



Provider Compliance Tips for Hospital Based Hospice



What's Changed?

- Updated the 2020 Medicare Fee-for-Service (FFS) improper payment rate for hospital based hospice programs.

You'll find substantive content updates in dark red font.

Provider Types Affected

Medicare certified hospital based hospice programs

Introduction

This publication educates providers on how to prevent denials for hospital based hospice claims. It outlines certification and re-certification requirements and offers compliance tips to help you keep the correct documents in the medical record.

Background

The Medicare FFS improper payment rate for hospital based hospice programs for the 2020 reporting period is 20.4%; accounting for 1.2% of the overall Medicare FFS improper payment rate in 2020. The projected improper payment amount for hospital-based hospice during the 2020 reporting period is \$325.9 million.

Reasons for Denial

For the 2020 reporting period, insufficient documentation accounts for 90.9% of hospital based hospice improper payments. Other types of errors found for hospital based hospice claims in the 2020 reporting period:

- Incorrect coding (44.4%)
- Medical necessity (4.8%)

How to Prevent Denials

When billing Medicare for hospital based hospice services, remember the following certification requirements:

- The hospice must get written certification of terminal illness for each of the election periods listed in [42 CFR 418.21](#), even if a single election continues in effect for an unlimited number of periods.
- If the hospice can't get written certification within 2 calendar days, it must get oral certification within 2 calendar days. The hospice must get written certification before it submits a claim for payment.
- Payment normally begins with the effective date of election, which is the same date as the admission date. If the Medicare provider forgets to date the certification, the hospice can get a notarized statement or some other acceptable document from the Medicare provider verifying the certification date.
- For the initial 90-day period, the hospice must get written certification statements (and oral certification statements) from:
 - The hospice medical director physician member of the hospice interdisciplinary group.
 - The patient's attending physician, if the patient has an attending physician. (The attending physician must meet the definition of physician specified in [42 CFR 410.20](#)) Don't complete certifications more than 15 calendar days before the effective date of election. Don't complete re-certifications more than 15 calendar days before the start of the next benefit period.
 - For the next periods, the hospice may complete re-certifications up to 15 days before the next benefit period begins. For later periods, the hospice must get a written certification statement from the hospice medical director or the Medicare provider member of the hospice's interdisciplinary group (no later than 2 calendar days after the first day of each period. If the hospice can't get written certification within 2 calendar days, it must get oral certification within 2 calendar days.
 - The hospice must get written certification of terminal illness for each benefit period, even if a single election continues in effect.
 - The hospice must file a written certification in the patient's record before submission of a claim to the A/B Medicare Administrative Contractor (MAC), Home Health and Hospice (HHH). The hospice must file clinical information and other documentation that support the medical prognosis in the medical record with the written certification. Initially, the hospice physician may give the clinical information verbally, then document it in the medical record and include it as part of the hospice's eligibility assessment.

A complete written certification must include:

1. A statement that the patient's life expectancy is 6 months or less if the terminal illness runs its normal course
2. Specific clinical findings and other documentation supporting a life expectancy of 6 months or less
3. The signature(s) of the Medicare provider(s), the date signed, and the benefit period dates that the certification or recertification covers
4. As of October 1, 2009, the Medicare provider's brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less 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, then the narrative must be located immediately above the Medicare provider's signature.
 - If the narrative exists as an addendum to the certification or recertification form, also to the Medicare provider's signature on the certification or recertification form, the Medicare provider must also sign immediately following the narrative in the addendum.
 - The narrative must include a statement directly above the Medicare provider signature attesting that by signing, the Medicare provider confirms that they composed the narrative based on their review of the patient's medical record or, if applicable, their examination of the patient. The Medicare provider may dictate the narrative.
 - The narrative must show the patient's individual clinical circumstances and can't contain check boxes or standard language used for all patients. The Medicare provider must combine the patient's comprehensive medical information to compose this brief clinical justification narrative.
 - For re-certifications on or after January 1, 2011, the narrative associated with the third benefit period recertification and every following recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.
5. Face-to-face encounter. (See below for more requirements related to the face-to-face encounter.)

Face-to-Face Encounters

For re-certifications on or after January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient before the beginning of the patient's third benefit period and before each following benefit period. Failure to meet the face-to-face encounter requirements listed in the [Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services under Hospital Insurance](#) - Coverage of Hospice Services under Hospital Insurance means the hospice fails to meet the patient's recertification of terminal illness eligibility requirement, resulting in the patient is no longer eligible for the benefit.

When billing Medicare for hospital based hospice services, remember:

- If the re-certification requires a face-to-face encounter, and documentation of the encounter is missing, the re-certification isn't complete. The statute requires a complete certification or recertification for Medicare to cover and pay for hospice services.

- If the patient is no longer eligible for the Medicare hospice benefit because the hospice didn't meet the face-to-face requirement, Medicare expects the hospice to discharge the patient from the Medicare hospice benefit. The hospice must continue to care for the patient at its own expense until the required encounter occurs, allowing the hospice to re-establish Medicare eligibility. The hospice can re-admit the patient to the Medicare hospice benefit once the required encounter occurs if the patient continues to meet all eligibility requirements and the patient (or representative) files an election statement in accordance with CMS regulations.
- The hospice must file written certification statements and keep them in the medical record. Hospice staff must make a proper entry in the patient's medical record as soon as they get an oral certification.

Resources

- [42 CFR Section 418.21](#)
- [2020 Medicare Fee-for-Service Supplemental Improper Payment Data](#)
- [Medicare Benefit Policy Manual, Chapter 9](#)

The Center for Program Integrity/ Provider Compliance Group Policy Disclaimer

[Contact your MAC](#) for any updates or changes to the Policy Article (PA) and the Local Coverage Determination (LCD) regarding policy and general documentation requirements.

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