expectancy is six months or less. In addition, the individual must have knowledge of the illness and life expectancy and elect to receive hospice services rather than active treatment for the illness. ~~Both the attending physician if the individual has an attending physician and the hospice medical director must certify the~~

~~life expectancy.~~ Both the attending physician if the individual has an attending physician, and either the hospice medical director or the physician member of the hospice interdisciplinary team must initially certify the life expectancy of the recipient, and for any subsequent certifications, either the hospice medical director or the physician member of the hospice interdisciplinary team must certify the life expectancy.

B. The hospice must obtain the certification that an individual is terminally ill in accordance with the ~~following~~ procedures enumerated at 12 VAC 30-60-130.

~~1. For the first 90-day period of hospice coverage, the hospice must obtain, within two calendar days after the period begins, a written certification statement signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician if the individual has an attending physician. For the initial 90-day period, if the hospice cannot obtain written certifications within two calendar days, it must obtain oral certifications within two calendar days, and written certifications no later than eight calendar days after the period begins.~~

~~2. For any subsequent 90-day or 30 -day period or a subsequent extension period during the individual's lifetime, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the statement that the individual's medical prognosis is that his life expectancy is six months or less and the signature or signatures of the physician or physicians. The hospice must maintain the certification statements.~~

~~3. An election to receive hospice care shall be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual remains in the care of a hospice and does not revoke the election. An election period means one of three periods, plus a subsequent extension period during the individual's lifetime, for which an individual may elect to receive coverage of hospice care. The periods consist of two 90-day periods, one 30-day period, and a subsequent extension period during the individual's lifetime. An election to receive hospice care may be made by an individual's representative who is acting pursuant to state law. An individual or representative may designate an effective date for the election period that begins with the first day of hospice care or any subsequent day of hospice care but may not designate an effective date than is earlier than the date that the election is made.~~

C. For purposes of the Medicaid hospice benefit, a nursing facility may be considered the residence of a recipient. An addition to hospice reimbursement is made in this situation to take the room and board provided by the facility into account. The hospice shall reimburse the nursing facility for these services.

~~4. The election statement must include (i) identification of the hospice that will provide care to the individual; (ii) the individual's or representative's acknowledgement that he has been given a full understanding of the palliative rather than curative nature of hospice care as it relates to the individual's terminal illness; (iii) acknowledgement that certain Medicaid services are waived by the election; (iv) the effective date of the election, and (v) the signature of the individual or representative.~~

12 VAC 30-130-530. Hospice services to terminally ill patients.

A. As required under Medicare and applicable to Medicaid, the hospice itself must provide all of the "core" services applicable for the terminal illness which are nursing care, ~~physician services~~, social work, and counseling (bereavement, dietary, and spiritual).

The "core" services must be provided routinely and directly by hospice employees. Supplemental services may be contracted for to meet unusual staffing needs that cannot be anticipated and that occur so infrequently that it would not be practical to hire additional staff to fill these needs. Hospices may also contract to obtain physician specialty services. If contracting is used for any services, the hospice must maintain professional, financial and administrative responsibility for the services and must assure that all staff meet the regulatory qualification requirements.

Other services applicable for the terminal illness that must be available but are not considered "core" services are physician services, drugs and biologicals, home health aide and homemaker services, inpatient care, medical supplies, and occupational, physical and speech therapies, and any other item or service which is specified under the plan and which is reasonable and necessary for the palliation and management of terminal illness and for which payment may otherwise be made under Title XIX.

These other services may be arranged, such as by contractual agreement, or provided directly by the

hospice.

B. To be covered, a certification that the individual is terminally ill must have been completed and hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a multidisciplinary plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care designed by a physician after any needed consultation with other hospice team members.

C. All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

1. Nursing care. Nursing care must be provided by a registered nurse or by a licensed practical nurse under the supervision of a graduate of an approved school of professional nursing and who is licensed as a registered nurse.

2. Home health aide and homemaker services. Home health aides providing services to hospice recipients must meet the qualifications specified for home health aides by 42 CFR 484.36. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing

the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse.

3. Medical social services. Medical social services must be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

4. Physician services. Physician services must be performed by a professional who is legally authorized to practice, who is acting within the scope of his or her license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team must be a licensed doctor of medicine or osteopathy.

Attending physician means a physician who is a doctor of medicine or osteopathy and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

5. Counseling services. Counseling services must be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary

counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.

Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. "Family" includes family members or other persons caring for the individual at home. Bereavement counseling is a required hospice service, but it is not reimbursable.

6. Short-term inpatient care. Short-term inpatient care may be provided in a participating hospice inpatient unit, or a participating hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings.

Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home. Respite care means short-term inpatient care provided in an approved facility (freestanding hospice, hospital, or nursing facility) to relieve the primary caregiver or caregivers providing at-home care for the recipient. No more than 5 consecutive days will be allowed.

Hospice patients are exempted from the preadmission screening requirements. However, the above criteria must be met for inpatient hospital stays.

7. Durable medical equipment and supplies. Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness are covered. Medical supplies include those supplies that are part of the written plan of care.

8. Drugs and biologicals. Only drugs used which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered.

9. Rehabilitation services. Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

a. Occupational therapy services shall be those services furnished a patient which meet all of the following conditions:

(1)The services shall be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with an occupational therapist registered and certified by the American Occupational Therapy Certification Board;

(2)The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature, that the services can only be performed by an occupational therapist registered

and certified by the American Occupational Therapy Certification Board or an occupational therapy assistant certified by the American Occupational Therapy Board under the direct supervision of an occupational therapist as defined above;

(3)The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

b. Physical therapy services shall be those furnished a patient which meet all of the following conditions:

(1)The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a physical therapist licensed by the Board of Medicine;

(2)The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a physical therapist licensed by the Board of Medicine, or a physical therapy assistant who is licensed by the Board of Medicine and under the direct supervision of a physical therapist licensed by the Board of Medicine; and

(3)The services shall be specific and provide effective treatment for the patient's condition in

accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

c. Speech-language pathology services shall be those services furnished a patient which meet all of the following conditions:

(1)The services shall be directly and specifically related to an active written treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Board of Audiology and Speech-Language Pathology;

(2)The services shall be of a level of complexity and sophistication, or the condition of the patient shall be of a nature that the services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech-Language Pathology; and

(3)The services shall be specific and provide effective treatment for the patient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.