

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



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MLN Matters® Number: MM8727

Related Change Request (CR) #: CR 8727

Related CR Release Date: May 1, 2014

Effective Date: August 4, 2014

Related CR Transmittal #: R188BP

Implementation Date: August 4, 2014

Updates and Clarifications to the Hospice Policy Chapter of the Benefit Policy Manual

Provider Types Affected

This MLN Matters® Article is intended for hospices submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8727, which updates the "Medicare Benefit Policy Manual," Chapter 9, to incorporate policy language from existing regulations, prior rules, an Office of Inspector General Memorandum Report, and two Change Requests, and to clarify existing policy. No changes were made to existing policies. Make sure your billing staffs are aware of these manual updates.

Background

The hospice portion of the "Medicare Benefit Policy Manual" describes Medicare policies related to eligibility, coverage, payment, some Conditions of Participation, and beneficiary

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cost-sharing. It is based on the hospice regulations found in 42 Code of Federal Regulations (CFR), Part 418, and clarifications made in rulemaking.

In response to industry questions and concerns, the Centers for Medicare & Medicaid Services (CMS) finalized regulations related to discharge in the November 22, 2005, Hospice Care Amendments final rule (70 Federal Register (FR) 70532). These regulations outlined requirements for discharging a patient if the patient or family member(s) became uncooperative or hostile, to the extent that hospice staff could not provide care to the patient, known as discharge-for-cause. This rule also implemented a discharge planning process to deal with the prospect that a patient's condition might stabilize or otherwise change such that the patient can no longer be certified as terminally ill.

In the August 31, 2007, Hospice Wage Index Final Rule (72 FR 50214), CMS clarified the requirements for providing General Inpatient Care (GIP). This clarification occurred as a result of concerns that some hospices were seeking payment for GIP for circumstances where the hospice patient did not meet the criteria given in section 1861(dd)(1)(G) of the Act or in regulation at Section 418.202(e). CMS clarified that to provide GIP care, the intensity of interventions required for pain and symptom management must be such that care cannot be provided in any other setting but an inpatient setting. CMS wrote that a breakdown of caregiver support should not be billed as GIP unless the coverage requirements for GIP have been met.

With passage of the Affordable Care Act in March 2010, Congress required hospice physicians or hospice nurse practitioners to have a face-to-face encounter with Medicare hospice patients prior to the 180th-day recertification and every recertification thereafter, and to attest that the encounter occurred. CMS proposed and implemented policies related to this new requirement in the Home Health Prospective Payment System Rate Update for CY 2011: Changes in Certification Requirements for Home Health Agencies and Hospices Final Rule (75 FR 70372). This new face-to-face encounter requirement became effective on January 1, 2011. In the August 4, 2011, FY 2012 Hospice Wage Index final rule (76 FR 47302), CMS further clarified that any hospice physician could conduct the face-to-face encounter, and that the attestation of the hospice clinician performing the encounter must note that the clinical findings of the visit were provided to the certifying physician, for use in determining continuing eligibility for hospice services.

On March 31, 2008, the Office of Inspector General (OIG) issued a Memorandum Report on March 31, 2008, entitled "Hospice Beneficiaries' Use of Respite Care" (OEI 02-06-00222), which noted that providing respite care to Medicare hospice beneficiaries who reside in nursing facilities is inappropriate.

On October 7, 2011, CMS issued CR 7478, which noted that when a face-to-face encounter is untimely, the beneficiary is not considered terminally ill for Medicare purposes due to lack of recertification, and therefore is not eligible for the hospice benefit. This CR required that a hospice must discharge the patient from the Medicare hospice benefit but can re-admit once the encounter occurs. Where the only reason the patient ceases to be eligible for the

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Medicare hospice benefit is the hospice's failure to meet the face-to-face requirement, CMS expects the hospice to continue to care for the patient at its own expense until the required encounter occurs, enabling the hospice to re-establish Medicare eligibility. CR 7478 is explained in MM7478, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7478.pdf> on the CMS website.

On February 3, 2012, CMS issued CR 7677, which clarified circumstances where discharge for moving outside of a hospice's service area could occur. This CR gave examples, including but not limited to when a hospice patient moves to another part of the country or when a hospice patient leaves the area for a vacation. A discharge may also be appropriate when a hospice patient is receiving treatment for a condition unrelated to the terminal illness or related conditions in a facility with which the hospice does not have a contract, and thus is unable to provide hospice services to that patient. Medicare's expectation is that the hospice provider would consider the amount of time the patient is in that facility, and the effect on the plan of care, before making a determination that discharging the patient from the hospice is appropriate. CR 7677 is explained in MM7677, which is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7677.pdf> on the CMS website.

CR8727 updates the "Medicare Hospice Benefit Policy Manual" to reflect policy changes or policy clarifications made previously through rulemaking, by the OIG, or through other CRs, as noted above. As part of the update, existing payment policy regulation text was also added to the manual if it was missing. Finally, there were a number of edits to update the manual language to reflect new terminology (for example, "managed care" instead of "HMO") or to improve readability (for example, providing a bulleted list of requirements for coverage rather than a paragraph listing of requirements for coverage). Additional edits were made to incorporate previous policy responses to some common questions, such as that the physician narrative may be dictated, or that oral certifications do not need to be signed by the certifying physician. The manual continues to describe existing hospice policy; no policy changes or new policy is included in this manual.

Additional Information

The official instruction, CR 8727, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R188BP.pdf> on the CMS website. The revised Chapter 9 of the manual is part of CR8727.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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