
Program Memorandum Intermediaries

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Transmittal A-03-016

Date: FEBRUARY 28, 2003

CHANGE REQUEST 2556

SUBJECT: Continuous Home Care Under Medicare Hospice

Purpose

The purpose of this Program Memorandum (PM) is to clarify the policy and interpretation for coverage of continuous home care (CHC) under the Medicare hospice benefit and the computation of CHC hours for billing purposes.

Introduction

Section 1861(dd)(1) of the Social Security Act (the Act) explains that nursing services provided by or under the supervision of a Registered Nurse (RN) and home health aide and homemaker services may be provided on a 24 - hour continuous basis only during periods of crisis and only as necessary to maintain the terminally ill individual at home. Section 418.204(a) in the CFR defines a crisis as the period in which an individual requires continuous care for as much as 24 hours to achieve palliation or management of acute medical symptoms. Section 230.3(A) of the Medicare Hospice Manual states that the care provided requires a minimum of 8 hours of primarily nursing care within a 24-hour period commencing at midnight and terminating on the following midnight. The 8-hours of care does not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of primarily nursing care is required. If a patient requires skilled interventions for palliation or symptom management, which can be accomplished in less than 8 aggregate hours within a 24 hour period or if the majority of care can be accomplished by a home health aide or homemaker, the care rendered would be covered as a routine home care day.

Section 230.3 of the Medicare Hospice Manual has been amended to reflect that care provided at a CHC level must be for at least half of the hours and must be predominantly nursing care, provided by either an RN or a licensed practical nurse (LPN). This change reflects the intent of the CFR definition in section 418.204(a). The "skilled" care provided by the nurse may be supplemented by a home health aide and/or homemaker services but the non-skilled care may be no greater than half of the nursing care required. This section of the manual goes on to explain that nursing care may include skilled observation and monitoring when necessary and skilled care needed to control pain and other symptoms. Additionally, if a patient's caregiver has been providing a skilled level of care and is now unwilling or unable to continue to provide this care, this may precipitate a period of crisis because the skills of a nurse may be needed to replace the skills of the caregiver.

Computation of CHC Hours

As discussed in the original Medicare hospice proposed and final rules published in the **Federal Register** in 1983, in order to be covered as a continuous home care day, 8 hours or more of predominately nursing care must be needed to achieve palliation or management of acute medical situations. 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 we believe that 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, we recognize that 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 3 hours of care. The nurse spends 2 hours phoning physicians, ordering medications, documenting and revising the plan of care.

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

Situation B: The patient experiences new onset seizures. He continues to have episodes of vomiting. The nurse remains with the patient for 4 hours (10 AM – 2 PM) until the seizures cease. During that time she provides skilled care and family teaching. The patient's wife states she is unable to provide any more care for her husband. A 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.

Conclusion

Medicare's requirements for coverage of CHC are that at least 8 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, we would expect to see appropriate documentation 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.

Provider Education

Intermediaries must share the information in this PM with providers through a [posting on their Web site within two weeks and publish this information in their next regularly scheduled bulletin.

The *effective date* for this PM is April 1, 2003.

The *implementation date* for this PM is April 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after 1 year upon release.

If you have any questions, contact Terri Deutsch @ 410-786-9462.