CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13503	**Date: December 5, 2025**
	Change Request 14272

SUBJECT: Manual Updates Adding Language to the Timing and Content of Certification and Revocation and Discharge Guidance

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to add language to section 20.1-Timing and Content to Certification to align with changes finalized in the FY 2026 Hospice final rule regarding amendments to the attestation requirement. This CR also adds language to sections 20.2.2 - Hospice Revocation and 20.2.3 - Hospice Discharge in response to the Office of Inspector General (OIG) recommendation to provide additional guidance to hospices regarding the effects on beneficiaries when they revoke their hospice election and when they are discharged from hospice care.

EFFECTIVE DATE: January 7, 2026
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 7, 2026

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	9/20/20.1/Timing and Content of Certification
R	9/20/20.2.2/Hospice Revocation
R	9/20/20.2.3/Hospice Discharge

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 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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II. GENERAL INFORMATION

A. Background: CMS finalized changes to the regulation text at § 418.22(b)(4) to resolve ambiguities that stem from prior rulemaking by clarifying that the attestation is identifiable and verifiable and therefore, must include the signature and date of the practitioner who conducted the face-to-face encounter in accordance with the statutory requirement at section 1814(a)(7)(D)(i) of the Act. This revision allowing the face-to-face clinical note to serve as meeting the attestation requirement also achieves the regulatory intent that was first implemented in the Calendar Year (CY) 2011 Home Health (HH) Prospective Payment System (PPS) final rule and amended in the FY 2012 Hospice Wage Index final rule, as the clinical note still requires a dated signature from the practitioner who conducted the face-to-face encounter in order to allow clear identification of the attestation within the medical record. Moreover, a dated signature on the face-to-face clinical note serves to meet the definition of a medical attestation since it is a formal statement by a qualified practitioner verifying the accuracy of medical documentation, which would include the clinical findings of the face-to-face encounter, the date of the visit, and the signature of the physician or nurse practitioner who conducted the face-to-face encounter, and the date of the signature. This CR makes the accompanying changes in the benefit policy manual.

OIG recommended CMS provide guidance to hospices that clarifies the effects that revocation and discharge have on the beneficiary. On September 15, 2016, OIG issued a report titled “Hospices Should Improve Their Election Statements and Certifications of Terminal Illness” in response to Audit Number: OEI-02-10-00492. This report indicated hospice confusion regarding whether a beneficiary could reelect the hospice benefit immediately after discharge or revocation or whether there is a waiting period. Specifically, it stated that the term “the remainder of the election period” could refer to the calendar days remaining in the election period or the election period itself. OIG recommended that CMS clarify through sub-regulatory guidance that there is no waiting period and that the beneficiary may elect hospice care immediately after either discharge or revocation if the beneficiary remains eligible.

B. Policy: As part of the certification process, 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 results in a failure by the hospice to meet the patient’s recertification of terminal illness eligibility requirement and the patient would cease to be eligible for the benefit. The amendments discussed above state the physician or nurse practitioner who performs the face-to-face encounter with the patient must attest in writing that he or she had a face-to-face encounter with the patient, including the date of that visit. The attestation must include the physician's or nurse practitioner's signature and the date it was signed. The attestation could be a separate and distinct section of, or an

addendum to, the recertification or the signed and dated face-to-face clinical note itself, as long as said clinical note indicates the face-to-face encounter occurred, and includes the clinical findings of the face-to-face encounter, the date of the visit, the signature of the physician or nurse practitioner who conducted the face-to-face encounter, and the date of the signature. If the attestation of the nurse practitioner or a non-certifying hospice physician is a separate and distinct section of, or an addendum to, the recertification, the attestation shall state that the clinical findings of that visit were provided to the certifying physician for use in determining continued eligibility for hospice care.

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. The regulations at 42 CFR 418.28(c)(3) state that an individual may, at any time (emphasis added), elect to receive hospice coverage for any other hospice election periods that he or she is eligible to receive. This means there is no waiting period, and the hospice care may resume immediately if the patient remains eligible and reelects the benefit.

Similarly, the regulations at 42 CFR 418.26(c)(3) state that 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 (emphasis added) elect to receive hospice care if he or she is again eligible to receive the benefit. This means that there is no waiting period, and the hospice care may resume immediately if the patient remains eligible and reelects the benefit.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14272.1	The contractors shall be aware of the revisions to Pub. 100-02, chapter 9 related to the policies discussed in this CR.			X						

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. 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

VI. CONTACTS

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

VII. 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

20.1 - Timing and Content of Certification

(*Rev: 13503; Issued: 12-05-25; Effective: 01-07-26; Implementation: 01-07-26*)

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.

No one other than a medical doctor or doctor of osteopathy can certify or re-certify an individual as terminally ill, meaning that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. Nurse practitioners and physician assistants cannot certify or re-certify an individual as terminally ill. In the event that a beneficiary's attending physician is a nurse practitioner or a physician assistant, the hospice medical director or the physician member of the hospice IDG certifies the individual as terminally ill.

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, a nurse practitioner, or physician assistant, 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. A PA is defined as a professional who has graduated from an accredited physician assistant educational program who performs such services as he or she is 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 the training, education, and experience requirements as the Secretary may prescribe. The PA qualifications for eligibility for furnishing services under the Medicare program can be found in the regulations at 42 CFR 410.74 (c).

Note that a rural health clinic (RHC) or federally qualified health center (FQHC) physician can be the patient's attending physician. Refer to Chapter 13, section 210 for more information.

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, *may* be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. *The attestation requirement may also be fulfilled by not only a clearly titled section of or an addendum to the recertification form, but also by a signed and dated clinical note within the medical record that documents clear indication that the face-to-face encounter occurred and includes the date of the visit, the signature of the practitioner who conducted the face-to-face encounter, and the date of the signature.* Where a nurse practitioner or noncertifying hospice physician performed the encounter, *and* the attestation *is a separate and distinct section of, or an addendum to*, the recertification, *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.

20.2.2 - Hospice Revocation

(*Rev: 13503; Issued: 12-05-25; Effective: 01-07-26; Implementation: 01-07-26*)

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. *There is no waiting period for the hospice beneficiary to reelect the hospice benefit after revocation, and a subsequent election period can begin immediately after reelection if the individual continues to meet eligibility requirements.*

20.2.3 – Hospice Discharge

(*Rev: 13503; Issued: 12-05-25; Effective: 01-07-26; Implementation: 01-07-26*)

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 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.

Discharge from a hospice can 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. *There is no waiting period for the hospice beneficiary to reelect the hospice benefit after discharge, and a subsequent election period can begin immediately after reelection if the individual continues to meet eligibility requirements.*

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.