

Medicare Benefit Policy Manual

Chapter 9 - Coverage of Hospice Services Under Hospital Insurance

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10 - Requirements - General

(Rev. 22, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

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 six months or less if the illness runs its normal course.

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 physician and the individual's attending physician if he/she has one or the medical director 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 40.2.5.

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 an unlimited number of election periods of hospice care. The periods consist of 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 elections from the individual and forward them to the intermediary, 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 death or until an election termination is received.

An individual must waive all rights to Medicare payments for the duration of the election/revocation of hospice care 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 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 - Certification and Election Requirements

(Rev. 1, 10-01-03)

A3-3141, HO-204

20.1 - Timing and Content of Certification

(Rev. 22, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

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 interdisciplinary group and the individual's attending physician if the individual has an attending physician.

The attending physician is a doctor of medicine or osteopathy 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 (RHC) 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 RHC or FQHC services or claims (e.g., the physicians do not bill under the RHC provider number but they bill under their own provider number).

Written certification must be on file in the hospice patient's record prior to submission of a claim to the fiscal intermediary.

Certifications may be completed up to 2 weeks before hospice care is elected. If these requirements are not met, no payment is made for the days prior to the certification. Instead, payment begins with the day of certification, i.e., the date verbal certification (or written certification if that is done first) is obtained. 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, the hospice must obtain, no later than two 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 interdisciplinary group. If the hospice cannot obtain written certification within two calendar days, it must obtain oral certification within two calendar days. A written certification must be on file in the hospice patient's record prior to submission of a claim to the fiscal intermediary.

The 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 six months or less; and
3. The signature(s) of the physician(s).

The hospice must retain the certification statements.

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

20.2 - Election, Revocation, and Change of Hospice (Rev. 1, 10-01-03) A3-3141.1, HO-210

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;
- 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; and
- The signature of the individual or representative.

An individual or representative may revoke the election of hospice care at any time in writing. 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. Note that a verbal revocation of benefits is NOT acceptable. The individual forfeits hospice coverage for any remaining days in that

election period. An individual may not designate an effective date earlier than the date that the revocation is made.

Upon revoking the election of Medicare coverage of hospice care for a particular election period, an individual resumes Medicare coverage of the benefits waived when hospice care was elected. An individual may at any time elect to receive hospice coverage.

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. 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. (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 regional home health intermediaries (RHHIs) maintain payment responsibility for hospice services and for other claims the RHHI may pay as a regular servicing fiscal intermediary (FI) for managed care enrollees who elect hospice; specifically regulations at 42 CFR 417, Subpart P, 42 CFR 417.585 Special Rules: Hospice Care (b), and 42 CFR 417.531 Hospice Care Services (b). FI claims for services not related to the terminal illness would otherwise be the responsibility of another FI.

Managed care enrollees that 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 the Medicare Claims Processing Manual, Chapter 2, "Admission and Registration" and Chapter 11, "Hospice," for requirements for hospice reporting to the intermediary and carrier.

20.2.1 - Hospice Discharge **(Rev. 1, 10-01-03)** **HOSP 210, and Sue Jesse Pennington comment**

The hospice benefit is available only to individuals who are terminally ill; therefore, a hospice may discharge a patient if it discovers that the patient is not terminally ill. Discharge may also be necessary when the patient moves out of the service area of the hospice. The hospice notifies the intermediary of the discharge so that hospice services

and billings are terminated as of that date. In this situation, the patient loses the remaining days in the benefit period. However, there is no increase 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 nor demand that the patient revoke his/her election.

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

- The beneficiary decides to revoke the hospice benefit;
- The beneficiary moves away from the geographic area that the hospice defines in its policies as its service area;
- The beneficiary transfers to another hospice;
- 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; or
- The beneficiary dies.

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. The hospice must make every effort to resolve these problems satisfactorily before it considers discharge an option. All efforts by the hospice to resolve the problem(s) must be documented in detail in the patient's clinical record and the hospice must notify the fiscal intermediary 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.

20.3 - Election by Skilled Nursing Facility (SNF) and Nursing Facilities (NFs) Residents and Dually Eligible Beneficiaries **(Rev. 1, 10-01-03)** **HO-204.2**

A Medicare beneficiary who resides in an SNF or NF may elect the hospice benefit if:

- The residential care is paid for by the beneficiary; or

- The beneficiary is eligible for Medicaid and the facility is being reimbursed for the beneficiary's care by Medicaid, and
- The hospice and the facility have a written agreement under which the hospice takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual.

A beneficiary could be in a SNF under the SNF benefit for a condition unrelated to the terminal condition and simultaneously be receiving hospice for the terminal condition.

The State Medicaid Agency pays the hospice the daily amount allowed by the State for room and board while the patient is receiving hospice care, and the hospice pays the facility. Room and board services include the performance of personal care services, assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.

Whenever Medicaid is involved, the hospice sends a copy of the election form to the State Medicaid Agency at the time of election, and also notifies this agency when the patient is no longer receiving hospice care.

In States that offer the hospice benefit under the Medicaid program, dually eligible beneficiaries must elect the benefit under both programs at once.

20.4 - Election by HMO Enrollees

(Rev. 22, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

An HMO enrollee may elect the hospice benefit. After the hospice election, Medicare pays the hospice for hospice services and pays the HMO for services of the attending physician, who may be a nurse practitioner, (as defined in section 20.1 of this manual) and services not related to the patient's terminal illness. (See 42 CFR 417.531 and 417.585.)

30 - Coinsurance

(Rev. 1, 10-01-03)

A3-3142

Hospices may charge individuals for the applicable coinsurance amounts. An individual who has elected hospice care is liable for the following coinsurance payments.

30.1 - Drugs and Biologicals Coinsurance

(Rev. 1, 10-01-03)

A3-3142.A

An individual is liable for a coinsurance payment for each palliative drug and biological prescription furnished by the hospice while the individual is not an inpatient. The

amount of coinsurance for each prescription approximates five 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 intermediary before it is used.

30.2 - Respite Care Coinsurance

(Rev. 1, 10-01-03)

A3-3142.B

The amount of coinsurance for each respite care day is equal to five percent of the payment made by CMS 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 elects to use all three of his/her election periods consecutively (without a 2-week break), they are 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. 22, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

For an individual to receive covered hospice services, a certification of the individual's terminal illness must have been completed as set forth in §20.1, and a plan of care must be established before services are provided. Services must be consistent with the plan of care and reasonable and necessary for the palliation or management of the terminal illness and related conditions.

In establishing the initial plan of care the member of the interdisciplinary group (IDG) who assesses the patient's needs must meet or call at least one other group member (nurse, physician, medical social worker or counselor) before writing the initial plan of care. At least one of the persons involved in developing the initial plan must be a nurse or physician. The plan must be established on the same day as the individual's assessment if the day of assessment is to be a covered day of hospice care. Date the plan of care on the day it is first established. The other two members of the interdisciplinary group (the attending physician, who may be a nurse practitioner, and the medical director or physician designee) must review the initial plan of care within 2 calendar days following the day of assessment. A meeting of the group members is not required within this 2-day period; input may be provided by telephone.

A nurse practitioner serving as an attending physician should participate as a member of the interdisciplinary group 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.

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);
- Continuous home care (refer to §40.2.1);
- Inpatient respite care (refer to §40.2.2); and
- General inpatient care (refer to §40.2.2).

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 Medicare Claims Processing Manual, Chapter 11, "Hospice," for a description of billing procedures.

40.1 - Covered Services

(Rev. 1, 10-01-03)

A3-3143.1, HO-230.1

Appropriately qualified personnel must perform all services, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services.

40.1.1 - Nursing Care

(Rev. 22, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

To be covered as nursing services, the services must require the skills of a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury.

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 a nurse practitioner, a registered nurse (RN) 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 a registered nurse, which could also be provided by a nurse practitioner, for which separate payment is not made:

- a. A patient with a terminal diagnosis of lung cancer complains of leg pain. In the absence of a nurse practitioner, a registered nurse would assess the patient.
- b. Assessment of pain and or symptoms for the determination for the need of medications, other treatments, continuous home care, general inpatient care etc. In the absence of a nurse practitioner, a registered nurse would assess the patient.
- c. Administration of medications through intravenous (e.g., PICC, central, etc.), intrathecal or any other means. In the absence of a nurse practitioner, a registered nurse would administer the medication.
- d. Family counseling. In the absence of a nurse practitioner, a registered nurse, social worker or counselor would provide this service.
- e. Providing a home visit visits for assessment or provision of care to a patient who is not his/her patient. In the absence of the nurse practitioner, the service would be provided by a registered or licensed nurse. Therefore the NP cannot bill separately for the service.

40.1.2 - Medical Social Services

(Rev. 1, 10-01-03)

A3-3143.1.B, HO-230.1.B

Medical social services must be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

Services of these professionals which may be covered include, but are not limited to:

1. Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care;

2. Assessment of the relationship of the patient's medical and nursing requirements to the patient's home situation, financial resources and availability of community resources;
3. Appropriate action to obtain available community resources to assist in resolving the patient's problem (**NOTE:** Medicare does not cover the services of a medical social worker to complete or assist in the completion of an application for Medicaid because Federal regulations require the State to provide assistance in completing the application to anyone who chooses to apply for Medicaid.);
4. Counseling services that are required by the patient; and
5. Medical social services furnished to the patient's family member or caregiver on a short-term basis when the hospice can demonstrate that a brief intervention (that is, two or three visits) by a medical social worker is necessary to remove a clear and direct impediment to the effective treatment of the patient's medical condition or to the patient's rate of recovery. To be considered "clear and direct," the behavior or actions of the family member or caregiver must plainly obstruct, contravene, or prevent the patient's medical treatment or rate of recovery. Medical social services to address general problems that do not clearly and directly impede treatment or recovery as well as long-term social services furnished to family members, such as ongoing alcohol counseling, are not covered.

40.1.3 - Physicians' Services

(Rev. 22, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

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 40.1.3b.

40.1.3.1 - Attending Physician Services

The attending physician is a doctor of medicine or osteopathy 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.

40.1.3.2 - Nurse Practitioners as Attending Physicians

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 diagnosis, 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.

Services provided by a nurse practitioner that are medical in nature must be reasonable and necessary, be included in the plan of care and must be services that, in the absence of a nurse practitioner, would be performed by a physician. If the services performed by a nurse practitioner are such that a registered nurse could perform them in the absence of a physician, they are not considered attending physician services and are not separately billable. Services that are duplicative of what the hospice nurse would provide are not separately billable.

Nurse practitioners cannot certify a terminal diagnosis or the prognosis of six months or less, if the illness or disease runs its normal course, or re-certify terminal diagnosis 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 or re-certify the terminal illness.

40.1.4 - Counseling Services

(Rev. 1, 10-01-03)

A3-3143.1.D, HO-230.1.D

Counseling services are provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for the individual to adjust to the individual's approaching death. Also, see §40.4 regarding waivers under certain conditions for making dietary counseling available.

40.1.5 - Short-Term Inpatient Care

(Rev. 22, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

Short-term inpatient care may be provided in a participating 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 may be required for procedures necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings. Skilled nursing care may be needed by a patient whose home support has broken down if this breakdown makes it no longer feasible to furnish needed care in the home setting.

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, or a patient whose family is unwilling to permit needed care to be furnished in the home.

Inpatient respite care may be furnished to provide respite for the individual's family or other persons caring for the individual at home.

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, and elects 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. 1, 10-01-03)

A3-3143.1.F, HO-230.1.F

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. 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.

40.1.7 - Home Health Aide Services

(Rev. 1, 10-01-03)

A3-3143.1.G, HO-230.1.G

Only individuals who have successfully completed a home health aide training and competency evaluation program or competency evaluation program as required in 42 CFR 484.36 may provide home health aide services. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse.

“General supervision” of a registered nurse is further clarified in the Medicare State Operations Manual, Appendix M, CFR 418.82, L 191, and L105.

40.1.8 - Physical Therapy, Occupational Therapy, and Speech-Language Pathology

(Rev. 1, 10-01-03)

A3-3143.1.H, HO-230.1.H

Physical therapy, occupational therapy, and speech-language pathology services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills. Also, see §40.4 regarding waivers available under certain conditions for provision of these services.

40.1.9 - Other Items and Services

(Rev. 121; Issued: 02-05-10; Effective Date: For claims submitted on or after July 6, 2010; Implementation Date: 07-06-10)

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 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 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 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 diagnosis and which occur after the effective date of election, are the responsibility of the hospice.

EXAMPLE:

A hospice determines that a 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 - Special Services

(Rev. 1, 10-01-03)

A3-3143.2, HO-230.3

40.2.1 - Continuous Home Care (CHC)

(Rev. 22, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

Continuous home care may be provided only during a period of crisis. A period of crisis is a period in which a patient requires continuous care which is primarily 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 is in a long term care facility.

The hospice must provide a minimum of eight hours of care during a 24-hour day, which begins and ends at midnight. This care need not be continuous, e.g., four hours could be provided in the morning and another four hours in the evening. But a need for an aggregate of 8 hours of primarily nursing care is required. The care must be predominately nursing care provided by either a registered nurse (RN) or licensed practical nurse (LPN). Services provided by a nurse practitioner that, in the absence of a nurse practitioner, would be performed by a registered or licensed practical nurse, are nursing services and are paid at the same continuous home care rate. This means that at least half of the hours of care are provided by RN or LPN. Homemaker or home health aide services may be provided to supplement the nursing care.

NOTE: When fewer than eight hours of nursing 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 therapy visits, drugs, supplies and equipment, and the average daily cost of the hospice interdisciplinary group

(IDG). The computation of the required 8 hours for the CHC level of care applies only to direct patient care provided by a nurse, a homemaker, or a home health aide and, in general, assumes that one hourly payment would be made per hour. 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 home health aide. In these circumstances, the overlapping hours would be counted separately. 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 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 it qualify as necessitating the services of more than one provider. In addition, 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, however, 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 home health aide provides three 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 home health 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 4 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, 16 hours of 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 is 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 home health 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 home health 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 home health aide. In addition, it would not be correct to discount any portion of the home health 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 home health aide provides care during one hour of this period. The nurse leaves and the home health 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 hrs of direct skilled nursing care; the aide provided 4 hours of direct care resulting in a total of 10 hours of registered nurse and home health 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 eight hours of primarily 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 covered only as necessary to maintain the terminally ill individual at home.

40.2.2 - Respite Care

(Rev. 1, 10-01-03)

A3-3143.2.B, HO-230.3.B

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 be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time.

40.2.3 - Bereavement Counseling

(Rev. 1, 10-01-03)

A3-3143.2.C, HO-230.3.C

Bereavement counseling consists of counseling services provided to the individual's family after the individual's death. Bereavement counseling is a required hospice service, provided for a period up to one year following the patients' death. It is not separately reimbursable.

Bereavement specifics are found in State Operations Manual, Appendix M, CFR 418.88, L199 and L200.

40.2.4 - Special Modalities

(Rev. 1, 10-01-03)

Hospice 230.3.D

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 Hospice care giving philosophy. No additional Medicare payment may be made regardless of the cost of the services.

40.3 - Contracting With Physicians

(Rev. 22, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

Section 1861(dd)(2) of the Act allows hospices to contract for physician services. Medical directors and physician members of the interdisciplinary group (IDG) are not required to be employed by the hospice. These physicians can be "under contract" with the hospice. Although the Act does not specify what the terms of that contract must be, requirements at 42 CFR 418.56 and 418.86 are applicable to hospice, as well as all other responsibilities under the hospice conditions of participation. Hospices retain professional management responsibilities for these services and must ensure that qualified persons furnish them in a safe and effective manner. Since nurse practitioners are not included in the definition of a physician, this section does not apply to nurse practitioners.

40.4 - Core Services

(Rev. 1, 10-01-03)

HO-230.2

Nursing services, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. Supplemental services may be contracted in order to meet unusual staffing needs that cannot be anticipated and that occur so infrequently it would not be practical to hire additional staff to fill these needs.

Other services may be provided under arrangement. Arrangements made by a hospice to furnish items or services must be such that receipt of payment by the hospice for the services relieves the beneficiary of liability or any other persons to pay for the services. Whether the services and items are furnished by the hospice itself or by another organization under arrangements made by the hospice, both must agree not to charge the patient for covered services and items and must agree to return money incorrectly collected.

The arrangement agreement includes at least the following:

1. Identification of the services to be provided;
2. A stipulation that services may be provided only with the express authorization of the hospice;
3. The manner in which the contracted services are coordinated, supervised, and evaluated by the hospice;
4. The delineation of the role(s) of the hospice and the contractors in the admission process, patient/family assessment, and the interdisciplinary group care conferences;
5. Requirements for documenting that services are furnished in accordance with the agreement; and
6. The qualifications of the personnel providing the services.

The hospice must maintain professional, financial and administrative responsibility for the services and assure that all staff meet the regulatory qualification requirements.

40.4.1 - Waiver for Core Services (Rev. 1, 10-01-03)

If the hospice is located in a nonurbanized area, it may apply for a waiver of the core nursing, physical therapy, occupational therapy, speech language pathology, and dietary counseling requirements if it can demonstrate that it made a good faith or diligent effort to hire these specialties. Determinations as to urbanized and nonurbanized areas are based on the current Census Bureau. The location of a hospice that operates in several areas is considered to be the location of its central office.

To qualify for the nursing services waiver, the hospice must have been operational on or before January 1, 1983.

Determinations as to whether it was operational on or before January 1, 1983, are based on:

- Proof that it was established to provide hospice services prior to 1983 (e.g., newspaper advertisements, dated correspondence on hospice letterhead, dated invoices, articles of incorporation, governing body minutes);
- Evidence that it furnished hospice-type services to patients on or before that time (e.g., dated copies of medical records, dated nursing notes, dated pharmaceutical orders); and
- Evidence that hospice care was a discrete activity rather than an aspect of a provider's patient care program prior to January 1, 1983.

Determinations of good faith or diligent efforts to hire appropriate personnel for all waiver services are based on the following evidence:

- Recruitment efforts through advertisements in local newspapers;
- Job descriptions for nurses, physical therapists, occupational therapists, speech-language pathologist, and dietary counselors;
- Evidence that salary and benefits are competitive for the area; and
- Any other recruiting activities (e.g., recruiting efforts at health fair and contacts with appropriate personnel at other providers in the area).

A waiver remains in effect for a 1-year period. A waiver may be extended for two additional 1-year periods. Prior to each additional year, the hospice must request the extension and certify that the employment market for appropriate personnel has not changed significantly since the initial waiver was granted if this is the case. No additional evidence is required with this certification.

Waiver requests and any extensions with supporting documentation must be sent to the regional office for review. Regional offices have the authority to review, and approve, or deny the waiver application.

40.4.2 - Temporary Measure to Allow a Waiver for Core Nursing Services

(Rev. 1, 10-01-03)

S&C-02-44 dated 9/12/2002, Comments from Mavis Connolly

The CMS instituted a temporary measure to allow individual hospices to contract for nurses until September 30, 2004, if the hospice can demonstrate that the nursing shortage is creating an extraordinary circumstance that prevents it from hiring an adequate number of nurses directly. The CMS designated the current nursing shortage as an "extraordinary circumstance," as referenced in the regulations at 42 CFR 418.80, in order to allow hospices affected by the shortage to utilize contracted nursing staff. This temporary measure does not

extend to counseling services and medical social services, which are the other core hospice services.

40.4.2.1 - Qualifying for an “Extraordinary Circumstance” Exemption (Rev. 1, 10-01-03)

Between October 1, 2002, and September 30, 2004, in order to qualify for an “extraordinary circumstance” exemption, a hospice must notify the state agency responsible for licensing and certification that it intends to elect an exception under the “extraordinary circumstance” authority. This may be accomplished by providing written notification to the state survey agency when it believes that the nursing shortage has become an “extraordinary circumstance” in its ability to hire nurses directly, and it must estimate the number of nurses that it believes it will currently need to employ under contract. Notification may be made during the period from October 1, 2002, through September 30, 2004, and should address the following:

- a. An estimate of the number of patients that it has not been able to admit during the past three months due to the nursing shortage and provide the current and desired patient/nurse ratio for the agency;
- b. Evidence that the hospice has made a good faith effort to hire and retain nurses, including:
 - Copies of advertisements in local newspapers that demonstrate recruitment efforts;
 - Copies of reports of telephone contacts with potential hires, professional schools and organizations, recruiting services, etc.;
 - Job descriptions for nurse employees;
 - Evidence that salary and benefits are competitive for the area;
 - Evidence of any other recruiting activities (e.g., recruiting efforts at health fairs, educational institutions, health care facilities, and contacts with nurses at other providers in the area); and
 - Ongoing self-analysis of the hospice’s trends in hiring and retaining qualified staff.
- c. The hospice must also demonstrate that it has a training program in place to assure that contracted staff is trained in the hospice philosophy and the provision of palliative care prior to patient contact.
- d. The hospice must assure that contracted staff is providing care that is consistent with the hospice philosophy and the patient’s plan of care.

- e. Contracted nurses are used to supplement the hospice nurses employed directly. Contracted nurses should not be used solely to provide the continuous nursing level of care or on call service.
- f. The hospice is expected to continue its recruitment efforts during the period that it is contracting for nurses.

40.4.2.2 - Monitoring the Need for Exemption **(Rev. 1, 10-01-03)**

The state survey agency will maintain copies of each exception notification and validate the hospice's stated need for an exemption during complaint and standard surveys. Of particular importance will be the extent to which the hospice nurses have been trained in the hospice philosophy and are able to effectively provide care to the patient that is consistent with the plan of care established by the attending physician, the medical director or physician designee and interdisciplinary group.

50 - Limitation on Liability of Beneficiaries for Certain Hospice Coverage Denials **(Rev. 1, 10-01-03)** **PM-A-97-11**

Section 1879 of the Act provides protections from liability for charges for certain denied claims to beneficiaries who, acting in good faith, receive inpatient or outpatient services from Medicare Part A providers, or items or services from Medicare Part B suppliers which accept assignment. Likewise, providers and suppliers may also be protected from liability under §1879 of the Act when it is determined that they did not know and could not reasonably have been expected to know that Medicare would deny payment. When the beneficiary is held not liable and the provider also is held to be not liable, payment may be made for a denied claim under §1879, as if the service were covered.

Section 1879(g) of the Act extends limitation on liability protection to a beneficiary enrolled in a hospice when there is a denial of claims due to a determination that the individual is not terminally ill, effective for services furnished on or after August 5, 1997.

When a denial of payment for hospice services is based upon a determination that the beneficiary is not terminally ill, the contractor will apply the usual procedures of the limitation on liability provision.

See the Medicare Claims Processing Manual, Chapter 30, "Limitation on Liability."

60 - Provision of Hospice Services to Medicare/Veteran's Eligible Beneficiaries **(Rev. 1, 10-01-03)** **CCP/DCPC Comments - Tom Saltz, Carol Blackford, Terrie Deutsch**

Medicare beneficiaries that are dually eligible veterans, and reside at home in their community may elect the Medicare Hospice Benefit and have hospice services paid for under the Medicare Hospice Benefit. See §1853(c) and 1814(d) of the Act.

If a duly eligible veteran, who had been receiving Medicare hospice services in his/her home, is admitted to a VA owned and operated inpatient facility, the beneficiary must revoke the Medicare hospice benefit. Medicare is not allowed to pay for those services for which another federal entity is primary payer (§1853(c) and 1814(d)).

Dually eligible veterans may elect to receive Medicare hospice services while residing in community nursing homes and state homes and have those services paid for under the Medicare hospice benefit. (This is similar to paying for hospice care if a beneficiary lives in a nursing facility. See §20.3.)

70 – Hospice Contracts with An Entity for Services not Considered Hospice Services

(Rev. 1, 10-01-03)
A-02-102

The law governing the provision of Medicare hospice services is found at §1861(dd) of the Act. This law specifies the services covered as hospice care and the conditions a hospice program must meet in order to participate in the Medicare program. One of the conditions a hospice program must meet is that it be “primarily engaged” in providing hospice care and services to terminally ill individuals. The law further clarifies that “terminally ill individuals” are individuals having a “medical prognosis that their life expectancy is six months or less if the illness runs its normal course.” Although the law does not explicitly define its expectations for “primarily engaged,” CMS has interpreted it to mean exactly what it says, that a hospice provider must be primarily engaged in providing hospice care and services (§1861(dd)(2)(A)(i)). “Primarily” does not mean “exclusively.” This requirement does not preclude provision of non-hospice services to terminally ill individuals who are not hospice patients or services to individuals, who are not terminally ill, so long as the primary activity of the hospice is the provision of hospice services to terminally ill individuals.

The CMS recognizes that there may be circumstances in which another health care entity may wish to “purchase” some of the highly specialized staff time or services of a hospice to better meet the needs of its specific patient population. In these cases, the services are not “hospice” services in terms of Medicare payment but become part of the service package of the provider under whose care the patient is. Examples of such circumstances are provided below.

EXAMPLE 1:

A dually eligible Medicare/Medicaid beneficiary enrolled in the Program of All-Inclusive Care for the Elderly (PACE) program for approximately 2 years has been diagnosed with

a life limiting terminal illness with a prognosis of six months or less. In the course of routine assessments, the PACE provider recognizes that the beneficiary would benefit from the specialized services of a pain management specialist or a grief counselor. The PACE provider would then enter into a contractual arrangement with a Medicare certified hospice to purchase these specialized services. The hospice provider would bill the PACE provider for the services, and the PACE provider would in turn pay the hospice provider directly. Neither provider type would be allowed to bill Medicare separately for the contracted services (which in this example are PACE services and included in the PACE provider's capitated rate). In this example, the PACE provider would maintain a medical record on the patient and the hospice provider would submit any documentation related to the care of the PACE patient to the PACE provider.

EXAMPLE 2:

A Medicare beneficiary is receiving skilled services from a Medicare certified home health agency (HHA). The beneficiary has been diagnosed with a life limiting terminal illness, but chooses to continue curative treatments, thereby rendering him ineligible for the Medicare hospice benefit. The beneficiary is experiencing a period of intractable pain, and the HHA wishes to purchase specialized pain control services from the hospice provider. The HHA would then enter into a contractual arrangement with a Medicare certified hospice to purchase specialized nursing services. The hospice would bill the HHA and the HHA would pay the hospice provider directly. Neither provider type would be allowed to bill Medicare separately for the contracted services (which, in this example, are home health services and therefore included in the HHA's episode payment). In this example, the HHA would maintain a medical record on the patient, and the hospice submits any documentation related to the pain management to the HHA.

EXAMPLE 3:

A Medicare beneficiary (non-dual eligible) resides in a skilled nursing facility (SNF) and has a diagnosis of Alzheimer's disease. The beneficiary's disease process has progressed to a stage in which he/she can no longer ingest food or fluids. The beneficiary's family has been approached by the SNF regarding the placement of a feeding tube and has been told, "their loved one may not live much longer." The family is struggling with this concept and has requested assistance from the SNF regarding hospice care and grief counseling. The SNF has provided information about the Medicare hospice benefit to the family, but the patient's legal representative has made a decision not to elect hospice care at this time. The SNF does not have a trained grief counselor or full-time social worker on staff, but has a business relationship with a local hospice and has requested the services of a pastoral or grief counselor. The SNF and hospice enter into a contractual arrangement for the provision of grief counseling to this beneficiary's family by a pastoral care counselor. The hospice provider would bill the SNF, and the SNF would pay the hospice provider directly. Neither provider type would be allowed to bill Medicare Part A or B separately for the pastoral care services (which in this example are included in the Medicare's Resource Utilization Group or RUG payments to the SNF).

The SNF maintains the medical record on this patient and the hospice provider would submit any documentation related to the pastoral care services provided to the SNF.

In all of the examples provided above, the billing and payment for the services are between each of the providers. Medicare must not be billed separately for any of the contracted services referred to in the examples provided above.

70.1 - Instructions for the Contractual Arrangement (Rev. 1, 10-01-03)

A contractual agreement between both parties must be on file and available for review by the state survey agency responsible for conducting surveys on behalf of CMS to assess compliance with the relevant conditions of participation for the provider contracting for the hospice services. Where a PACE organization contracts with a hospice organization, the contract, which is reviewed by CMS, must meet the requirements specified in 42 CFR 460.70. The agreement must specify each of the services to be provided, the credentials required for any of the professionals providing the services, the billing method and payment amounts, and any required documentation.

80 - Hospice – Pre-Election Evaluation and Counseling Services (Rev. 28, Issued: 12-03-04, Effective: 01-01-05, Implementation: 01-03-05)

Effective January 1, 2005, section 512 of the MMA amends section 1812(a)(1)(5) of the Act which, provides for a one-time payment to be made to a hospice for evaluation and counseling services furnished by a physician who is either the medical director of or employee of a hospice agency. In order to be eligible to receive this service, a beneficiary must:

- be determined to have a terminal illness (which is defined as having a prognosis of 6 months or less if the disease or illness runs its normal course;
- not have made a hospice election, and
- not previously received the pre-election hospice services

Services under this benefit are comprised of:

- evaluating the individual's need for pain and symptom management;
- counseling the individual regarding hospice and other care options, and may include;
- advising the individual regarding advanced care planning.

The services that comprise this benefit are currently available through other Medicare benefits. For example, evaluation and counseling are often provided by an individual's

physician as well as by other sources such as discharge planners, case managers, social workers and nonphysician providers. Therefore, this service may not be reasonable and necessary for all individuals. To the extent that beneficiaries have already received Medicare-covered evaluation and counseling with respect to end-of-life care, the hospice pre-election benefit would seem duplicative. However, if a beneficiary or the beneficiary's physician deem it necessary to seek the expertise of a hospice medical director or physician employee, this benefit is available to assure that a beneficiary's end-of-life options for care and pain management are addressed.

Since the decision to utilize this benefit is determined by the beneficiary or the beneficiary's physician, the evaluation and counseling service may not be initiated by the hospice, that is, the entity receiving payment for the service. Payments by hospice agencies to physicians or others in a position to refer patients for services furnished under this provision may implicate the Federal anti-kickback statute.

If the beneficiary's physician is also the medical director or physician employed by a hospice or possesses expertise in the provision of palliative or hospice care, that physician already possesses the expertise necessary to furnish end-of-life services and will have received payment for these services through the use of evaluation and management codes.

For example:

A thoracic surgeon has diagnosed a patient hospitalized in an acute care facility, with end-stage lung cancer with a prognosis of 6 months or less, if the disease runs its normal course. The patient has been informed of this diagnosis. The physician, with the patient's concurrence, requests a consult by the hospital's palliative care team. The team meets with the patient, discusses options, evaluates the patient's pain and symptoms, and makes recommendations including hospice care. Utilization of the evaluation and consultation benefit would be duplicative.

A patient with terminal cervical cancer has been receiving aggressive curative care as an outpatient, which has not been successful. The patient's physician, nurse and social worker have discussed the possibility of hospice. The patient decides to seek information from a hospice. Utilization of the evaluation and consultation benefit would be appropriate.

Hospice A receives referrals from various physicians and facilities that the patients are certified as having a terminal illness and wish to elect the hospice benefit. Hospice A utilizes the evaluation and consultation benefit for every patient as a preliminary evaluation, prior to the actual election of the benefit. Utilization of the evaluation and consultation benefit would not be appropriate.

Nursing home B contacts Hospice C providing them with a list of patients that can be certified as having a terminal illness. The medical director of Hospice C makes "rounds" on these patients, many of whom are unable to communicate and whose symptoms are

being managed well. Utilization of the evaluation and consultation benefit would not be appropriate.

A patient is being treated by a physician for end-stage COPD. The patient is experiencing distressing symptoms, but has not been able to make any definitive decision as to advanced directive decisions. The patient's physician feels that the expertise of the medical director in Hospice D would be able to provide recommendations as to symptom management and advance directive decisions. The medical director provides the evaluation and consultation services. The patient does not elect the hospice benefit, but is able to make determinations as to his wishes and the physician has recommendations to assist in his provision of care. Utilization of the evaluation and consultation benefit would be appropriate.

80.1 - Documentation

(Rev. 28, Issued: 12-03-04, Effective: 01-01-05, Implementation: 01-03-05)

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 diagnosis. Since this provision is not a prerequisite of or part of the hospice benefit, certification of the terminal diagnosis 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.

80.2 - Payment

(Rev. 28, Issued: 12-03-04, Effective: 01-01-05, Implementation: 01-03-05)

Section 512(b) of the MMA amends section 1814(i) of the Act and establishes payment for this service. The statute specifies that the payment will be made to the hospice for services provided by the hospice medical director or physician employed by the hospice. The provision of these services may not be delegated to other hospice personnel (i.e., nurse practitioners, registered nurses, social workers, etc.) and may not be furnished by a physician under contract with the hospice. We intend to monitor data regarding the use of this benefit.

Since the evaluation and counseling provision is not a service within the hospice benefit, payment for these services are not included in the hospice payment cap.

Payment to the hospice agency for the provision of this evaluation and counseling service is made using HCPCS code G0337. The national payment amount for this service for FY

2005 will be \$54.57. Future changes in the rate will be identified in the Physician Fee Schedules. See Pub 100-04, chapter 11, section 10.1 for claims processing instructions.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R121BP	02/05/2010	Medicare Systems Edits Refinements Related to Hospice Services	07/06/2010	6778
R28BP	12/03/2004	Hospice Pre-Election Evaluation and Counseling Services	01/03/2005	3585
R22BP	10/24/2004	Nurse Practitioners As Attending Physicians in the Medicare Hospice Benefit	06/28/2004	3226
R15BP	06/15/2004	Nurse Practitioners As Attending Physicians in the Medicare Hospice Benefit	N/A	3226
R1BP	10/01/2003	Introduction to the Benefit Policy Manual	N/A	N/A

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