Medicare
Hospice Manual

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

Transmittal 68 **Date: JUNE 20, 2003**

REFER TO CHANGE REQUEST 2750

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
230 – 230.2	2.5 – 2.8 (4 pp.)	2.5 – 2.8 (4 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 1, 2003*
IMPLEMENTATION DATE: July 1, 2003

Section 230.1, Covered Services, adds language to clarify the role of the nurse practitioner in hospice.

DISCLAIMER: The revision date and transmittal number apply only to the redlined material. All other material was previously published in the manual and is only being reprinted.

210. ELECTION, REVOCATION, AND CHANGE OF HOSPICE

Each hospice designs and prints its own 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 acknowledgment that he/she has been given a full understanding of hospice care;
- The individual's or representative's acknowledgment that he/she 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. 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. The individual forfeits coverage for any remaining days in that election period. The individual may at any future time elect to receive hospice coverage for any other hospice election periods for which he/she is eligible. An individual may not designate an effective date earlier than the date that the revocation is made.

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. Notify 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. General coverage under Medicare is reinstated at the time the patient revokes the benefit or is discharged.

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 for any other hospice election periods for which he/she is eligible.

An individual may change, once in each election period, the designation of the particular hospice from which he/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/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 he or she plans 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 individual's designation of a hospice, and requires no action on the individual's part.

230. REQUIREMENTS FOR COVERAGE

To be covered, a certification that the individual is terminally ill must have been completed as set forth in §201. The individual must elect hospice care in accordance with §210, and a plan of care must be established before services are provided. To be covered, 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 basic interdisciplinary group 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. This 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 basic interdisciplinary group (the attending physician, and the medical director or physician designee) must review the initial plan of care and provide their input into the process of establishing the plan of care within 2 calendar days following the day of assessment. A meeting of group members is not required within this 2-day period; input may be provided by telephone.

230.1 Covered Services.--All services must be performed by appropriately qualified personnel, 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:

A. Nursing Care.--Nursing care provided by or under the supervision of a registered nurse.

B. Nurse Practitioner.--Nurse practitioner services performed by a nurse practitioner (as defined in §1861(s)(K)(11) of the Act) working in collaboration (as defined in §1861(aa)(5)), in which the nurse practitioner "…is legally authorized to perform by the State in which the services are performed, may see, treat or write orders…" as described in the individual written POC. Nurse practitioners may not serve as the individual's attending physician, certify terminal diagnosis and prognosis of 6 months or less if the illness or disease runs its usual course, or recertify terminal diagnosis and prognosis. The nurse practitioner may not independently establish or update the plan of care, but may review the POC as part of the IDG.

C. Medical Social Services.--Medical social services 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.

D. Physicians' Services.--Physician's services performed by a physician (as defined in 42 CFR 410.20 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.

E. Counseling Services.--Counseling services 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 him or her to adjust to the individual's approaching death.

F. Short-Term Inpatient Care.--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. A hospice may not arrange to provide inpatient services to a Medicare beneficiary in a V.A. or military hospital because Medicare cannot pay for services for which another government agency has paid or is obligated to pay. Services provided in an inpatient setting must conform to the written plan of care.

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, which 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 he or she 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.

G. Medical Appliances and Supplies, 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 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 he or she is under hospice care. Medical supplies include those that are part of the written plan of care.

H. Home Health Aide and Homemaker Services.--Home health aide services may only be provided by 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. 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. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

I. Physical Therapy, Occupational Therapy and Speech-Language Pathology Services.--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.

J. Other Items and Services.-- 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.

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 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.

230.2 Core Services.--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. You may also contract to obtain physician specialty services. If contracting is used for any services, maintain professional, financial and administrative responsibility for the services and assure that all staff meet the regulatory qualification requirements.

If you are located in a nonurbanized area, you may apply for a waiver of the core nursing, physical therapy, occupational therapy, speech language pathology, and dietary counseling requirements if you can demonstrate that you 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 of the designations. 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, you must have been operational on or before January 1, 1983.

Determinations as to whether you were operational on or before January 1, 1983 are based on:

- Proof that you were 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 you 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 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, 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.

Send requests for this waiver and any extensions with supporting documentation to your regional office for review. Regional offices have the authority to review, and approve, or deny the waiver application.