Document ID: AETAMA - 095494	Title: Aetna Medicaid Administrator (AMA) 7200.74 Hospice Services Louisiana Policy	
Parent Documents: N/A		
Effective Date: See Document Information Page	Last Review Date: See Review and Revision History Section	Business Process Owner (BPO): Principle Clinical LDR CS AMA UM Leadership
Exhibit(s):		
Document Type: Policy and Procedure		

PURPOSE

The purpose of this policy is to describe the health plan's process for prior authorization decision-making conditions in which Hospice Services may be authorized according to the directives from state of Louisiana Medicaid.

SCOPE

The scope of this policy applies to the Louisiana Prior Authorization staff and all colleagues processing Louisiana authorization requests for Hospice Services.

POLICY

It is the policy of the plan that specific state directives, in addition to MCG® criteria are used when processing authorization requests for Hospice Services. Louisiana state qualifications, authorization and documentation requirements must be met. This policy defines additional Louisiana state qualifications and authorization and documentation requirements.

STANDARD

Coverage of Hospice Services requires prior authorization. All Providers (both facility and ordering authorized healthcare professional must be registered in the state and the health plan's registry. The provider should be a preferred provider for the health plan.

Covered Services[1]

Hospice care includes services needed to meet the needs of the member as related to the terminal illness and related conditions. Core services must be available twenty-four (24) hours a day for nursing, physicians, and biologicals. Services include:

- **Physician Services**- that treat and management of the terminal illness and related conditions as well as directing the hospice multidisciplinary team as defined in 42 CFR 410.20..
- **Nursing Services**- any skilled nursing care must be provided by a registered nurse or under the supervision of a registered nurse or a nurse practitioner.

[1] 2025 Louisiana Medicaid Service Manual Chapter 24.3 Hospice, pages 1-9 of 9

- **Medical Social Services**- has a minimum of a master's degree, providing resource assistance, support, and counseling working under the direction of a physician.
- **Counseling services**- available to the terminally ill member and family during the illness and after death family bereavement counseling.
- **Dietary Counseling**- from a qualified individual providing counseling and training to the member or family or other caregivers on how to provide and prepare meals .
- **Bereavement Counseling**- during hospice and up to one year after death must provide an organized program under the supervision of a qualified professional . The plan of care (POC) should reflect family needs as well as clear delineation of services to be provided and the frequency of service delivery. It is a required component of hospice but it is not reimbursable.
- **Pastoral Care**- Clergy visits are arranged according to member and family requests. Families and members must be advised this is available.
- **Short-Term Inpatient Care**- provides inpatient care in a hospital or a hospice inpatient setting. This may be needed for a procedure for pain control or acute or chronic symptom management or other comfort measures or for family respite. This cannot be provided in a nursing home or an intermediate care facility or a veteran's medical facility. A cap is placed on the number of allowable inpatient hospice days that can be provided by a hospice facility to fee-for-service beneficiaries during the twelve-month period beginning November 1st of each year to October 31st of the following year. This cap is calculated as twenty percent (20%) of the total number of hospice days provided by the facility.
- **Inpatient Respite Care**- a short-term inpatient respite care day to relieve family caring for the member at home. The inpatient respite care rate is paid daily for a maximum of five (5) consecutive days which includes the admission day but not the discharge day. Payment for the sixth (6) day and any subsequent days is made at the routine homecare rate. Respite care is not covered when the member resides in a nursing facility or ICF-IDD facility.
- **Hospice Aide and Homemaker**- provides personal care and household services to provide comfort and cleanliness of environment. All aides provide services under the supervision of a registered nurse and must have successfully completed a home health aide training and evaluation program. Aides may perform household services to maintain a safe and sanitary environment. The registered nurse supervision must be performed in the home when the aide is providing services.
- **Medical Appliances and Supplies** – including drugs and biologicals are provided by the hospice provider a defined in Section 1861(t) of the Social Security Act used for pain relief and symptom control related to the terminal illness. Appliances may include DME, self-help and personal comfort items related to the terminal illness. Supplies and all biologicals will be listed in the written Plan of Care (POC). The hospice provider will

have a written policy for the disposal of controlled drugs maintained in the home when they are no longer needed. Drugs and biologicals must be administered by:
    - a licensed nurse or physician,
    - an employee who has completed a state approved training program in medication administration,
    - The member if their attending physician has approved.
    - Any other individual in accordance with applicable state and local laws.
- **Therapy Services** – Physical therapy, Occupational therapy and Speech-language pathology services are provided for symptom control, or to enable the member to continue activities of daily living and basic functional skills.
- **Other services**- Other services may be needed at the discretion of the hospice company, such as ambulance services for transportation to an inpatient facility.

Once a member elects to receive hospice services, the hospice is responsible for payment of all covered services. The member gives up the option for therapeutic care for any and all other related conditions. A member cannot elect hospice for one condition and not the other.[2]
The member may present with multiple medical conditions and the physician certifies that at least one condition has created a terminal illness with a six month or less life expectancy. Hospice members give up the option for therapeutic care for any and all of the related conditions.

Any claim for services submitted by a provider other than the elected hospice provider will be denied if the claim does not have attached justification that the service was medically necessary and was not related to the terminal condition for which hospice care was elected. The hospice provider is not responsible for payment of the life prolonging services.

Members under twenty-one (21) years of age may continue to receive life prolonging therapies that are focused on treating, modifying, or curing a medical condition so that the member can live as long as possible described later in this policy.

Reimbursement Rates[3]

There are four payment rates according to the level of care required.
- Routine Home care
- Continuous home care
- Inpatient respite care
- General Inpatient care

[2] 2025 Louisiana Medicaid Service Manual Chapter 24.3 Hospice page 6 of 9
[3] 2025 Louisiana Medicaid Service Manual Chapter 24.3 Hospice page 6 of 9

Provider Responsibilities[4]

- Must have a Practitioner Referral and a signed authorized healthcare provider's signed order noting the hours requested and reviewed in the Plan of Care (POC) every 60 day.
- Providers must be an authorized healthcare provider and on the Aetna Better Health of Louisiana registry to provide services.
- All Hospice programs must obtain a license from the Louisiana Department of Health (LDH) and must ensure all employee requirements are met.
- A hospice provider must be Medicare -certified in order to qualify for enrollment as a Louisiana Medicaid hospice provider prior to billing for services .
- The hospice provider must provide an interdisciplinary group(IDG) composed of qualified medical professionals and social support staff from all core services with expertise in meeting the special needs of Hospice members and families. The interdisciplinary group must include a Physician, Registered Nurse, Social Worker and Pastoral or other counsel.
- Members may receive waiver services concurrently as long as the developmental disabilities diagnosis is not related to the terminal hospice condition and are not duplicative care.
- .
- The provider must be responsible for coordinating all waiver services to ensure there is no duplication of services. [5]
- The hospice provider is responsible for providing durable medical equipment.

Hospice providers will cover payments for: any medical consultants, any services or inpatient charges when provided to the member on the day Hospice is chosen,

Member Criteria [6]

- To be eligible for hospice care, a member must meet all Louisiana Medicaid eligibility criteria and be certified as terminally ill. "Terminally Ill" is defined as a medical prognosis of limited expected survival, of approximately six months or less at the time of the referral to hospice, of a member who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone are no longer appropriate.
- Member should have the BHSF for Hospice-CTI or Certification of Terminal Illness and the BHSF-Form Hospice-NOE or Notice of election obtained by the Hospice.
- The beneficiary must have an established Plan of Care (POC) by the Hospice medical team.

---

[4] 2025 Louisiana Medicaid Services Manual Chapter 24.0 Hospice page 1-of1 and section 24.2 page 1-12

[5] 2025 Louisiana Medicaid Services Manual Chapter 24.2: Hospice page 7 of 12

[6] 2025Louisiana Medicaid Services Manual Chapter 24.0 Hospice page 1of 1

Plan of Care[7]

A plan of care is created by the hospice provider with the interdisciplinary team and the member. In establishing the initial POC, the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member (nurse, physician, or medical social worker or counselor) before writing the initial POC. At least one of the persons involved in developing the initial POC must be a nurse or physician. The POC is signed by the attending physician or an appropriate member of the interdisciplinary group. The POC must encompass plans on access to emergency care and address the condition of the beneficiary as a whole. All co-morbidities must be included even those not related to the terminal illness. In addition, the POC must meet general medical needs of beneficiaries to the extent that these needs are not being met by the attending physician. This information is being required to assess the beneficiary for complications and risk factors that would affect care planning (i.e., access to emergency care). Providers may not be responsible for providing care for the unrelated co-morbidities.

Prior Authorization

Prior authorization (PA) is required upon the initial request for hospice coverage. Requests for PA must be submitted within 10 calendar days of the hospice election date. If the PA is approved, it covers 90 days.

First Benefit Period (90 days) Required Documentation [8]

1. Hospice Notice of Election Form (NOE) (primary diagnosis code(s) using the International Classification of Disease, Tenth Revision (ICD-10) or its successor; other codes)
    a. The top portion of this form must be completed by the member or their representative.
    b. The member's signature acknowledges they have been informed and fully understand the palliative rather than curative nature of hospice care which waives certain Medicaid services.
2. If the member signs with an "X," there must be two witnesses also sign. Hospice Certification of Terminal Illness (CTI) form (BHSF Form Hospice – CTI)
    a. The hospice provider must obtain two completed certifications: One from the member's attending physician with full knowledge of the member's medical care and needs and the second from the hospice's medical director.
    b. If the attending physician is also the medical director, a physician member of the interdisciplinary group (IDG) must also sign the Hospice Certification.
    c. The attending physician is defined as the physician most involved with the member's care prior to the election of hospice services.
    d. The member is not required to relinquish their attending physician in order to

[7] 2025 Louisiana Medicaid Services Manual Chapter 24.5 Hospice page 2 of 8
[8] 2025 Louisiana Department of Health Provider Manual Chapter 24.6 Hospice p. 2 of 5

receive hospice. If the attending physician wishes to relinquish care of the member, the attending physician must submit a narrative statement indicating relinquishment of the member's care and sign the CTI form.

3. Clinical/medical information Required Documentation[9]
    a. Documentation should paint a picture of the member's condition by illustrating the member's decline in detail. The following information will be required upon the initial request for hospice services.
    b. Last month's status compared to this month's status and should not merely summarize the member's condition for a month).
    c. Daily and weekly notes and
    d. Illustrate why the member is considered to be terminal and not "chronic."
    e. Explanation should include the reason the member's diagnosis has created a terminal prognosis and show how the systems of the body are in a terminal condition.
    f. Telephone courtesy calls are not considered face-to-face encounters and will not be reviewed for prior authorization.

4. Hospice provider plan of care (POC) includes the following:
    a. Progress notes (hospital, home health, physician's office, etc.)
    b. Physician orders for POC and
    c. Include Minimum Data Set (MDS) or jRaven form (original and current) if member is in a facility; weight chart; laboratory tests; physician and nursing notes.

Recertification and Authorization Required Documentation[10]

If another 90-day election period is required, the Prior Authorization (PA) request must be submitted at least 10 days prior to the end of the current election period. This will ensure that requests are received and approved or denied before the preceding period ends.

- Section 3131(b) of the Affordable Care Act of 2010 requires a hospice physician or NP to have a face-to-face encounter with every hospice beneficiary to determine the continued eligibility of that beneficiary prior to the beneficiary's 180th day recertification and each subsequent recertification.
    - **Second and Subsequent Periods Providers requesting PA for the second period, and each subsequent period, must send the request packet to the PAU at (see Appendix D for Contact/Referral Information) that includes the following:**

[9] 2025 Louisiana Department of Health Provider Manual Chapter 24.5 Hospice p. 3 of 5
[10] 2025 Louisiana Department of Health Provider Manual Chapter 24.6 Hospice p.3 of 5

  - **1. MDS/jRaven forms (original and current) are required; weight chart; laboratory tests; physician and nursing progress notes if the beneficiary resides in a nursing facility;**
  - **2. An updated Hospice - CTI form (BHSF Form Hospice - CTI) and a face-to-face encounter signed and dated by the hospice provider's medical director or physician member of the interdisciplinary team (IDT) for the third and subsequent requested PA periods**
  - **3. An updated POC;**
  - **4. Updated physician's orders;**
  - **5. List of current medications (within last 60 days);**
  - **6. Current laboratory/test results (within last 60 days if available)**
  - **7. Description of hospice diagnosis**
  - **8. Description of changes in diagnoses**
  - **9. Progress notes for all services rendered (daily/weekly physician, nursing, social worker, aide, volunteer and chaplain);**
  - **10. A social evaluation;**
  - **11. An updated scale such as: Karnofsky Performance Status Scale, Palliative Performance Scale or the Functional Assessment Tool (FAST)**
  - **12. The beneficiary's current weight, vital sign ranges, lab tests and any other documentation supporting the continuation of hospice services. Documentation must illustrate the beneficiary's decline in detail. Compare last month's status to this month's status; and**
  - **13. Original MDS/jRaven; current MDS/jRaven form if beneficiary is a resident in a facility**
- Denied - If this requirement is not met and the period ends, reimbursement will not be available for the days prior to receipt of the new request.
- Approved: If approved, reimbursement will be effective the date the Prior Authorization Unit (PAU) receives the proper documentation. The completed PA :
  - Includes the updated and signed "Hospice Certification of Terminal Illness (CTI)" (BHSF Form Hospice CTI) and
  - Includes all related documents,
  - Must be received before the period ends.
- Any PA request received after the period has ended will become effective on the date the request is received by the PAU if the request is approved.
- This policy also applies to PA packets received after Medicaid eligibility has ended.
- It is the responsibility of the provider to verify eligibility on a monthly basis.
- The PA only approves the existence of medical necessity, not member eligibility.
- (See Appendix B for detailed information regarding BHSF Form Hospice CTI).

NOTE: Prior Authorization is not required for dual eligible members (Medicare primary) during the two 90-day election periods and the subsequent 60-day election periods. However, they must submit a copy of the Medicare Common Working File screen showing the hospice segment through the ePA system and the signed CTI and Notice of Election (NOE) forms.

Revocation of Election[11]

A member may revoke or request discharge alive during an existing election period will lose the remaining days in the election or certification period.

Changing Hospice Provider[12]

A member or their legal representative is allowed to change the designated hospice provider once in each election period. To change the hospice provider, the member or legal representative must file a signed statement with the current hospice provider as well as the new designated hospice provider. Within five (5) calendar days after receipt of the notification, the new hospice provider must submit a Notification of Election/Revocation/Discharge/Transfer form to the prior authorization unit.

Inpatient Respite Care[13]

Inpatient Respite Care is available to all members in Hospice Care. An inpatient respite care day is a day where the member receives care in an approved facility on a short-term basis to relieve the family members or other persons caring for the member at home. An Inpatient facility must meet the standards provided in 42 Code of Federal Regulations (CFR) Section 418.98(b). The inpatient respite care rate is paid for each day the member is in an approved inpatient facility and is receiving respite care. Members have a benefit of a maximum of five continuous days at a time in any Hospice certification period and includes the date of admission but does not include the day of discharge. Days beyond the fifth day are reimbursed is made at the routine home care rate. Respite care is not a benefit for members residing in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

Service Coordination and Waivers[14]

Hospice providers must interact with other non-hospice providers to ensure the member's overall care needs are met and non-hospice providers do not compromise or duplicate the hospice plan of care. All members with waivers considering hospice must be counseled thoroughly to make an informed decision. Additional information is also included for members under twenty-one.

---

[11] 2025 Louisiana Medicaid Services Manual Program issued 5/19/25 Replaced 3/22/24 Chapter 24: Hospice Section 24.2 Page 5 of 12.
[12] 2025 Louisiana Medicaid Services Manual Program issued 5/19/25 Replaced 3/22/24 Chapter 24: Hospice Section 24.2 Page 6 of 12.

[13] 2025 Louisiana Medicaid Services Manual Program issued 5/19/25 Replaced 3/22/24 Chapter 24: Hospice Section 24.9 Reimbursement page 11 Inpatient Respite Care (Revenue Code 655).
[14] 2025 Louisiana Medicaid Services Manual Program issued 5/19/25 Replaced 3/22/24 Chapter 24: Hospice Section 24.2 Page 5-6 of 12.

- **Adult Day Healthcare (ADHC) waiver** - Members with this waiver may also participate with hospice services as long as there is not duplication of services. Once the hospice program requirements are met, the ADHC Waiver services and Long Term h
- **Community Choice Waiver** – This waiver provides services so members can stay in their home. Hospice participants may only receive Personal Assistance Services (PAS) for ADL assistance to remain safely in their home. Services must be coordinated so as not to duplicate services.
- **Long Term – Personal Care Services** – Members may elect hospice services and LT-PCS services. The Hospice Plan of Care must detail services and frequency of services to prevent duplication of services.

Hospice Supplies[15]

- Hospice supplies are reimbursable under the durable Medical Equipment (DME) program. Prior authorization for covered supplies must be obtained. Hospice supplies are included in the Hospice reimbursement.
- Pharmaceutical and Biological Services are provided by the hospice provider.

Concurrent Hospice for Members Under Twenty-one[16]

Members under twenty-one (21) who choose hospice are eligible for the Concurrent Care model of hospice. Concurrent care allows the member to receive life-prolonging therapies. This includes anything in the plan of care that focuses on treating, modifying, or curing a medical condition so that the member may live as long as possible, even if the medical condition also is a hospice qualifying diagnosis. Once a member turns twenty-one, the concurrent care benefit is no longer available. The member and families may change their hospice election between standard and concurrent care anytime during the hospice benefit period. The hospice is responsible for making daily visits available to coordinate care and ensure there is no duplication of services. If the member or family declines the visit, the hospice must document any visits not made and the reason. All treatments and therapies must be included in the Plan of Care (POC). Durable Medical Equipment necessary for life-prolonging therapy will be reimbursed separately by the provider.

Hospice members under twenty-one may also receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Pediatric Day Health Care (PDHC), Personal Care Services (PCS) and Intermittent or Extended Home Health Services concurrently.

---

[15] 2025 Louisiana Medicaid Services Provider Manual Chapter 24.2 Hospice p.10 of 12

[16] 2025 Louisiana Medicaid Services Provider Manual Chapter 24.2 Hospice p.10-12 of 12

Hospice members under twenty-one may also receive wavier services such as the New Opportunities Waiver (NOW), Residential Options Waiver (ROW), Supports Waiver (SW) and Children's Choice Waiver (CCW) concurrently as long as the developmental disabilities diagnosis is not related to the terminal hospice condition and are not a duplicative service of hospice care as coordinated by the hospital company.
Members with a serious illness may continue to receive care from multiple subspecialists along with the pediatrician as necessitated by the goals of care. The hospice providers and subspecialist/pediatrician will work together to ensure a collaborative approach when concurrent care model is being utilized.

APPLICABLE CPT CODES

This policy applies the additional definitions, qualifications, criteria, and documentation requirements to the procedure codes listed below. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS	Description
Q5001	Hospice or home health care provided in member's home/residence
Q5002	Hospice or home health care provided in assisted living facility
Q5003	Hospice care provided in nursing long term care facility (LTC) or non-skilled nursing facility (NF)
Q5004	Hospice care provided in skilled nursing facility (SNF)
Q5005	Hospice care provided in inpatient hospital
Q5006	Hospice care provided in inpatient hospice facility
Q5007	Hospice care provided in long term care facility
Q5008	Hospice care provided in inpatient psychiatric facility
Q5009	Hospice or home health care provided in a place not otherwise specified
Q5010	Hospice home care provided in a hospice facility
S9126	Hospice care, in the home, per diem
T2042	Hospice routine home care; per diem
T2043	Hospice continuous home care; per diem
T2044	Hospice inpatient respite care; per diem
T2045	Hospice general inpatient care; per diem

T2046	Hospice long term car, room, and board only; per diem

DEFINITIONS:

1. **Activities of Daily Living (ADLs)** - The functions or basic self-care tasks which an individual performs in a typical day, either independently or with supervision/assistance. Activities of daily living include bathing, dressing, eating, grooming, walking, transferring and/or toileting.
2. **Adult Day Health Care (ADHC) Waiver** - A Medicaid Home and Community-Based Services (HCBS) Waiver program helps to bridge the gap between independence and institutional care by allowing a member to remain in their own home and community.
3. **Attending Physician** – the physician most involved in the member's care at the time of the referral and prior to election of hospice care.
4. **Bereavement Counseling** - Organized counseling provided under the supervision of a qualified professional to help the family cope with death and grief related to loss issues. This is provided for at least 1 year following the death of a member.
5. **Certification of Terminal Illness (CTI)** - Written certification that due to the member's prognosis, his or her life expectancy is 6 months or less if the illness runs its normal course, also includes a brief narrative, and benefit period.
6. **Clinical Condition** - A diagnosis or member state (physical or mental), that may be associated with more than one diagnosis or may be as yet undiagnosed.
7. **Concurrent Care** - Members who are under 21 years of age and elect hospice are entitled to receive a hospice benefit while continuing to receive all necessary disease-directed and life prolonging therapies with the goal of providing access to comprehensive care, in order to live as long and as well as possible.**Core Services -** Nursing services, physician services, medical social services and counseling services, including bereavement counseling, dietary counseling, spiritual counseling, and any other counseling services provided to meet the needs of the individual and family.
8. **Discharge -** The point at which the member's active involvement with the hospice services is ended and the hospice provider no longer has active responsibility for the care of the member.
9. **Hospice -** Hospice care is an alternative treatment approach that is based on recognition that impending death requires a change from curative treatment to palliative care for the terminally ill patient and support for the family. Hospice care is an interdisciplinary approach to the delivery of care with attention to needs of both the member and of the family.
10. **iRaven assessment -** A standardized assessment used to determine patient needs and assist with appropriate placement setting.

11. Legal Representative - Legal representatives related to the member include relatives by blood, marriage adopted or by court appointed legal guardian.[17]
12. **Level of Care -** Hospice care is divided into four categories of care rendered to the hospice member: (1) routine home care; (2) continuous home care; (3) inpatient respite care; and (4) general inpatient care.
13. **Life-Prolonging Therapies -** Any aspects of the member's medical plan of care that are focused on treating, modifying, or curing a medical condition so that the member may live as long as possible, even if that medical condition is also the hospice qualifying diagnosis. Members under age 21 are entitled to receive life-prolonging therapies in the concurrent care model of hospice.
14. **MCG ®** - A standard set of guidelines and criteria that offer evidence-based criteria, goals, optimal care pathways, and other decision -support tools for proactive care management, case review and assessment of people facing hospitalizations, treatments, and equipment. [18]
15. **Minimum Data Set (MDS) -** A standardized evaluation form to help determine the acuity and needs of the member. It can assist in the determination of the appropriate setting for care.
16. **Life-Prolonging Therapies -** Any aspects of the member's medical plan of care that are focused on treating, modifying, or curing a medical condition so that the member may live as long as possible, even if that medical condition is also the hospice qualifying diagnosis. Members under age 21 are entitled to receive life-prolonging therapies in the concurrent care model of hospice.[19]
17. **Plan of Care (POC) -** A written document established and maintained for each individual admitted to a hospice program. Care provided to an individual must be in accordance with the plan. The plan includes an assessment of the individual's needs and identification of the services, including the management of discomfort and symptom relief.[20]
18. **Program of All-Inclusive Care for the Elderly (PACE) -** Program which coordinates and provides all needed preventive, primary health, acute and long-term care services to qualified members aged 55 and older in order to enhance their quality of life and allow them to continue to live in the community.[21]
19. **Notice of Election (NOE) -** A signed election from a member acknowledging that he or she wishes to enroll in hospice.[22]

---

[17] 2025 Louisiana Department of Health Provider Manual Chapter 24.2 Hospice Page 4 of 12
[18] MCG Health definition found at https://www.mcg.com
[19] 2025 Louisiana Department of Health Provider Manual Chapter 24.14 HOSPICE p. 1 of 4
[20] 2025 Louisiana Department of Health Provider Manual Chapter 24.14 HOSPICE p. 1 of 4
[21] 2025 Louisiana Department of Health Provider Manual Chapter 24.14 HOSPICE p. 1 of 4
[22] 2025 Louisiana Department of Health Provider Manual Chapter 24 HOSPICE Appendix A p. 1 of 11

20. **Relatives -** A relative is defined as all persons related to the member by virtue of blood, marriage, adoption, or court appointed legal guardians.[23]
21. **Terminally ill -** Defined as a member having a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.[24]

REVIEW AND REVISION HISTORY

Date	Revision No.	Reason for Change	Sections Affected
2/9/2024	1.0	New Policy	
5/13/2025	2.0	Updated to revised state Hospice Manual; format changes.	All pages
9/17/2025	3.0	Review and Revised Second and Subsequent Periods	Pg. 6,7

Aetna Better Health of Louisiana

Bridget Galatas
Interim Chief Operating Officer

Antoinette Logarbo M.D.
Chief Medical Officer

STANDARD

- 2023 Louisiana Medicaid Managed Care Organization Attachment A Model Contract,
- 2025 Louisiana Medicaid Managed Care Organization (MCO) Manual
- 2025 Louisiana Medicaid Provider Manual Chapter 24: Hospice

[23] 2025 Louisiana Department of Health Provider Manual Chapter 24.2 HOSPICE p. 4of 12
[24] 2025 Louisiana Department of Health Provider Manual Chapter 24.1 HOSPICE p. 1