

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 188	Date: May 1, 2014
	Change Request 8727

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

I. SUMMARY OF CHANGES: To update the hospice policy chapter 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.

EFFECTIVE DATE: August 4, 2014

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: August 4, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	9/Table of Contents
R	9/10/Requirements - General
R	9/20.1/Timing and Content of Certification
R	9/20.2/Election, Revocation, and Change of Hospice
R	9/20.2.1/Hospice Discharge
R	9/20.4/Election by Managed Care Enrollees
R	9/30.1/Drugs and Biologicals Coinsurance
R	9/30.2/Respite Care Coinsurance
R	9/40/Benefit Coverage
R	9/40.1.1/Nursing Care
R	9/40.1.3/Physicians' Services
R	9/40.1.3.2/Nurse Practitioners as Attending Physicians
R	9/40.1.5/Short-Term Inpatient Care
R	9/40.1.6/Medical Appliances and Supplies

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	9/40.1.9/Other Items and Services
R	9/40.2.1/Continuous Home Care (CHC)
R	9/40.2.2/Respite Care
R	9/40.2.4/Special Modalities
R	9/40.5/Non-core Services
R	9/50/Limitation on Liability for Certain Hospice Coverage Denials
R	9/80.1/Documentation
R	9/90.1/Limitations on Payments for Inpatient Care
R	9/90.2.3/Counting Beneficiaries for Calculation
R	9/90.2.5/Other Issues

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

Pub. 100-02	Transmittal: 188	Date: May 1, 2014	Change Request: 8727
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SUBJECT: Updates and Clarifications to the Hospice Policy Chapter of the Benefit Policy Manual

EFFECTIVE DATE: August 4, 2014

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I. GENERAL INFORMATION

A. Background: Chapter 9 of the Medicare Benefit Policy Manual describes Medicare hospice policies related to eligibility, coverage, payment, some Conditions of Participation, and beneficiary cost-sharing. It is based on the hospice regulations found in 42 CFR, Part 418, and clarifications made in rulemaking.

In response to industry questions and concerns, CMS finalized regulations related to discharge in the November 22, 2005, Hospice Care Amendments final rule (70 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 §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 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 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.

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.

B. Policy: Chapter 9 of the Medicare Benefit Policy Manual has been updated to reflect hospice policy changes or policy clarifications made previously through rulemaking, by the OIG, or through other Change Requests, as noted above. As part of the update, existing payment policy regulation text was also added to the chapter if it was missing. Finally, there were a number of edits to update the chapter 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 chapter continues to describe existing hospice policy; no policy changes or new policy is included in this chapter.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								Other
		A/B MAC			D M E M A C	Shared- System Maintainers				
		A	B	H H H		F I S S	M C S	V M S	C W F	
8727.1	Medicare contractors shall make providers aware of the hospice policy updates and clarifications to chapter 9 of the Medicare Benefit Policy Manual provided in the updated sections attached to this instruction.	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
8727.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Katherine Lucas, 410-786-7723 or katherine.lucas@cms.hhs.gov, Hillary Loeffler, 410-786-0456 or hillary.loeffler@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and

immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Benefit Policy Manual

Chapter 9 - Coverage of Hospice Services Under Hospital Insurance

Table of Contents *(Rev. 188, 05-01-14)*

20.4 - Election by *Managed Care* Enrollees

50 - Limitation on Liability for Certain Hospice Coverage Denials

10 - Requirements - General

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

Hospice care is a benefit under the hospital insurance program. To be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is 6 months or less if the illness runs its normal course. *Only care provided by (or under arrangements made by) a Medicare certified hospice is covered under the Medicare hospice benefit.*

The hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician (if any).

In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:

- (1) Diagnosis of the terminal condition of the patient.*
- (2) Other health conditions, whether related or unrelated to the terminal condition.*
- (3) Current clinically relevant information supporting all diagnoses.*

Section §1814(a)(7) of the Social Security Act (the Act) specifies that certification of terminal illness for hospice benefits shall be based on the clinical judgment of the hospice medical director or physician member of the interdisciplinary group (IDG) and the individual's attending physician, if he/she has one, regarding the normal course of the individual's illness. No one other than a medical doctor or doctor of osteopathy can certify or re-certify a terminal illness. Predicting of life expectancy is not always exact. The fact that a beneficiary lives longer than expected in itself is not cause to terminate benefits. "Attending physician" is further defined in section 20.1 and 40.1.3.1.

An individual (or his authorized representative) must elect hospice care to receive it. The first election is for a 90-day period. An individual may elect to receive Medicare coverage for two 90-day periods, and an unlimited number of 60-day periods. If the individual (or authorized representative) elects to receive hospice care, he or she must file an election statement with a particular hospice. Hospices obtain election *statements* from the individual and *file a Notice of Election with* the Medicare contractor, which transmits them to the Common Working File (CWF) in electronic format. Once the initial election is processed, CWF maintains the beneficiary in hospice status until *a final claim indicates a discharge (alive or due to death)* or until an election termination is received.

For the duration of the election of hospice care, an individual must waive all rights to Medicare payments for the following services:

- Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice); and

- Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition, or services that are equivalent to hospice care, except for services provided by:
 1. The designated hospice (either directly or under arrangement);
 2. Another hospice under arrangements made by the designated hospice; or
 3. The individual's attending physician, who may be a nurse practitioner (NP), if that physician or nurse practitioner is not an employee of the designated hospice or receiving compensation from the hospice for those services.

Medicare services for a condition completely unrelated to the terminal condition for which hospice was elected remain available to the patient if he or she is eligible for such care.

20.1 - Timing and Content of Certification

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

For the first 90-day period of hospice coverage, the hospice must obtain, no later than 2 calendar days after hospice care is initiated, (that is, by the end of the third day), oral or written certification of the terminal illness by the medical director of the hospice or the physician member of the hospice IDG, and the individual's attending physician if the individual has an attending physician.

The attending physician is a doctor of medicine or osteopathy *who is legally authorized to practice medicine or surgery by the state in which he or she performs that function*, or a nurse practitioner, 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. A nurse practitioner is defined as a registered nurse who performs such services as legally authorized to perform (in the state in which the services are performed) in accordance with State law (or State regulatory mechanism provided by State law) and who meets training, education, and experience requirements described in 42 CFR 410.75.

Note that a rural health clinic or federally qualified healthcare clinic (FQHC) physician can be the patient's attending physician but may only bill for services as a physician under regular Part B rules. These services would not be considered *rural health clinic* or FQHC services or claims (e.g., the physicians do not bill under the *rural health clinic* provider number but they bill under their own provider number).

Initial certifications may be completed up to 15 days before hospice care is elected. *Payment normally begins with the effective date of election, which is the same as the admission date.* If the physician forgets to date the certification, a notarized statement or

some other acceptable documentation can be obtained to verify when the certification was obtained.

For the subsequent periods, recertifications may be completed up to 15 days before the next benefit period begins. For subsequent periods, the hospice must obtain, no later than 2 calendar days after the first day of each period, a written certification statement from the medical director of the hospice or the physician member of the hospice's IDG. If the hospice cannot obtain written certification within 2 calendar days, it must obtain oral certification within 2 calendar days. *When making an oral certification, the certifying physician(s) should state that the patient is terminally ill, with a prognosis of 6 months or less. Because oral certifications are an interim step sometimes needed while all the necessary documentation for the written certification is gathered, it is not necessary for the physician to sign the oral certification. Hospice staff must make an appropriate entry in the patient's medical record as soon as they receive an oral certification.*

The hospice must obtain written certification of terminal illness for each benefit period, even if a single election continues in effect.

A written certification must be on file in the hospice patient's record prior to submission of a claim to the Medicare contractor. *Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification. Initially, the clinical information may be provided verbally, and must be documented in the medical record and included as part of the hospice's eligibility assessment.*

A complete written certification must include:

1. the statement that the individual's medical prognosis is that their 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 physician(s), the date signed, and the benefit period dates that the certification or recertification covers (*for more on signature requirements, see Pub. 100-08, Medicare Program Integrity Manual, chapter 3, section 3.3.2.4*).
4. as of October 1, 2009, the physician'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 physician's signature.

- If the narrative exists as 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.
- The narrative shall 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. *The physician may dictate the narrative.*
- The narrative 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.
- For recertifications on or after January 1, 2011, the narrative associated with the third benefit period recertification and every subsequent 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. For recertifications on or after January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient prior to the beginning of the patient's third benefit period, and prior to each subsequent benefit period. Failure to meet the face-to-face encounter requirements specified in this section results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement. The patient would cease to be eligible for the benefit.

The face to face encounter requirement is satisfied when the following criteria are met:

- a. Timeframe of the encounter: The encounter must occur *prior to the recertification for the third benefit period and each subsequent benefit period.* The encounter must occur no more than 30 calendar days *before* the third benefit period *recertification* and *each subsequent recertification.* *A face-to-face encounter may occur on the first day of the benefit period and still be considered timely.* (Refer to section 20.1.5.d below for an exception to this timeframe).
- b. 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 nurse practitioner *or non-certifying hospice physician* 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.

c. Practitioners who can perform the encounter: A hospice physician or a hospice nurse practitioner can perform the encounter. A hospice physician is a physician who is employed by the hospice or working under contract with the hospice. 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. *If the hospice is a subdivision of an agency or organization, an employee of that agency or organization assigned to the hospice is also considered a hospice employee. Physician Assistants (PAs), clinical nurse specialists, and outside attending physicians are not authorized by section 1814(a)(7)(D)(i) of the Act to perform the face-to-face encounter for recertification.*

d. Timeframe exceptional circumstances for new hospice admissions in the third or later benefit period: 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.

Recertifications that require a face-to-face encounter but which are missing the encounter are not complete. The statute requires a complete certification or recertification in order for Medicare to cover and pay for hospice services. Where the only reason the patient ceases to be eligible for the Medicare hospice benefit is the hospice's failure to meet the face-to-face requirement, Medicare would expect the hospice to discharge the patient from the Medicare hospice benefit, but to continue to care for the patient at its own expense until the required encounter occurs, enabling the hospice to re-establish Medicare eligibility. The hospice can re-admit the patient to the Medicare hospice benefit once the required encounter occurs, provided the patient continues to meet all of the eligibility requirements and the patient (or representative) files an election statement in accordance with CMS regulations.

The hospice must *file written* certification statements and retain them *in the medical record*. *Hospice staff must make an appropriate entry in the patient's medical record as soon as they receive an oral certification.*

These requirements also apply to individuals who had been previously discharged during a benefit period and are being recertified for hospice care.

20.2 - Election, Revocation, and Change of Hospice

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

Each hospice designs and prints its election statement. The election statement must include the following items of information:

- Identification of the particular hospice that will provide care to the individual;
- The individual's or representative's (as applicable) acknowledgment that the individual has been given a full understanding of hospice care, particularly the palliative rather than curative nature of treatment;
- The individual's or representative's (as applicable) acknowledgment that the individual understands that certain Medicare services are waived by the election;
- The effective date of the election, *which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive;* and
- The signature of the individual or representative.

An election to receive hospice care will 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:

- (1) Remains in the care of a hospice;*
- (2) Does not revoke the election; and*
- (3) Is not discharged from the hospice.*

For Medicare payment purposes, an election for Medicare hospice care must be made on or after the date that the hospice provider is Medicare-certified. As with any election, the hospice must fulfill all other admission requirements, such as certification or recertification, any required face-to-face encounters, or CoP assessments. See also Pub. 100-04, Medicare Claims Processing Manual, chapter 11, section 20.1.1.

An individual or representative may revoke the election of hospice care at any time in writing, *however a hospice cannot "revoke" a patient's election.* To revoke the election of hospice care, the individual must file a document with the hospice that includes:

- A signed statement that the individual revokes the election for Medicare coverage of hospice care for the remainder of that election period and

- The effective date of that revocation. An individual may not designate an effective date earlier than the date that the revocation is made.

Note that a verbal revocation of benefits is NOT acceptable. The individual forfeits hospice coverage for any remaining days in that election period.

Upon revoking the election of Medicare coverage of hospice care for a particular election period, *the individual is no longer covered under the Medicare hospice benefit, and resumes Medicare coverage of the benefits waived when hospice care was elected. An individual may at any time elect to receive hospice coverage for any other hospice election periods that he or she is eligible to receive.*

An individual may change, once in each election period, the designation of the particular hospice from which he or she elects to receive hospice care. The change of the designated hospice is not considered a revocation of the election, *but is a transfer*. To change the designation of hospice programs, the individual must file, with the hospice from which he or she has received care and with the newly designated hospice, a signed statement that includes the following information:

- the name of the hospice from which the individual has received care,
- the name of the hospice from which they plan to receive care, and
- the date the change is to be effective.

As described in Pub. 100-04, Medicare Claims Processing Manual, chapter 11, section 20.1.1, when a hospice patient transfers to a new hospice, the receiving hospice must file a new Notice of Election; however, the benefit period dates are unaffected. The receiving hospice must complete all assessments required by the hospice conditions of participation as described in 42 CFR 418.54. Because the benefit period does not change in a transfer situation, if the patient is in the third or later benefit period and transfers hospices, a face-to-face encounter is not required if the receiving hospice can verify that the originating hospice had the encounter.

A change of ownership of a hospice is not considered a change in the patient's designation of a hospice and requires no action on the patient's part.

Medicare beneficiaries enrolled in managed care plans may elect hospice benefits. Federal regulations require that the Medicare contractor assigned the hospice specialty workload maintain payment responsibility for hospice services and may pay for other claims if that contractor is the geographically assigned Medicare contractor for the managed care enrollees who elect hospice; for specifics, see regulations at 42 CFR 417, Subpart P, 417.585, Special Rules: Hospice Care (b), and 42 CFR 417.531 Hospice Care Services (b). Institutional claims for services not related to the terminal illness would otherwise be the responsibility of another geographically assigned Medicare contractor.

Managed care enrollees who have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors as if the

beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice was revoked. As specified above, by regulation, the duration of payment responsibility by fee-for-service contractors extends through the remainder of the month in which hospice is revoked by hospice beneficiaries.

See Pub. 100-04, Medicare Claims Processing Manual, Chapter 2, “Admission and Registration” and Chapter 11, “Processing Hospice Claims,” for requirements for hospice reporting to the Medicare contractor.

20.2.1 - Hospice Discharge

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

The hospice notifies the Medicare contractor of *any* discharge so that hospice services and billings are terminated as of that date. *Upon discharge*, the patient loses the remaining days in the benefit period. However, there is no increased *d* cost to the beneficiary. General coverage under Medicare is reinstated at the time the patient revokes the benefit or is discharged.

Once a hospice chooses to admit a Medicare beneficiary, it may not automatically or routinely discharge the beneficiary at its discretion, even if the care promises to be costly or inconvenient, or the State allows for discharge under State requirements. The election of the hospice benefit is the beneficiary’s choice rather than the hospice’s choice, and the hospice cannot revoke the beneficiary’s election. Neither should the hospice request or demand that the patient revoke his/her election.

In most situations, discharge from a hospice will occur as a result of one *of* the following:

- The beneficiary decides to revoke the hospice benefit;
- The beneficiary transfers to another hospice;
- The beneficiary dies;
- The beneficiary moves *out of* the geographic area that the hospice defines in its policies as its service area. *Some examples of moving out of the hospice’s service area include, but are 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. Another example would be 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 the hospice is unable to access the patient to provide hospice services. In this example, 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;*

- The beneficiary's condition improves and he/she is no longer considered terminally ill. In this situation, the hospice will be unable to recertify the patient. *The beneficiary can ask the Quality Improvement Organization (QIO) for an expedited review of the discharge (see Pub. 100-04, chapter 30, section 260 for more information); or*
- *Discharge for cause*: There may be extraordinary circumstances in which a hospice would be unable to continue to provide hospice care to a patient. These situations would include issues where patient safety or hospice staff safety is compromised. *When a hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired, the hospice can consider discharge for cause. The hospice must do the following before it seeks to discharge a patient for cause:*
 - *Advise the patient that a discharge for cause is being considered;*
 - *Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation;*
 - *Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and*
 - *Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into the patient's medical records.*

The hospice must notify the Medicare contractor and State Survey Agency of the circumstances surrounding the impending discharge. The hospice may also need to make referrals to other relevant state/community agencies (i.e., Adult Protective Services) as appropriate.

Discharge order: Prior to discharging a patient for any reason other than a patient revocation, transfer, or death, the hospice must obtain a written physician's discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.

Effect of discharge: An individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice—

- *Is no longer covered under Medicare for hospice care;*
- *Resumes Medicare coverage of the benefits waived; and*
- *May at any time elect to receive hospice care if he or she is again eligible to receive the benefit.*

Discharge planning: The hospice must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.

The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

Once a patient is no longer considered terminally ill with a life expectancy of 6 months or less if the disease runs its normal course, Medicare coverage and payment for hospice care should cease. Medicare does not expect that a discharge would be the result of a single moment that does not allow time for some post-discharge planning. Rather, it would be expected that the hospice's interdisciplinary group is following the patient, and if there are indications of improvement in the individual's condition such that hospice may soon no longer be appropriate, then planning should begin. If the patient seems to be stabilizing, and the disease progression has halted, then it could be the time to begin preparing the patient for alternative care. Discharge planning should be a process, and planning should begin before the date of discharge.

In some cases, the hospice must provide Advanced Beneficiary Notification (ABN) or a Notice of Medicare Non-Coverage (NOMNC) to patients who are being discharged. See Pub. 100-04, Medicare Claims Processing Manual, Chapter 30 "Financial Liability Protections", Section 50.15.3.1, for information on these requirements.

20.4 - Election by *Managed Care* Enrollees

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

A managed care enrollee may elect the hospice benefit. After the hospice election, Medicare pays the hospice for hospice services and pays for services of the managed care attending physician, who may be a nurse practitioner, (as defined in section 20.1 of this chapter) and services not related to the patient's terminal illness, through the fee-for-service system. (See 42 CFR 417.531 and 417.585.) Once under a hospice election, a managed care patient may also choose to use a provider outside of his or her managed care organization for care unrelated to the terminal illness or related conditions, or as the attending physician. See Pub. 100-04, Medicare Claims Processing Manual, chapter 11, section 40 for requirements for physician billing.

Once a managed care enrollee has elected hospice, all his or her Medicare benefits revert to fee-for-service, though the enrollee still remains on managed care for any additional benefits provided by his or her managed care plan, such as dental or vision coverage. The Medicare hospice benefit, through fee-for-service Medicare, covers all hospice care from the effective date of election to the date of discharge or revocation. During the election, fee-for-service Medicare also covers attending physician services and all care unrelated to the terminal illness. Upon discharge or revocation, fee-for-service Medicare continues to cover the beneficiary through the end of the month when the beneficiary revokes or is discharged from hospice alive. At the start of the month

following revocation or discharge, all billing and coverage revert back to the managed care plan (see Pub 100-04, Medicare Claims Processing Manual, chapter 11, §30.4).

30.1 - Drugs and Biologicals Coinsurance

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

Hospices are to provide all drugs and biologicals for the palliation and management of pain and symptoms of a patient's terminal illness and related conditions. An individual is liable for a coinsurance payment for each palliative drug and biological prescription furnished by the hospice while the individual is receiving routine home care or continuous home care. The individual is not liable for any coinsurance for hospice-related drugs or biologicals provided while he or she is receiving general inpatient care or respite care.

The amount of coinsurance for each prescription approximates 5 percent of the cost of the drug or biological to the hospice, determined in accordance with the drug copayment schedule established by the hospice, except that the amount of coinsurance for each prescription may not exceed \$5.00. The cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances. The drug copayment schedule must be periodically reviewed for reasonableness and approved by the Medicare contractor before it is used.

30.2 - Respite Care Coinsurance

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

The amount of coinsurance for each respite care day is equal to 5 percent of the payment made by *Medicare* for a respite care day. The amount of the individual's coinsurance liability for respite care during a hospice coinsurance period may not exceed the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began.

The individual hospice coinsurance period begins on the first day an election is in effect for the beneficiary and ends with the close of the first period of 14 consecutive days on each of which an election is not in effect for the beneficiary.

Thus, if a beneficiary *receives hospice care for* three election periods consecutively (without a 2-week break), *he or she is* subject to a maximum coinsurance for respite care equal to the hospital inpatient deductible. Similarly, if a break between election periods exceeds 14 days, the maximum coinsurance for respite care doubles, triples, or quadruples (depending on the number of election periods used and the timing of subsequent elections).

EXAMPLE: Mr. Brown elected an initial 90-day period of hospice care. Five days after the initial period of hospice care ended, he began another period of hospice care under a subsequent election. Immediately after the period ended, he began a third period of hospice care. Mr. Brown received inpatient respite care during all three periods of

hospice care. Since these election periods were not separated by 14 consecutive days, they constitute a single hospice coinsurance period. Therefore, a maximum coinsurance for respite care during all three periods of hospice care may not exceed the amount of the inpatient hospital deductible for the year in which the first period began.

40 - Benefit Coverage

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

To be covered, hospice services must meet all of the following requirements:

- They must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions; and*
- The individual must elect hospice care in accordance with sections 20.2 – 20.4 of this chapter; and*
- A plan of care must be established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary group of the hospice program; and*
- That plan of care must be established before hospice care is provided; and*
- The services provided must be consistent with the plan of care; and*
- A certification that the individual is terminally ill must be completed as set forth in section 20.1 of this chapter.*

A nurse practitioner serving as an attending physician should participate as a member of the IDG that establishes and/or updates the individual's plan of care. The nurse practitioner may not serve as or replace the medical director or physician designee.

All services provided by the hospice must be in accordance with a patient's individualized plan of care that is established and updated by the hospice interdisciplinary group, in consultation with the patient's attending physician (if any). The individualized plan of care is a continually evolving document. As such, Medicare expects the plan of care to be initiated based upon the information gathered in the patient's initial assessment, and the plan of care will be expanded upon, as appropriate, based on the information that is gathered during the comprehensive assessment.

Provided the above coverage criteria are met, hospices are paid a per diem rate based on the number of days and level of care provided during the election period. Levels of care are defined as:

- Routine home care (refer to §40.2.1); A routine home care day is a day on which an individual who has elected to receive hospice care is at home and is not receiving continuous home care.*

- Continuous home care (refer to §40.2.1); *A continuous home care day is a day on which an individual who has elected to receive hospice care is not in an inpatient facility (hospital, SNF, or hospice inpatient unit) and receives hospice care consisting predominantly of nursing care on a continuous basis at home. Hospice aide or homemaker services or both may also be provided on a continuous basis. Continuous home care is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill patient at home.*
- Inpatient respite care (refer to §40.1.5 and §40.2.2); *An inpatient respite care day is a day on which the individual who has elected hospice care receives care in an approved facility on a short-term basis for respite.*
- General inpatient care (refer to §40.1.5); *A general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.*

Hospices are expected to furnish the following services to the extent specified by the plan of care for the individual. The categories listed above are used in billing to describe the acuity of the services furnished. See Pub. 100-04, Medicare Claims Processing Manual, Chapter 11, “Processing Hospice Claims,” for a description of billing procedures.

40.1.1 - Nursing Care

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

To be covered as nursing services, the services must require the skills of a registered nurse (*RN*), *or* a licensed practical nurse (LPN) or a licensed vocational nurse (LVN) under the supervision of a registered nurse, and must be reasonable and necessary *for the palliation and management of the patient’s terminal illness and related conditions.*

Services provided by a nurse practitioner (NP) who is not the patient’s attending physician, are included under nursing care. This means that, in the absence of an NP, *an RN, LPN, or LVN* would provide the service. Since the services are nursing, payment is encompassed in the hospice per diem rate and may not be billed separately regardless of whether the services are provided by an NP or an RN. The following are examples of some services that traditionally are provided by an RN, which could also be provided by an NP, for which separate payment is not made:

- a. A patient with a terminal *illness* of lung cancer complains of leg pain. In the absence of an NP, an RN would assess the patient.
- b. Assessment of pain and or symptoms *to determine* the need for medications, other treatments, continuous home care, general inpatient care etc. In the absence of an NP, an RN would assess the patient.

- c. Administration of medications through intravenous (e.g., PICC, central, etc.), intrathecal or any other means. In the absence of an NP, an RN would administer the medication.
- d. Family counseling. In the absence of an NP, an RN, social worker or counselor would provide this service.
- e. Providing a home visit for assessment or provision of care to a patient who is not his/her patient. In the absence of the NP, the service would be provided by an RN, LPN or LVN. Therefore, the NP cannot bill separately for the service.

40.1.3 - Physicians' Services

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

A physician must perform physicians' services (as defined in 42 CFR 410.20(b)(1)(1)), except that the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy. Nurse practitioners may not serve as a medical director or as the physician member of the interdisciplinary group. Nurse practitioners may not bill for medical services other than those described in 40.1.3.2.

The hospice face-to-face encounter is an administrative requirement related to certifying the terminal illness as required in §1814(a)(7)(D)(i) of the Social Security Act (the Act). By itself, it is not billable, as it is considered administrative (see Pub. 100-04, Medicare Claims Processing Manual, chapter 11, §40.1.1). However, if a hospice physician, or a hospice nurse practitioner who is also the patient's attending physician, provides reasonable and necessary non-administrative patient care during the face-to-face visit, that portion of the visit would be billable. See section 40.1.3.2 below for additional requirements for billing physician services provided by NPs.

40.1.3.2 - Nurse Practitioners as Attending Physicians

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

A nurse practitioner is defined as a registered nurse who is permitted to perform such services as legally authorized to perform (in the state in which the services are performed) in accordance with State law (or State regulatory mechanism provided by State law) and who meets training, education and experience requirements described in 42 CFR 410.75.

If a beneficiary does not have an attending physician or a nurse practitioner who has provided primary care prior to or at the time of the terminal *illness*, the beneficiary may choose to be served by either a physician or a nurse practitioner who is employed by the hospice. The beneficiary must be provided with a choice of a physician or a nurse practitioner.

Medicare pays for attending physician services provided by nurse practitioners to Medicare beneficiaries who have elected the hospice benefit and who have selected a nurse practitioner as their attending physician. This applies to nurse practitioners without regard to whether they are hospice employees.

Physician services provided by nurse practitioners may be billed to Medicare only if the:

- *Nurse practitioner is the beneficiary's designated attending physician; and*
- *Services are medically reasonable and necessary; and*
- *Services are performed by a physician in the absence of the nurse practitioner; and*
- *Services are not related to the certification of terminal illness.*

If the nurse practitioner is employed by the hospice, the hospice can bill Part A for physician services meeting the above criteria on a hospice claim. If the nurse practitioner is not employed by the hospice, the nurse practitioner can bill Part B for physician services meeting the above criteria.

Payment for nurse practitioner services is made at 85 percent of the physician fee schedule amount. Services that are duplicative of what the hospice nurse would provide are not separately billable.

Nurse practitioners cannot certify a terminal *illness* or the prognosis of 6 months or less, if the illness or disease runs its normal course, or re-certify terminal *illness* or prognosis. In the event that a beneficiary's attending physician is a nurse practitioner, the hospice medical director and/or physician designee may certify the terminal illness.

Hospice nurse practitioners may conduct face-to-face encounters as described in §20.1(5) as part of the certification process, but are still prohibited by statute from certifying the terminal illness.

40.1.5 - Short-Term Inpatient Care

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

Short-term inpatient care may be provided in a participating *hospital*, hospice inpatient unit, or a participating SNF or NF that additionally meets the special hospice standards regarding patient and staffing areas. Medicare payment cannot be made for inpatient hospice care provided in a VA facility to Medicare beneficiaries eligible to receive Veteran's health services. Services provided in an inpatient setting must conform to the written plan of care. However, dually eligible veterans residing at home in their community may elect the Medicare hospice benefit. See §60.

Medicare covers two levels of inpatient care: respite care for relief of the patient's caregivers, and general inpatient care which is for pain control and symptom management. *General inpatient care (GIP) may only be provided in a Medicare participating hospital, SNF, or hospice inpatient facility. Respite care may only be*

provided in a Medicare participating hospital or hospice inpatient facility, or a Medicare or Medicaid participating nursing facility.

General inpatient care *is allowed when the patient's medical condition warrants a short-term inpatient stay for* pain control or acute or chronic symptom management that cannot feasibly be provided in other settings.

General inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit. For example, a brief period of general inpatient care may be needed in some cases when a patient elects the hospice benefit at the end of a covered hospital stay. If a patient in this circumstance continues to need pain control or symptom management, which cannot be feasibly provided in other settings while the patient prepares to receive hospice home care, general inpatient care is appropriate.

Other examples of appropriate general inpatient care include a patient in need of medication adjustment, observation, or other stabilizing treatment, such as psycho-social monitoring. *It is not appropriate to bill Medicare for general inpatient care days for situations where the individual's caregiver support has broken down unless the coverage requirements for the general inpatient level of care are otherwise met. For a hospice to provide and bill for the general inpatient level of care, the patient must require an intensity of care directed towards pain control and symptom management that cannot be managed in any other setting.*

Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons who normally care for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than 5 consecutive days at a time. Payment for the sixth and any subsequent day of respite care is made at the routine home care rate, and the patient would be liable for room and board. Respite care cannot be provided to hospice patients who reside in a facility (such as a long term care nursing facility). Provision of respite care depends upon the needs of the patient and of the patient's caregiver, within the limitations given.

Several examples of appropriate respite care for a patient who does not reside in a facility include providing a few days for the caregiver to rest at home, to visit family, attend a wedding, or attend a graduation for a needed break, or providing a few days immediately following a GIP stay if the usual caregiver has fallen ill. See also, section 40.2.2.

Note that hospice inpatient care in an SNF or NF serves to prolong current benefit periods for general Medicare hospital and SNF benefits. This could potentially affect patients who revoke the hospice benefit.

If a hospice patient receives general inpatient care for 3 days or more *in a hospital*, and *chooses* to revoke hospice, then the 3 day stay (although not equivalent to a hospital level of care) would still qualify the beneficiary for covered SNF services.

40.1.6 - Medical Appliances and Supplies

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

Medical appliances and supplies may be provided, including drugs and biologicals. Only drugs as defined in §1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. *This includes both prescription and over-the-counter drugs as defined in §1861(t) of the Act.* Appliances may include covered durable medical equipment as described in 42 CFR 410.38 as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while the patient is under hospice care. Medical supplies include those that are part of the written plan of care *and that are for palliation and management of the terminal illness or related conditions.*

40.1.9 - Other Items and Services

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

Any other item or service which is included in the plan of care and for which payment may otherwise be made under Medicare, in accordance with title XVIII of the Social Security Act, is a covered service under the Medicare hospice benefit. The hospice is responsible for providing any and all services indicated in the plan of care as *reasonable and* necessary for the palliation and management of the terminal illness and related conditions.

The hospice Interpretive Guidelines for 42 CFR 418.54(a), published via a Survey and Certification letter (S & C 09-19, Advance Copy-Hospice Program Interpretive Guidance Version 1.1), require that the initial assessment be conducted in the location where hospice services will be provided. The plan of care is developed from that initial assessment and from the comprehensive assessment. Ambulance transports to a patient's home which occur on the effective date of the hospice election (i.e., the date of admission), would occur prior to the initial assessment and therefore prior to the plan of care's development. As such, these transports are not the responsibility of the hospice. Medicare will pay for ambulance transports of hospice patients to their home, which occur on the effective date of hospice election, through the ambulance benefit rather than through the hospice benefit. Ambulance transports of a hospice patient, which are related to the terminal *illness* and which occur after the effective date of election, are the responsibility of the hospice.

EXAMPLE:

A hospice determines that an existing patient's condition has worsened and has become medically unstable. An inpatient stay will be necessary for proper palliation and management of the condition. The hospice adds this inpatient stay to the plan of care and decides that, due to the patient's fragile condition, the patient will need to be transported

to the hospital by ambulance. In this case, the ambulance service becomes a covered hospice service.

40.2.1 - Continuous Home Care (CHC)

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

Continuous home care may be provided only during a period of crisis *as necessary to maintain an individual at home*. A period of crisis is a period in which a patient requires continuous care which is *predominantly* nursing care to achieve palliation or management of acute medical symptoms. If a patient's caregiver has been providing a skilled level of care for the patient and the caregiver is unwilling or unable to continue providing care, this may precipitate a period of crisis because the skills of a nurse may be needed to replace the services that had been provided by the caregiver. This type of care can also be given when a patient *resides* in a long term care facility. *However, Medicare regulations do not permit CHC to be provided in an inpatient facility (a hospice inpatient unit, a hospital, or SNF).*

The hospice must provide a minimum of 8 hours of *nursing, hospice aide, and/or homemaker* care during a 24-hour day, which begins and ends at midnight. This care need not be continuous, e.g., 4 hours could be provided in the morning and another 4 hours in the evening. *In addition to the 8 hour minimum, the services provided must* be predominantly nursing care, provided by either an RN, an LPN, or an LVN. Services provided by a nurse practitioner that, in the absence of a nurse practitioner, would be performed by an RN, LPN, or LVN, are nursing services and are paid at the same continuous home care rate. This means that *more than* half of the hours of care are provided by an RN, LPN, or LVN. Homemaker or hospice aide services may be provided to supplement the nursing care.

NOTE: When fewer than 8 hours of care are required, the services are covered as routine home care rather than continuous home care.

Nursing care in the hospice setting can include skilled observation and monitoring when necessary, and skilled care needed to control pain and other symptoms.

The development of the CHC rate included the daily costs of *nursing, hospice aide, social worker, and* therapy visits; drugs; supplies and equipment; and the average daily cost of the hospice IDG. *However, the statute limits the billable CHC hours of direct patient care to care* provided by a nurse, a homemaker, or a hospice aide. *Medicare regulations require that an hourly payment be made*. While in the majority of situations, one individual would provide continuous care during any given hour, there may be circumstances where the patient's needs require direct interventions by more than one covered discipline resulting in an overlapping of hours between the nurse and hospice aide. In these circumstances, the overlapping hours would be counted separately. *The total hours paid cannot exceed 24 hours per day.*

The hospice would need to ensure that these direct patient care services are clearly documented and are reasonable and necessary. Computation of hours of care should also reflect the total hours of direct care provided to an individual that support the care that is needed and required. This means that all nursing and aide hours should be included in the computation for CHC and when the aide hours exceed the nursing hours, CHC would be denied and routine payment will be made. The statutory definition of continuous home care is meant to include the full range of services needed to achieve palliation and management of acute medical situations. Deconstructing what is provided in order to meet payment rules is not allowed. In other words, hospices cannot discount any portion of the hours provided in order to qualify for a continuous home care day.

Documentation of care, modification of the plan of care, and supervision of aides or homemakers would not qualify as direct care nor would *these activities* qualify as necessitating the services of more than one *care* provider. In addition, *while* the services provided by other disciplines such as medical social workers or pastoral counselors are an integral part of the care provided to a hospice patient, these services are not included in the statutory definition of continuous care and are not counted towards total hours of continuous care. However, the services of social workers and pastoral counselors would be expected during these periods of crisis, if warranted as part of hospice care, and are included in the provisions of routine hospice care.

The following are used to illustrate circumstances that may qualify as CHC. This list is not all-inclusive nor does it indicate that if a patient presents with similar situations, that it would constitute CHC.

1. Frequent medication adjustment to control symptoms/collapse of family support system

Situation A: The patient has had a central venous catheter inserted to provide access for continuous Fentanyl drip for pain control and for the administration of antiemetic medication to control continuous nausea and vomiting. The nurse spends 2 hours teaching the family members how to administer IV medications. She returns in the evening for 1 hour. The hospice aide provides 3 hours of care. The nurse spends 2 hours phoning physicians, ordering medications, documenting and revising the plan of care.

Determination: Despite 8 hours of service, this does not constitute CHC since 2 of the 8 hours were not activities related to direct patient care.

Situation B: The patient experiences new onset seizures. He continues to have episodes of vomiting. The nurse remains with the patient for 4 hours (10 AM – 2 PM) until the seizures cease. During that time she provides skilled care and family teaching. The patient's wife states she is unable to provide any more care for her husband. A hospice aide is assigned to the patient for monitoring for 24 hours, beginning at 2:00 PM, with a total of 8 hours of direct care in the first day. The nurse returns intermittently for a total of an additional 5 hours to administer

medications, assess the patient and to relieve the aide for breaks. The social worker provides 3 hours of services to work with the patient's wife in identifying alternative methods to care for the patient.

Determination: This qualifies as a continuous home care day. This constitutes a medical crisis, including collapse of family structure. The caregiver has been providing skilled care and the change in the patient's condition requires the nurse's interventions. Since there is no overlap in nursing care, 17 hours of care (i.e., 9 hours of nursing care and 8 hours of aide care) would be computed as CHC. The social worker hours would not be incorporated. If the caregiver had been providing custodial care and his medical crisis resolved within a short time frame, this situation would not have qualified as CHC.

2. Symptom management/rapid deterioration/imminent death

Situation A: 77-year-old patient with lung cancer whose caregiver is 80 years old. The caregiver has been caring for this patient for 4 months and is now exhausted and scared. The care provided consists of assisting with bathing, assisting the patient to ambulate, preparing meals, housekeeping and administering oral medications. Since the patient is dyspneic at rest, she requires assistance in all ADLs, which equates to 9 hours of assistance within a 24-hour period.

Determination: This would not qualify as CHC since there is little nursing care that requires a nurse. The patient would however be a candidate for an inpatient respite level of care.

Situation B: The patient's condition deteriorates. The patient now has circumoral cyanosis, respiratory rate of 44 and labored with intermittent episodes of apnea. The nurse performs a complete assessment and teaches the caregiver on methods to make the patient comfortable. The nurse returns twice within the 24-hour period to assess the patient. She revises the plan of care after conferring with the patient's attending physician and with the hospice physician. The homemaker and hospice aide are sent to assist the caregiver. Within the 24-hour period, the direct care provided by the nurse equates to 3 hours, homemaker with 2 hours, and hospice aide of 6 hours.

Determination: Since only 3 of the 11 hours were skilled care requiring the services of a nurse, this would not constitute CHC. In this situation, the care required is not predominantly nursing but are comprised of services provided by a hospice aide. In addition, it would not be correct to discount any portion of the hospice aide's hours or to provide these services gratis in order to qualify for the CHC benefit.

Situation C: The next day, the patient's condition deteriorates further. She has increased periods of apnea and air hunger. In addition she is experiencing

continuous vomiting and increasing pain. Her blood pressure is beginning to decrease and her respirations are increasing. The nurse remains at the patient's bedside for 4 hours while attempting to control her pain and symptoms. The hospice aide provides care during 1 hour of this period. The nurse leaves and the hospice aide remains at the bedside for 3 hours. The social worker comes and talks with the caregiver and remains for 1 hour. The nurse returns while the aide leaves. The nurse remains with the patient for 2 hours until she dies. The social worker returns and stays with the caregiver for 1 hour until the mortuary arrives.

Determination: The nurse provided 6 hours of direct skilled nursing care; the aide provided 4 hours of direct care resulting in a total of 10 hours of registered nurse and hospice aide care. Since at least 6 of the 10 hours were direct nursing care, and since nursing care was the predominant service provided during the 10 hours, the care meets the criteria for CHC. In addition, since the nurse and the aide provided direct care for the patient simultaneously, it would be appropriate to bill for each resulting in total of 10 billable hours. The patient received 12 hours of care. The 2 hours for the social worker are not counted towards the CHC hours.

Medicare's requirements for coverage of CHC are that at least 8 hours of *predominantly* nursing care are needed in order to manage an acute medical crisis as necessary to maintain the individual at home. When a hospice determines that a beneficiary meets the requirements for CHC, appropriate documentation must be available to support the requirement that the services provided were reasonable and necessary and were in compliance with an established plan of care in order to meet a particular crisis situation. This would include the appropriate documentation of the situation and the need for continuous care services consistent with the plan of care.

Continuous home care is *only furnished during brief periods of crisis and covered* only as necessary to maintain the terminally ill individual at home.

40.2.2 - Respite Care

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. *Respite care may only be provided in a Medicare participating hospital or hospice inpatient facility, or a Medicare or Medicaid participating nursing facility.* Respite care may be provided only on an occasional basis and may not be reimbursed for more than 5 consecutive days at a time. *Respite care provided for more than 5 consecutive days at a time must be billed as routine home care for day 6 and beyond, and the patient may be liable for room and board charges for day 6 and beyond. See §40.1.5 for additional information.*

40.2.4 - Special Modalities

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

A hospice may use chemotherapy, radiation therapy, and other modalities for palliative purposes if it determines that these services are needed. This determination is based on the patient's condition and the *individual hospice's* care-giving philosophy. No additional Medicare payment may be made regardless of the cost of the services.

40.5 - Non-core Services

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

In addition to the hospice core services (physician services, nursing services, medical social services, and counseling), the following services must be provided by the hospice, either directly or under arrangements, to meet the needs of the patient and family:

- 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 §1891(a)(3) of the Act 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 *illness* and related conditions.
- 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.

Section 1861(dd)(5) of the Act 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. These waivers 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.

50 - Limitation on Liability for Certain Hospice Coverage Denials

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

Section 1879 of the Act provides *beneficiaries with liability* protections *from unexpected* charges for certain denied claims *when items or services are furnished by* Medicare Part

A *hospice* providers. *Hospice* providers may also be protected from liability under §1879 of the Act when *certain conditions apply to a claim denial. The limitation on liability protections applies when a hospice claim denial is expected because:*

- *the beneficiary is determined to be not “terminally ill” as defined in §1879(g)(2) of the Act;*
- *specific items or services billed separately from the hospice per diem, such as physician services, are not reasonable and necessary as defined in either §1862(a)(1)(A) or §1862(a)(1)(C); or*
- *the level of hospice care is determined to be not reasonable or medically necessary as defined in §1862(a)(1)(A) or §1862(a)(1)(C), specifically for the management of the terminal illness and/or related conditions.*

Contractors will apply the usual procedures of the limitation on liability provision *when a claim denial is based upon one of these reasons. When limitation on liability protections applies, the hospice provider must issue the Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, per CMS guidelines in order to transfer liability to the beneficiary.*

See *Pub. 100-04*, Medicare Claims Processing Manual, Chapter 30, “*Financial Liability Protections*,” particularly *Section 50*, “*Advance Beneficiary Notice of Noncoverage*.”

80.1 - Documentation

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

If the beneficiary’s physician initiates the request for the evaluation and counseling service, appropriate documentation guidelines should be followed, including the determination of the terminal *illness*. Since this provision is not a prerequisite of or part of the hospice benefit, certification of the terminal *illness* is not required. The request or referral should be in writing, and the hospice medical director or physician employee would be expected to provide a written note on the patient’s medical chart as well as maintaining a written record of this service.

If the beneficiary initiates the request for the service, the hospice agency should maintain a written record of the service and communication with the beneficiary’s physician, with the beneficiary’s permission, would occur, to the extent necessary to ensure continuity of care.

90.1 – Limitation on Payments for Inpatient Care

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

Payments to a hospice for inpatient care are subject to a limitation on the number of days of inpatient care furnished to Medicare patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days

for general inpatient care and inpatient respite care may not exceed 20 percent of the aggregate number of days of hospice care provided to all Medicare beneficiaries in that hospice during that same period. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 - October 31). The inpatient cap is calculated by the contractor as follows:

1. The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicare hospice care by 0.20.
2. If the total number of days of inpatient care furnished to Medicare hospice patients is less than or equal to the maximum, no adjustment is necessary.
3. If the total number of days of inpatient care exceeds the maximum allowable number, the limitation is determined by:
 - Calculating the ratio of the maximum allowable inpatient care days to total inpatient care days reported on the Provider Statistical and Reimbursement Report (PS&R). The calculated ratio is multiplied by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) paid to the provider.
 - Multiplying the excess inpatient care days by the routine home care (RHC) rate, wage adjusted for the location of the hospice.
 - Adding together the amounts calculated in the two bullets above to derive the total allowable payments for inpatient care.
 - Comparing the total allowable payments for inpatient care in bullet 3 above with actual payments made to the hospice for inpatient care during the "cap period" in order to determine the overpayments paid to the provider.

Any excess reimbursement must be refunded by the hospice.

EXAMPLE: Assume that:

40,000 total hospice days x 0.20 = 8,000 = the maximum allowable inpatient care days.

10,000 inpatient care days were reported and paid to the hospice.

The ratio of maximum allowable days to the number of actual days equals 8,000 to 10,000 or 0.80.

Assume the total reimbursement for inpatient care revenue codes 0655 and 0656 for services provided between November 1st and October 31st is \$4,000,000.

$\$4,000,000 \times 0.80 = \$3,200,000 =$ payments for allowable inpatient care days.

Excess inpatient days = (10,000 actual days) – (8,000 allowable days) = 2,000.
Multiply the excess inpatient care days by the routine home care rate (wage adjusted for a hospice located in Redding, California, using the FY 2012 Wage Index value of 1.4631): $2,000 \times \$199.09 = \$398,180 =$ allowable payments for the excess inpatient care days.

Add the allowable inpatient payments and the allowable payments for excess days to derive the inpatient cap: $\$3,200,000 + \$398,180 = \$3,598,180 =$ inpatient cap.

Compare $\$3,598,180$ inpatient cap with $\$4,000,000$ actually paid for inpatient revenue codes.

The hospice must refund $\$4,000,000 - \$3,598,180 = \$401,820$

If a provider's covered days of hospice care or Medicare payments are adjusted through an audit or other review, the Medicare contractor may recalculate the inpatient cap if the amount is material.

90.2.3 – Counting Beneficiaries for Calculation

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

From the inception of the benefit in 1983 until April 14, 2011, the original method for counting beneficiaries for use in the aggregate cap calculation remained unchanged. That method is described below:

Each hospice's cap amount is calculated by the contractor multiplying the adjusted cap amount by the number of Medicare beneficiaries who elected to receive hospice care from that hospice during the cap period. For purposes of this calculation, the number of Medicare beneficiaries includes—

(1) Those Medicare beneficiaries who have not previously been included in the calculation of any hospice cap and who have filed an election to receive hospice care from the hospice during the period beginning on September 28 (34 days before the beginning of the cap period) and ending on September 27 (35 days before the end of the cap period).

(2) In the case in which a beneficiary has elected to receive care from more than one hospice, each hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total stay in all hospices that was spent in that hospice.

The following descriptions of CMS policies outlining procedures for counting beneficiaries used in the hospice cap calculation were described in CMS Ruling 1355-R

and in the FY 2012 Hospice Wage Index Final Rule. The policies differ by timeframe, so note carefully the timeframe and cap years mentioned. The two methods for counting beneficiaries are the streamlined method and the proportional method, and are explained below.

A. Hospice Appeals for Review of an Overpayment Determination (Ruling CMS-1355-R):

Effective April 14, 2011, a CMS Ruling entitled “Medicare Program; Hospice Appeals for Review of an Overpayment Determination” (CMS-1355-R), and also published in the **Federal Register** as CMS-1355-NR (76 FR 26731, May 9, 2011, found at <http://www.gpo.gov/fdsys/pkg/FR-2011-05-09/pdf/2011-10694.pdf#page=1>), was issued related to the aggregate cap calculation for hospices. This ruling provided for application of a proportional method to hospices that have challenged the original method of counting beneficiaries (shown at the beginning of section 90.2.3) for the aggregate cap calculation. Specifically, the Ruling provides that, for any hospice which has a timely-filed administrative appeal of the method used to determine the number of Medicare beneficiaries used in the aggregate cap calculation for a cap year ending on or before October 31, 2011, the Medicare contractors shall recalculate that year’s cap determination using the proportional method. The proportional method is described in section 90.2.3.C below.

B. Cap year ending October 31, 2011 (the 2011 cap year) and all prior cap years:

Ruling CMS-1355-R applies only to the 2011 cap year and any prior cap year(s) for which a hospice received an overpayment determination and filed a timely qualifying appeal. For any hospice that received relief through Ruling CMS-1355-R in the form of a recalculation of one or more of its cap determinations, or for any hospice that receives relief from a court after challenging the validity of the cap regulation, the hospice’s cap determination for any subsequent cap year is also calculated using a proportional method, as opposed to the original method described at the beginning of this section. The proportional method is defined below in section 90.2.3.C.

Additionally, there are hospices that have not filed an appeal of an overpayment determination challenging the validity of the original method for counting beneficiaries and which are waiting for CMS to make a cap determination for cap years ending on or before October 31, 2011. Any such hospice provider, as of October 1, 2011, may elect to have its final cap determination for such cap year(s), and all subsequent cap years, calculated using the proportional method.

Finally, those hospices which would like to continue to have the original method (hereafter called the streamlined method) used to determine the number of beneficiaries in a given cap year would not need to take any action, and would have their cap calculated using the streamlined method for cap years ending on or before October 31, 2011. The streamlined method is defined in section 90.2.3.C below.

C. Cap year ending October 31, 2012 (the 2012 cap year) and subsequent cap years:

For cap years ending on or after October 31, 2012, and all subsequent cap years, the hospice aggregate cap is calculated using the proportional method, except that eligible hospices can make a one-time election up to 60 days after receiving their 2012 cap determination to have their aggregate cap calculated using the streamlined method, as described later in this section. Contractors shall provide hospices with details on how to make that one-time election.

Proportional Method: Under the proportional method, for each hospice, the contractor shall include in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all hospices and all years that was spent in that hospice in that cap year (November 1st to October 31st), using the best data available at the time of the calculation (subject to revision at a later time based on updated data). The whole and fractional shares of Medicare beneficiaries' time in a given cap year are then summed to compute the total number of Medicare beneficiaries served by that hospice in that cap year.

When a hospice's cap is calculated using the proportional method, and a beneficiary included in that calculation survives into another cap year, the contractor may need to make adjustments to prior cap determinations. Reopening is allowed for up to 3 years from the date of the cap determination notice, except in the case of fraud, where reopening is unlimited. A revised cap determination letter issued as a result of a reopening may itself be reopened, subject to the 3 year limitation on reopening.

Streamlined Method: Eligible hospices can exercise a one-time election to have its cap determination for cap years 2012 and beyond calculated using the streamlined method. The option to elect the continued use of the streamlined method for cap years 2012 and beyond is available only to hospices that have had their cap determinations calculated using the streamlined method for all cap years prior to cap year 2012.

- **When a beneficiary receives care from only one hospice:** The hospice includes in its number of Medicare beneficiaries those Medicare beneficiaries who have not previously been included in the calculation of any hospice cap, and who have filed an election to receive hospice care during the period beginning on September 28 (34 days before the beginning of the cap year) and ending on September 27 (35 days before the end of the cap year), using the best data available at the time of the calculation.

Once a beneficiary has been included in the calculation of a hospice cap, he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent cap year exceeds that of the period where the beneficiary was included (this could occur when the beneficiary has breaks between periods of election).

- When a beneficiary receives care from more than one Medicare-certified hospice during a cap year or years:** Each Medicare-certified hospice includes in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all Medicare-certified hospices and all years that was spent in that hospice in that cap year (November 1st to October 31st), using the best data available at the time of the calculation. Cap determinations are subject to reopening/adjustment to account for updated data. The streamlined method cap calculation for a Medicare beneficiary who has been in more than one Medicare-certified hospice is identical to the proportional method.

D. Beneficiary Counting Examples

The following examples are for illustrative purposes only. As the examples indicate, if a hospice transitions from the streamlined method to the proportional method during the 2012 cap year, the transition might result in particular beneficiaries being counted a total of less or more than 1.0. As the examples illustrate, if the proportional method is applied for a given year, then every beneficiary who receives services in that year is counted based on the number of days of care furnished to the beneficiary in that year, relative to the total days of care for the beneficiary for all years.

Example 1. Jane Smith, a Medicare beneficiary, initially elected hospice care from Hospice A beginning on June 1, 2011. Her condition improved, and she was discharged from Hospice A on August 15, 2011, as she was no longer terminally ill. However, in January 2012 Ms. Smith's condition worsened; she re-elected hospice at Hospice A on January 15, 2012, and subsequently died on February 26, 2012.

Streamlined Method: Hospice A would count Ms. Smith as 1 in its 2011 cap year, but would not count Ms. Smith again in its 2012 cap year. Medicare payments for hospice care provided would be counted in the cap year in which those services were provided, regardless of when payments were actually made, using the best data available at the time of the calculation.

Proportional Method: Ms. Smith would be counted as follows:

2011 cap year (June 1 st – August 15 th):	76 days =	76/119 =	0.64
2012 cap year (Jan 15 th – Feb 26 th):	43 days =	43/119 =	<u>0.36</u>
Total days:	119 days =		1.00

The contractor uses the best data available at the time the cap is calculated to determine the proportional allocation of Ms. Smith's time. Because the contractor calculates the cap after allowing time for claims and adjustments to flow through the claims processing system, and assuming Hospice A files its claims without delay, by the time the 2011 cap is calculated the contractor would have information about Ms. Smith's complete hospice stay. Therefore, the contractor is able to correctly count Ms. Smith's stay for the 2011

and 2012 cap determinations, without having to make prior year adjustments to her proportional shares.

Had Ms. Smith lived until August 25, 2012, the contractor would consider the information it has at the time it makes the cap calculation when determining proportional shares. For example, if the contractor calculated the 2011 cap on June 30, 2012, using claims for dates of service through April 30, 2012, Ms. Smith's total stay would have been 183 days, and the 2011 proportional share would be $76 / 183 = 0.42$. When calculating the 2012 cap determination, the contractor would be able to re-open the 2011 cap determination and correct the proportional allocation made in the previous cap year, to reflect a final allocation of $76/300 = 0.25$ for the 2011 cap determination and $224/300 = 0.75$ in the 2012 cap determination.

Transitioning from the Streamlined Method to the Proportional Method: There are advantages and disadvantages for hospices transitioning from the streamlined method to the proportional method. When a transition to the proportional method occurs for the 2012 cap year, contractors shall not re-open the cap determination for prior cap years to pro-rate beneficiaries calculated under the streamlined method, who are included in beneficiary count for the 2012 cap year, unless those beneficiaries were in more than one hospice. Contractors shall consider all days of hospice care for these beneficiaries, including those in the previous cap year(s), when computing the proportional share of a beneficiary headcount using the proportional method. Therefore, some beneficiaries that were previously counted as 1 may be counted as more than 1 as a result of the transition.

When a hospice that elects to continue to have the streamlined method used for its cap calculation in 2012, later elects to change to the proportional method for the 2013 cap year or a later cap year, contractors can reopen cap determinations for the 2012 and later cap years. Reopening is allowed for up to 3 years from the date of the applicable cap determination, except in the case of fraud, where reopening is unlimited.

Additionally, when a transition to the proportional method is made, the timeframe for counting beneficiaries changes from September 28th – September 27th to November 1st – October 31st. As a result, there is a 34 day period from September 28th to October 31st, 2011, in the transition year where beneficiaries who elect hospice and die within that period are not counted in the total number of beneficiaries for either the 2011 or the 2012 cap year. However, the payments associated with those beneficiaries are counted in the 2011 cap year.

When a hospice transitions from the streamlined method to the proportional method, the beneficiaries' days of care from September 28 – October 31, 2011 (34 days) would not be included in the numerator for the beneficiary count calculation. However, that 34-day period would be included in the denominator because the proportional method includes in the denominator all days of hospice care provided to a beneficiary in order to prorate the beneficiary correctly. As such, any beneficiary that elected hospice care during the 34-day period would be counted as less than 1, since the numerator only includes days of service in the new cap year, but the denominator includes all days of care, including the

days in the 34-day transition period. The counting of these beneficiaries as less than 1 could be offset (in whole or in part) by other beneficiaries that will be carried over from years prior to the 2012 cap year that would be counted as more than 1 (one) beneficiary.

Example 2. Hospice A's cap was calculated using the streamlined method for the 2011 cap year, but Hospice A changed to the proportional method for the 2012 cap year. Ms. Jones is a beneficiary who elected Hospice A on September 1, 2011, and who died November 15, 2011. Ms. Jones was counted as 1 in the 2011 cap determination, using the streamlined method. When computing the 2012 cap determination using the proportional method, the contractor does not re-open the 2011 cap determination to adjust Ms. Jones' count. Ms. Jones was in hospice care for a total of 76 days. In the 2012 cap year calculation using the proportional method, the contractor would count Ms. Jones as $15 / 76 = 0.20$. In this case, Ms. Jones was counted as 1.20 beneficiaries.

Example 3. Jason Smith, a Medicare beneficiary, initially elected hospice care from Hospice A in June 2012. He received hospice care for 30 days, but revoked the benefit to try a new treatment. The treatment put his disease into remission until 2016. Mr. Smith elected hospice at Hospice B in January 2016, and died 30 days later. The cap determination letter for the 2012 cap year was issued on December 29, 2013, and December 1, 2017, for the 2016 cap year. Mr. Smith received a total of 60 days of hospice care, with 30 days in the 2012 cap year and 30 days in the 2016 cap year. The contractor counted Mr. Smith in Hospice A's 2012 cap determination as 1. That 2012 cap determination is *not* subject to reopening limitations because the 3 year reopening timeframe from the date of the cap determination letter has passed. The contractor for Hospice B counted Mr. Smith as 0.50, because Hospice B provided 30 days of care out of a total of 60 days of care. In this case, Mr. Smith was counted as 1.5 beneficiaries.

Had Mr. Smith re-elected the hospice benefit for 30 days in 2014 instead of 2016, and then died, then the contractor would reopen Hospice A's 2012 cap determination and re-compute the cap after reducing the total beneficiary count by 0.5, to account for the adjustment to Mr. Smith's time. Hospice B's contractor would also count Mr. Smith as 0.5 in its 2014 cap calculation. Between the 2 hospices and the different years, Mr. Smith is counted as 1 in total.

Example 4. Mark Williams, a Medicare beneficiary, initially elected hospice care from Hospice A in June 2012. He received hospice care for 30 days, but revoked the benefit to try a new treatment, which put his disease into remission until 2014. Mr. Williams again elected hospice at Hospice A in January 2014, and died 30 days later. Hospice A has its contractor use the streamlined method. The contractor counted Mr. Williams in Hospice A's 2012 cap determination as 1. When computing the 2014 cap, the contractor would count Mr. Williams as 0, because the streamlined method requires that a beneficiary who receives care from a single hospice be counted in the initial year of election only.

Example 5. Marla Jackson, a Medicare beneficiary, initially elects hospice care from Hospice A on September 2, 2011. Ms. Jackson stays in Hospice A until October 1, 2011, (30 days) at which time she changes her election and transfers to Hospice B. Ms. Jackson

stays in Hospice B for 70 days until her death on December 9, 2011. Each hospice can count the day of transfer in its total days of care. The contractor determines that the total length of hospice stay for Ms. Jackson is 100 days (30 days in Hospice A and 70 days in Hospice B).

Since Ms. Jackson was in more than one hospice, it doesn't matter which calculation method Hospice A or B uses; the calculation is identical and is proportional. The timeframe for counting beneficiaries using the proportional method follows that of the cap year: November 1st to October 31st. Therefore, Ms. Jackson's hospice stay not only occurred in 2 hospices, but also in 2 cap years.

Since Ms. Jackson was in Hospice A for 30 days in the 2011 cap year only, Hospice A counts 0.3 of a Medicare beneficiary for her in its hospice cap calculation (30 days/100 days). Hospice B counts 0.7 of a Medicare beneficiary in its cap calculation (70 days/100 days), but Ms. Jackson's stay in Hospice B must also be allocated to the appropriate cap year:

	Hospice A	Hospice B
Total stay: 9/2/2011 – 12/9/2011	9/2/2011 – 10/1/2011	10/1/2011 – 12/9/2011
Total days: 100	30 days	70 days
2011 Cap year (11/1/2010 – 10/31/2011)	30/100= 0.30	31/100= 0.31
2012 Cap year (11/1/2011 – 10/31/2012)	----	39/100= <u>0.39</u>
Total	0.30	0.70

If Hospice A was not Medicare certified, then the contractor would only consider Ms. Jackson's time in Hospice B.

Example 6. Hospice A decided that it would like its contractor to calculate its cap using the proportional method beginning with the 2012 cap year. Hospice A admitted Susan Brown on October 1, 2011, and she passed away on October 20, 2011. In computing Hospice A's cap for the 2011 cap year, the contractor uses the streamlined method, which counts beneficiaries for the aggregate cap based on the date of initial election. Since Ms. Brown initially elected the Medicare hospice benefit on October 1st, she would not be included in Hospice A's beneficiary count for 2011, but the payments associated with her would be included in the total payments for the 2011 cap calculation. When the contractor calculates the 2012 cap using the proportional method, beneficiaries are counted based on the cap year timeframe (November 1, 2011 to October 31, 2012). As such, Ms. Brown is not included in the 2012 beneficiary count.

In the 2012 cap year, the transition from the streamlined method to the proportional method, beneficiaries who initially elect hospice and pass away during the 34 day period between September 28th and October 31st 2011, would not be included in either the count of beneficiaries for the prior year's streamlined cap calculation or in the approaching year's proportional cap calculation. However, the Medicare payments to the hospice

associated with those beneficiaries are included in the total actual payments used in the 2011 cap calculation.

Had Ms. Brown lived until November 15, 2011, she would have been included in Hospice A's cap calculation for the 2012 cap year. Her total hospice stay would then have been 46 days, with 15 of those days occurring during the 2012 cap year. Ms. Brown would be counted in the 2012 cap determination as $15/46=0.33$.

90.2.5 – Other Issues

(Rev. 188, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

The computation and application of the aggregate cap is made by the contractor after the cap year ends. The updated PS&R system enables each hospice's contractor to correctly determine proportional allocations. For all cap years through the 2011 cap year, hospices are responsible for reporting the number of Medicare beneficiaries electing hospice care during the period to the contractor. This must be done within 30 days after the end of the cap period. For the 2012 cap year and beyond, hospices no longer need to report the number of Medicare beneficiaries to be counted in the aggregate cap calculation due to the updated PS&R system.

Hospices can obtain instructions regarding the cap determination method election process from their contractors. Regardless of which method is used, the contractor shall continue to demand any additional overpayment amounts due to CMS at the time of the hospice cap determination. Cap determinations are subject to the existing CMS reopening regulations, which allow reopening for up to 3 years from the date of the cap determination letter, except in cases of fraud, where reopening is not limited.

If a provider's covered days of hospice care or Medicare payments are adjusted through an audit or other review, the Medicare contractor may recalculate the aggregate cap if the amount is material.