

**REGULATIONS FINALLY CONFORM WITH
MEDICARE HOSPICE AMENDMENTS:
WHAT PROVIDERS NEED TO KNOW AND DO NOW**

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On January 23, 2006 the Centers for Medicare & Medicaid Services (“CMS”) implemented final regulations revising the Medicare coverage and payment criteria governing hospice care to be consistent with changes in the Medicare statutes that became effective during the period 1997 through 2000. These regulations explain changes that have been in effect since the passage of the Balanced Budget Act of 1997 (“BBA”). The BBA clarified and changed the Medicare hospice benefit including the length of available benefit periods, how local payment rates are determined, the time frames for physician certifications and the definition of a covered Medicare hospice service. The Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (“BIPA”) made additional changes to the Medicare hospice benefit. The final regulations explain several provisions of these statutes, which have been in effect since the statutes were adopted by Congress.

The regulations described below appear to impose many new requirements on providers, but CMS takes the position that this is not the case. The regulations explain what hospices need to do now to be in compliance with these regulations. The significant changes are in three areas: (1) certification of terminal illness; (2) hospice admissions; and (3) hospice discharge. In each of these areas, set forth below are recommended actions for hospices to comply with the new regulations.

Part B: Eligibility, Election and Duration of Benefits

§418.21 Duration of Hospice Care Coverage

In 1997, the BBA restructured the hospice benefit periods to two ninety (90) day periods followed by an unlimited number of sixty (60) day periods. See BBA, §4443. Social Security Act (“SSA”) §1812(a)(4), §1812(d)(1). Since then, hospices have followed the 90-90-60 plus certification periods. These regulations revise the regulations to be consistent with the statute. Prior to this change, if a patient was discharged during their fourth benefit period, they could not elect hospice care ever again. The BBA provisions allow beneficiaries who elected hospice before BBA, and who after BBA were discharged from hospice care, because they were no longer terminally ill, to elect hospice care again if they became terminally ill again. When a Medicare beneficiary elects hospice care for his or her terminal illness, they still retain their Medicare coverage for medical needs unrelated to the terminal condition.

§418.22 Certification of Terminal Illness

The revisions to 42 C.F.R. §418.22 strengthen the rules governing the certification that the patient has a terminal illness. In 1995, Operation Restore Trust (“ORT”), an anti-fraud and abuse initiative, examined hospice admissions in the five states with the highest Medicare spending. Through ORT, the Center for Medicare & Medicaid Services (“CMS”) and the Office of the Inspector General (“OIG”) discovered that many hospice beneficiaries had inappropriate diagnoses and inadequate documentation of terminal illness. These BBA revisions address these issues.

The final regulations explain what has been the two-part rule since BBA. A written certification of terminal illness obtained within two (2) calendar days of the commencement of a benefit will ensure period eligibility. However, if the hospice cannot obtain a written certification within two days, the hospice must have the physician provide an oral certification within two days of the commencement of the benefit period and obtain the written certification before billing Medicare. This “new” regulation, effective since 1997, is intended to provide more time in obtaining the final written certification.

Congress intended to “*ease the burden of obtaining a written certification within 2, or at the latest, 8 days after the start of the initial period.*” Congress also intended to stop denied claims which resulted from failure to meet the 2/8 day rule. Congress indicated that “*hospice certification rule should follow the home health rule, and be on file before a claim is submitted.*” 70 Fed Reg 70532, 70537-38.

Before BBA, hospices were required to obtain a written certification no later than 2 calendar days after care was initiated. If the written certification was not obtained, a verbal certification had to be obtained no later than 2 calendar days after hospice care was initiated followed by a written certification no later than 8 calendar days after the care was initiated. Medicare denied reimbursement for the days when these requirements were not met. Section 4448 of BBA changed §1814(a)(7)(A)(i) of the SSA by specifying the time frame for the completion of a physician’s certification of terminal illness for admission to hospice to be at the beginning of the certification period. Although, after the passage of BBA, CMS continued to interpret “*beginning of the period*” to mean the 2/8 day rule in Program Memorandum A-98-27, these most current regulations confirm that CMS’s interpretation was not correct.

The oral certification for the initial benefit period must come from both the hospice Medical Director and the attending physician, if the patient has an attending physician. For subsequent certifications, only the Medical Director’s verbal certification is necessary, if the written certification cannot be obtained within two days. An attending physician cannot certify, on his own, that a patient has a terminal illness, without the certification from the hospice Medical Director. This applies for the initial certification period and subsequent certification periods. CMS expects the attending physician to be consulted by the Medical Director or Interdisciplinary Group (“IDG”), if the attending maintains significant involvement in the case.

In 1995, after reviewing the initial findings of ORT, CMS issued a letter to all Regional Offices and Regional Home Health Intermediaries describing the documentation that should be in a patient’s medical record to support the certification of terminal illness. The now-defunct

Program Memorandum A-98-27 (Sept. 1997) stated that the actual certification document must contain the clinical findings. At the time, this Program Memorandum was not consistent with either the statute or the regulations. BIPA §322 added the requirement that the certification “shall be based on the physician’s or Medical Director’s clinical judgement regarding the normal course of the individual’s illness.” Therefore, 42 C.F.R. §418.22(b)(2) contains new language requiring that the “clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the certification.” 42 C.F.R. §418.22(b)(2). The Medical Director should consider the terminal diagnosis and any related diagnosis or co-morbidities, and current relevant clinical information supporting the diagnosis. If the initial certification is given verbally, it must include, at a minimum, a verbal recitation of the clinical information supporting the certification. This verbal recitation, however, must be followed with the actual documentation to include in the patient’s medical record later. CMS emphasizes that verbal clinical information from the attending is “needed for the hospice’s IDG to develop the initial plan of care for the new patient.” *Id.*, at p. 70538.

Many hospices have incomplete protocols for their Medical Directors’ verbal certifications. Hospices may believe that the verbal certification of the Medical Director can await the first IDT meeting or may not be necessary to be recorded. Both situations are highly dangerous for the certification process because if the verbal certification and the written certification of the Medical Director both occur after the two days following start of care, the regulation has not been met. In fact, hospices must have a recordation process to show who received the Medical Director’s verbal certification, on what date, and with confirming signature of the receiving hospice employee. There should be a reliable “tickler” or computer-based system to ensure that by the second day after a patient’s admission, the Medical Director has either given a verbal certification that is properly recorded and dated by the hospice or has signed the written certification forms.

Suggested Actions:

- Revise certification forms to include clinical information, either recorded verbally from the attending physician or which accompany the certification, and to reflect the language regarding the hospice Medical Director’s determination in 42 C.F.R. §418.25.
- Create a “tickler” or computer-based system to ensure verbal certifications are timely.
- Obtain appropriate clinical information, such as the patient’s medical history, laboratory test results, therapy records, physician office notes, etc., to support the physician’s judgment that the patient is terminally ill.
- Audit patient records to ensure that the certifications are properly issued, and include clinical information to support the determination that the patient is terminally ill.

§418.24 Election of Hospice Care

The regulations also clarify the language regarding the duration of the hospice election. Only revocation by the beneficiary or discharge by the hospice can terminate a beneficiary’s election.

Pursuant to the new regulations, an election to receive hospice care will be considered to continue through the initial ninety-day election period and all subsequent election periods without a disruption in care as long as the individual: (1) remains in the care of a hospice; (2) does not revoke the election to receive hospice care; and (3) is not discharged from the hospice in accordance with the provisions of §418.26. While the content of the election has not changed, it is advisable for hospices to include this language in the election form.

§418.25 Admission to Hospice Care

In response to concerns raised by ORT, CMS added 42 C.F.R. §418.25 to set guidelines on hospice admission procedures. The new rule is aimed at clarifying the election and certification rules by detailing the process by which a Medical Director must certify that a patient is terminally ill, and thereby eligible for admission to hospice. A hospice may only admit a patient on the recommendation with the Medical Director in consultation with, or with input from, the patient's attending physician, if the patient has an attending physician. Referrals can still originate from other sources, but the patient's appropriateness for admission must be assessed by the Medical Director, in concert with the patient's attending physician.

The hospice Medical Director must consider the following information, at a minimum, in determining whether to certify that a patient is terminally ill: (1) the diagnosis of the terminal condition of the patient; (2) the patient's other health conditions, whether related or unrelated to the terminal condition; and (3) current clinically relevant information supporting all diagnoses. The documentation in the medical record should support that these three factors have been considered.

The preamble to the new regulations states that this section is not intended to require a face to face or direct consultation between the Medical Director of the hospice and the attending physician. The requirement was added to indicate that the Medical Director has reviewed the patient information from the attending physician, obtained directly through consultation or indirectly. The Medical Director does not necessarily need to physically possess the clinical information at the time of his decision. The medical documentation may arrive later for retention in the patient's medical record.

CMS's position is that the admission, election and certification rules do not apply to a patient who does not meet Medicare eligibility rules, but who the hospice cares for without cost. The same should apply to a palliative care patient whose care is paid for.

Suggested Actions:

- Consult the hospice Medical Director at the time of referral to the hospice.
- Review process by which information is transmitted to the hospice Medical Director at the time of admission.
- Establish procedures for ensuring the hospice Medical Director receives the required information and elements.

- Develop a documentation and audit procedure for maintaining records of verbal approvals for admission given by the Medical Director.

§418.26 Discharge from Hospice Care

As is the case with hospice admissions, the statute does not explicitly set forth the circumstances in which it is appropriate to discharge a patient from hospice care. Section 20.2.1 of the Medicare Benefit Policy Manual states that discharge is permitted only if the patient is no longer terminally ill or if the patient relocates. The final rule expands the reasons for discharge and encourages discharge planning if the patient's terminal condition stabilizes and the terminal disease progression has halted.

42 C.F.R. §418.26 allows a hospice to discharge a patient if: (1) the patient moves out of the service area or transfers to another hospice; (2) the hospice determines that the patient is no longer terminally ill; or (3) the hospice discharges the patient for cause. The concept of discharge for cause is new. It allows a hospice to discharge a patient if the patient's behavior is "*disruptive, abusive or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.*" 42 C.F.R. § 418.26(a)(3). Other examples of discharge for cause are threats from the patient's family, or drug dealing, or drug dealing by members of the patient's household. The test is whether the disruptive "*situation interferes with the ability of the hospice staff to provide care efficaciously.*" *Id.*, p. 70540.

Each hospice must develop a policy aimed at addressing potential discharge for cause cases. The final rule mandates that a hospice first advise the patient that it is considering discharging that patient for cause. The hospice must make a serious effort to resolve the issue or issues presented by the patient's behavior or situation. The hospice must also determine that the patient's proposed discharge is not due to the patient's use of necessary hospice services. Finally, the hospice must document the problems and all efforts made to resolve those problems. This documentation should be included in the patient's medical records. 42 C.F.R. §418.26(b) requires the hospice to obtain a written physician's discharge order from the hospice Medical Director. The patient's attending physician should be consulted before discharge, and his comments should be included in the discharge note.

In the comments to the final rule, CMS notes that a patient's failure to follow important clinical features of the plan of care is a valid reason for discharge for cause. However, a panicked reaction to an emergency and single trip to an Emergency Room without prior authorization from hospice is not a valid reason for discharge. CMS stresses that the patient and family must be educated before the start of care that electing hospice results in "*certain limits*" on care that is not provided by or arranged by hospice. The patient is financially responsible for care not in the hospice plan of care, and not authorized by hospice.

The hospice must also have a discharge planning process to address situations in which a patient's condition stabilizes and the disease progression halts, such that the patient cannot continue to be certified as terminally ill. CMS does not require automatic discharge planning for all hospice patients. When warranted, the discharge planning process should commence prior to discharge, and should include family counseling, patient education and other relevant services

before the patient is discharged. CMS intentionally did not stipulate prescriptive time frames for discharge planning, because CMS acknowledges that the attention of hospice service can have a “*beneficial effect, creating the impression*” that the patient is no longer actively dying. Discharge planning is not appropriate in response to a temporary stabilization occurring during a single certification period. The decision to discharge a hospice patient because they are no longer terminally ill requires “*physician/IDG judgment...supported by documentation in the medical record indicating the reason.*” *Id.*, p. 70540. CMS asks “*that the judgment be supported by documentation in the medical record indicating the reason why hospice should continue if there seems to be improvement such that discharge is under consideration.*” This approach allows hospices time for patients to transition from the Medicare hospice benefit to other care. As 42 C.F.R. §418.26(c) points out, upon discharge from hospice, a patient is no longer eligible for the Medicare hospice benefit. That person resumes Medicare coverage of the benefits waived under the above-described hospice care election. Post-discharge care is not the responsibility of hospice. The patient may elect to receive hospice care at any time in the future if he or she becomes eligible again to receive the hospice benefit.

Suggested Actions:

- Develop and implement a policy and procedure for discharging a patient for cause.
- Create a system for documenting problems and attempts to resolve them, discharge orders by the Medical Director and the review/input by the attending physician, if any.
- Develop and implement a procedure for discharge planning for patients who are no longer terminally ill.

If a patient temporarily leaves the hospice service area and obtains care, other than hospice care, for his terminal condition, the patient assumes financial responsibility for that care. However, this would not be a reason to discharge a patient unless this is a “*repeated pattern*” and it interferes with the care to be provided pursuant to the hospice plan of care. At time of admission, CMS expects hospice to explain to the patient the consequences of moving out of the service area, and electing hospice.

Part F: Covered Services

§418.202 Covered Services

All covered services must be performed by appropriately qualified personnel. The nature of the service, rather than the qualification of the person providing such service, determines the coverage category of that service. Furthermore, covered hospice services include any service specified as reasonable and necessary for the palliation and management of the patient’s terminal illness in the patient’s plan of care that would otherwise be eligible for payment under Medicare. “*It has always been Medicare’s policy that Medicare hospice includes not only those specific services listed in section 1861(dd)(1) of the [Social Security] Act, but also any service otherwise covered by Medicare that is needed for the palliation and management of the terminal illness.*” BBA §4444 codified this longstanding policy since 1998. Therefore, for example, radiation therapy which is not listed as a covered hospice service under §1861(dd)(1), is a hospice-covered

service if used for palliative purposes and part of the patient's hospice plan of care for his or her terminal illness. The statute and revised regulations elucidate that additional services deemed to be necessary and reasonable for the beneficiary's care are covered under the hospice benefit. Medicare cannot be billed separately for these additional services. This revision to the regulations should not result in any changes or generate any additional costs for Medicare hospices because the regulation merely clarifies existing Medicare policy, originally evidenced in a 1998 Program Memorandum, and implemented now in §4444 of BBA effective April 1, 1998.

Part G: Payment for Hospice Care

42 C.F.R. §418.301 prohibits a hospice from billing a patient for services for which Medicare would have paid. 42 C.F.R. §418.302 sets forth new payment procedures for hospice care. Historically, CMS had applied a local wage index value system based on the location of the provider, regardless of where the hospice care was furnished. Some hospices abused this rule by locating their offices in geographic areas with a high wage index value, even though services were provided in geographical areas where lower wages were paid to hospice staff. Section 4442 of the BBA amended the Social Security Act to require hospices to submit claims for payment for routine or continuous home care services on the basis of the geographic location of the provision of the services. Applying the wage index values for the geographic area where the hospice service was provided results in a reimbursement that more accurately reflects wages paid to hospice staff in that geographic area.

The prior versions of the regulations did not refer to the current payment methodology for physician services under Medicare Part B. The final rule updates the regulations by referring to the physician fee schedule rather than reimbursement based on reasonable charges. The Medicare contractor pays the hospice 100% of the physician fee schedule, rather than 100% of the physician's reasonable charge. The physician fee schedule has been in place since 1992, and the final rule clarifies existing policy and makes the regulations consistent with current practice. Services provided by the patient's attending physician who is not an employee, volunteer, or contractor of hospice, are paid under Medicare Part B by the physician's carrier.

Conclusion

The final rule, issued November 22, 2005, became effective January 23, 2006. These regulations are aimed at addressing the changing needs of beneficiaries, hospices and the Medicare program. Most of the changes announced in the final rule are codifications or clarifications of current practice. The new regulations governing hospice admissions, certifications and discharges impact the way hospices conduct admissions and discharges. Hospices will need to alter how they document these processes and become increasingly meticulous in maintaining and auditing patient medical records. Hospice certifications of terminal illness and election forms should be revised to comply with these regulatory requirements. In addition, hospices need to draft discharge policies consistent with the new regulations on discharge for cause. Finally, the hospice election forms should contain a statement as to the patient's appeal rights if discharged. The statement should specifically state that a patient is entitled to a "Notice of Medicare Provider Non-Coverage," and an expedited appeal of his discharge to the Quality Improvement Organization.

Additional proposed rules for Subparts C and D, which deal with Patient Care and Organizational Environment, respectively, were published in May 2005. The final rule for these subparts is expected in early 2008.