

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



News Flash – If you are a Medicare Fee-For-Service (FFS) physician, provider, or supplier submitting claims to Medicare for payment, this is very important information you need to know. Effective immediately, any Medicare Fee-For-Service claim with a date of service on or after January 1, 2010, must be received by your Medicare contractor no later than one Calendar Year (12 months) from the claim's date of service – or Medicare will deny the claim. For additional information, see Medicare Learning Network (MLN) Matters® Articles MM6960 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6960.pdf> and MM7080 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7080.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. You can also listen to a podcast on this subject by visiting <http://www.cms.gov/Outreach-and-Education/Outreach/CMSFeeds/listofpodcasts.html> on the CMS website.

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Hospice Benefit Policy Manual Update: New Certification Requirements and Revised Conditions of Participation

Note: This article was updated on August 17, 2012, to reflect current Web addresses. It was previously revised on November 8, 2011, to add a reference to MLN Matters® article MM7478 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7478.pdf>) that provides the definition of a timely face-to-face encounter and the consequence of an encounter that does not occur timely. All other information remains the same

Provider Types Affected

This article is for hospice providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or

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Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

What You Need to Know

CR7337, from which this article is taken, announces changes/clarifications in the "Medicare Benefit Policy Manual", including updates to the hospice Conditions of Participation (CoP) section (related to bereavement, the establishment of the plan of care, personnel requirements, physician contracting requirements, core services, and non-core services), and the certification section, along with some minor technical edits.. You should make sure that these clarifications are incorporated into your care of hospice patients.

Background

Under Section 1861(dd) of the Social Security Act (the Act), the Secretary of Health and Human Services is responsible for ensuring that the Conditions of Participation (CoP), and their enforcement are adequate to protect the health and safety of individuals under hospice care. The hospice CoPs were originally published in the Federal Register on December 16, 1983, (48 FR 56008), and were amended on December 11, 1990, (55 FR 50831) largely to implement provisions of Section 6005(b) of the Omnibus Budget Reconciliation Act of 1989; revised CoPs were published in the June 5, 2008, Hospice Conditions of Participation Final Rule (73 FR 32088).

The August 6, 2009, Hospice Wage Index Final Rule (74 FR 39384) required that certifications and re-certifications include a brief narrative describing the clinical basis for the patient's prognosis.

Finally, with passage of the Affordable Care Act in March 2010, Congress required hospice physicians or hospice Nurse Practitioners (NPs) 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. The Centers for Medicare & Medicaid Services (CMS) implemented the policies related to this new requirement (which became effective on January 1, 2011,) in the Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2011; Changes in Certification Requirements for Home Health Agencies and Hospices Final Rule (75 FR 70372).

CR7337, from which this article is taken, announces that Chapter 9 (Coverage of Hospice Services Under Hospital Insurance) of the "Medicare Benefit Policy Manual" is being revised to include the existing policies described above (which were implemented through notice-and-comment rulemaking), and to make a few technical corrections to the manual.

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The manual revisions are attached to CR7337, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R141BP.pdf> on the CMS website. A synopsis of the major manual revisions and technical edits is as follows:

MANUAL REVISIONS

- **Section 20.1 (Timing and Content of Certification)**

Initial certifications may be completed up to 15 days before hospice care is elected, and for the subsequent periods, re-certifications may be completed up to 15 days before the next benefit period begins.

In addition, as of October 1, 2009, physicians must briefly synthesize the clinical information supporting the terminal diagnosis in a narrative, and attest that they composed the narrative after reviewing the clinical information, and where applicable, examining the patient. The certifications or recertifications must be signed and dated by the physician(s), and provide the benefit period dates that the certification or recertification covers.

The physician's brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients. The physician must synthesize the patient's comprehensive medical information in order to compose this brief clinical justification narrative.

The narrative must be included as part of the certification and recertification forms, or as an addendum to the certification and recertification forms. If the narrative is part of the certification or recertification form, it must be located immediately above the physician's signature, or if it is an addendum to the certification or recertification form, (in addition to the physician's signature on the certification or recertification form), the physician must also sign immediately following the narrative in the addendum. In addition, it must include a statement directly above the physician signature attesting that (by signing), the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient.

For recertifications on or after January 1, 2011, a hospice physician or hospice Nurse Practitioner (NP) must have a face-to-face encounter with each hospice patient prior to the beginning of the patient's 3rd benefit period, and prior to each subsequent benefit period. Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement, and the patient would cease to be eligible for the benefit.

Also for recertifications on or after January 1, 2011, the narrative associated with the 3rd benefit period recertification (and every subsequent recertification) must

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include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.

The face to face encounter must meet the following criteria:

1. Timeframe - The encounter must occur no more than 30 calendar days prior to the start of the 3rd benefit period and no more than 30 calendar days prior to every subsequent benefit period thereafter; except as noted in item 4 below.
 2. Attestation requirements - A hospice physician or Nurse Practitioner who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. Where a NP performed the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course.
 3. Practitioners who can perform the encounter - A hospice physician or a hospice NP can perform the encounter. A hospice physician is a physician who is employed by the hospice or working under contract with the hospice, however a hospice Nurse Practitioner must be employed by the hospice. (A hospice employee is one who receives a W-2 from the hospice or who volunteers for the hospice.)
 4. Timeframe for Exceptional Circumstances - In cases where a hospice newly admits a patient who is in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period. For example, if the patient is an emergency weekend admission, it may be impossible for a hospice physician or NP to see the patient until the following Monday. Or, if CMS data systems are unavailable, the hospice may be unaware that the patient is in the third benefit period. In such documented cases, a face to face encounter which occurs within 2 days after admission will be considered to be timely. Additionally, for such documented exceptional cases, if the patient dies within 2 days of admission without a face to face encounter, a face to face encounter can be deemed as complete.
- **Section 40.2.3 – Bereavement Counseling**
Bereavement counseling consists of counseling services provided to the individual's family both *before and after* the individual's death.
 - **Section 40.3 Physician Contracting**
A hospice may contract for physician services as specified in the CoPs. The hospice medical director must supervise all physician employees, as well as those under contract.
 - **Section 40.4 (Core Services)**

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The following are hospice core services:

- Physician services;
- Nursing services, (routinely available and/or on call on a 24-hour basis, 7 days a week) provided by or under the supervision of a Registered Nurse (RN) functioning within a plan of care developed by the hospice Interdisciplinary Group (IDG) in consultation with the patient's attending physician, if the patient has one;
- Medical social services by a qualified social worker under the direction of a physician; and
- Counseling (including, but not limited to, bereavement, dietary, and spiritual counseling) with respect to care of the terminally ill individual and adjustment to death. (The hospice must make bereavement services available to the family and other individuals identified in the bereavement plan of care up to 1 year following the death of the patient.)

Except for physician services, your employees must routinely provide substantially all of the core services, and in a manner consistent with acceptable standards of practice. However, under extraordinary or other non-routine circumstances, you may use contracted staff (if necessary) to supplement your employees in order to meet patients' needs. Arranged services must be supported by written agreements that require that all services be: 1) Authorized by the hospice; 2) Furnished in a safe and effective manner by qualified personnel; and 3) Delivered in accordance with the patient's plan of care. To ensure the provision of quality care, the hospice must retain administrative and financial management, and oversight of all arranged staff and services.

Highly Specialized Nursing Services

You may contract for the services of a registered nurse if the services are highly specialized and provided non-routinely, and so infrequently that the direct provision of such services would be impracticable and prohibitively expensive. Highly specialized services are determined by the nature of the service and the nursing skill level required to be proficient in the service. For example, you may need to contract with a pediatric nurse if you care for pediatric patients infrequently and if employing a pediatric nurse would be impracticable and expensive.

NOTE: Continuous care is not a highly specialized service, because while time intensive, it does not require highly specialized nursing skills.

Waivers for Certain Circumstances

Hospices are prohibited from contracting with other hospices and non-hospice agencies for the provision of the core services of nursing, medical social services and counseling to hospice patients; but may enter into arrangements with another hospice program or other entity for the provision of these core services in extraordinary, exigent, or other non-routine circumstances.

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An extraordinary circumstance would generally be an unanticipated, short-term, temporary event such as periods of high patient loads, caused by an unexpectedly large number of patients requiring continuous care simultaneously, temporary staffing shortages due to illness, receiving patients evacuated from a disaster such as a hurricane or a wildfire, or temporary travel of a patient outside the hospice's service area.

You must maintain evidence of the extraordinary circumstances that required you to contract for the core services and comply with the following:

1. You must ensure that contracted staff is providing care that is consistent with the hospice philosophy and the patient's plan of care and is actively participating in the coordination of all aspects of the patient's hospice care;
2. You may not routinely contract for a specific level of care (e.g., continuous care) or for specific hours of care (e.g., evenings and week-ends); and
3. You must maintain professional management responsibility for all services provided under arrangement or contract at all times and in all settings.

Waiver for Certain Core Nursing Services

The CoPs allow CMS to waive the requirement that a hospice provide nursing services directly, if you are located in a non-urbanized area (as determined by the Bureau of the Census). In seeking this waiver, you must provide evidence to CMS that you have made a good faith effort to hire enough nurses to provide services.

NOTE: The location of a hospice that operates in several areas is considered to be the location of its central office.

• **Section 40.5 (Non-Core Services)**

In addition to the hospice core services (physician services, nursing services, medical social services, and counseling), you must also provide the following services, either directly or under arrangements, to meet the your patients' and their families' needs:

- Physical and occupational therapy and speech-language pathology services;
- Hospice aide services - A hospice aide employed by a hospice, either directly or under contract, must meet the qualifications required by Section 1891(a)(3) of the Social Security Act (http://www.socialsecurity.gov/OP_Home/ssact/title18/1891.htm) and implemented at 42CFR418.76;
- Homemaker services;
- Volunteers;
- Medical supplies (including drugs and biologicals on a 24-hour basis) and the use of medical appliances related to the terminal diagnosis and related conditions; and
- Short-term inpatient care (including respite care and interventions necessary for pain control and acute and chronic symptom management) in a Medicare/Medicaid participating facility.

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Section 1861(dd)(5) of the Social Security Act (http://www.socialsecurity.gov/OP_Home/ssact/title18/1861.htm) allows CMS to permit certain waivers of the requirements that the hospice make physical therapy, occupational therapy, speech language pathology services, and dietary counseling available (as needed) on a 24-hour basis. CMS is also allowed to waive the requirement that hospices provide dietary counseling directly.

As with the waivers mentioned in the section above, these are available only to an agency or organization that is located in an area which is not an urbanized area (as defined by the Bureau of Census) and that can demonstrate to CMS that it has been unable, despite diligent efforts, to recruit appropriate personnel.

MANUAL TECHNICAL EDITS

The following edits to the manual are not policy changes, but rather are technical corrections to manual sections that were either outdated or incorrect:

- Language from 42 CFR 418.24 was added to Section 20.2 to note that in electing the hospice benefit, **the patient should have a full understanding of the palliative rather than curative nature of the treatment;**
- Language in Section 40.1.2 that referred to the “treatment of the patient’s medical condition or to the patient’s rate of recovery” was removed and replaced with language referring to the “palliation and management of the patient’s terminal illness and related conditions;” and two references to the patient’s recovery were removed;
- Policy in Section 40.1.9 describing ambulance transports which occur on the effective date of election was clarified to note that the transports must be to the patient’s home to be covered by the ambulance benefit;
- Example 1.B in Section 40.2.1 was corrected to increase the hours of continuous care provided by a nurse, so that the total Continuous Home Care (CHC) hours were predominantly nursing hours, in keeping with existing CHC policy;
- Outdated language related to the establishment of the plan of care was removed; and
- Terminology was updated throughout the manual, as home health aides are now known as hospice aides, and Licensed Vocational Nurses (LVNs) were not previously mentioned.

Additional Information

You can find more information about the updates to the Hospice Benefit Policies by going to CR7337, located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R141BP.pdf> on the CMS website. You can find the updated “Medicare Benefit Policy Manual,” Chapter 9 as an attachment to that CR.

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If you have any questions, please contact your FI, RHHI, or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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