CMS Manual System

Pub. 100-02 Medicare Benefit Policy

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

Transmittal 15 **Date: JUNE 15, 2004**

CHANGE REQUEST 3226

NOTE: This transmittal replaces Pub. 100-02, Transmittal 11, which was issued on May 28, 2004. The transmittal page has been modified. All other information remains the same.

I. SUMMARY OF CHANGES: The Medicare Benefit Policy Manual, Chapter 9 – Coverage of Hospice Services under Hospital Insurance, has been edited to reflect the requirements to implement section 408 of the Medicare Prescription Drug Improvement and Modernization Act of 2003. This section allows nurse practitioners in hospice to serve as the attending physician.

NEW/REVISED MATERIAL - EFFECTIVE DATE: December 8, 2003

IMPLEMENTATION DATE: For providers billing Local Part B carriers, and Local Part B carriers, for all applicable requirements, June 28, 2004

For providers billing intermediaries, Use of the GV modifier is to be implemented June 28, 2004, as listed for the revised section 30.2 of the transmittal for Publication 100-04.

For intermediary billing and systems, for all other applicable requirements, October 4, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/Requirements - General
R	20.1/Timing and Content of Certification
R	20.4/Election by HMO Enrollees
R	40/Benefit Coverage
R	40.1.1/Nursing Care
R	40.1.3/Physicians' Services

R	40.1.5/Short-Term Inpatient Care
R	40.2.1/Continuous Home Care (CHC)
R	40.3/Contracting With Physicians

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

10 - Requirements - General

(Rev. 15, 06-15-04)

A3-3140, HO-201, A3-Rev. 1779 dated 07/99, PM AB-01-09, AB-02-009, AB-03-008

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.

The hospice also sends a copy of the election to the carrier with jurisdiction for the hospice's geographic area. The carrier maintains the election statement in its files to use when processing physician claims**.**

20.1 - Timing and Content of Certification

(Rev. 15, 06-15-04)

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 two 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 six 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.

20.4 - Election by HMO Enrollees

(Rev. 15, 06-15-04)

HO-204.3

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 20.1 of this manual)* and services not related to the patient's terminal illness. (See 42 CFR 417.531 and 417.585.)

40 - Benefit Coverage

(Rev. 15, 06-15-04)

A3-3143, HO-230, HO-402

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 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.

40.1.1 - Nursing Care

(Rev. 15, 06-15-04)

A3-3118.1, A3-3143.1.A, HO-230.1.A

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 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.*
- *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.*
- *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.*
- *Family counseling. In the absence of a nurse practitioner, a registered nurse, social worker or counselor would provide this service.*
- *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.*

40.1.3 - Physicians' Services

(Rev. 15, 06-15-04)

A3-3143.1.C, HO-230.1.C

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.*

40.1.3a - Attending Physician services

(Rev. 15, 06-15-04)

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.

40.1.3b - Nurse Practitioners as Attending Physicians

(Rev. 15, 06-15-04)

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.

40.1.5 - Short-Term Inpatient Care

(Rev. 15, 06-15-04)

A3-3143.1.E, HO-230.1.E

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.

40.2.1 - Continuous Home Care (CHC)

(Rev. 15, 06-15-04)

A3-3143.2.A, HO-230.3.A, A-03-016

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.

40.3 - Contracting With Physicians

(Rev. 15, 06-15-04)

PM-A-97-11

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.*