

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 141	Date: March 2, 2011
	Change Request 7337

SUBJECT: New Hospice Certification Requirements and Revised Conditions of Participation (CoPs)

I. SUMMARY OF CHANGES: To update the hospice chapter of the Benefit Policy Manual to incorporate changes implemented as a result of statutory changes, and through notice-and-comment rulemaking in 2008, 2009, and 2010. The changes include updates to the CoP and certification sections of the chapter as well as minor technical edits.

EFFECTIVE DATE: January 1, 2011

IMPLEMENTATION DATE: March 23, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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 is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	9/10/Requirements-General
R	9/20.1/Timing and Content of Certification
R	9/20.2/Election, Revocation, and Change of Hospice
R	9/20.2.1/Hospice Discharge
R	9/40/Benefit Coverage
R	9/40.1.1/Nursing Care
R	9/40.1.2/Medical Social Services
R	9/40.1.3/Physicians" Services
R	9/40.1.3.2/Nurse Practitioners as Attending Physicians
R	9/40.1.4/Counseling Services
R	9/40.1.7/Hospice Aide and Homemaker Services

R	9/40.1.8/Physical Therapy, Occupational Therapy, and Speech-Language Pathology
R	9/40.1.9/Other Items and Services
R	9/40.2.1/Continuous Home Care (CHC)
R	9/40.2.3/Bereavement Counseling
R	9/40.3/Contracting with Physicians
R	9/40.4/Core Services
R	9/40.4.1/Contracting for Core Services
N	9/40.4.1.1/Contracting for Highly Specialized Nursing Services
R	9/40.4.2/Waiver for Certain Core Staffing Requirements
R	9/40.4.2.1/Waiver for Certain Core Nursing Services
D	9/40.4.2.2/Monitoring the Need for Exemption
N	9/40.5/Non-core Services
R	9/80.2/Payment

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirements

Pub. 100-02	Transmittal: 141	Date: March 2, 2011	Change Request: 7337
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SUBJECT: New Hospice Certification Requirements and Revised Conditions of Participation (COP)

Effective Date: January 1, 2011

Implementation Date: March 23, 2011

I. GENERAL INFORMATION

A. Background: Under section 1861(dd) of the Act, the Secretary is responsible for ensuring that the CoPs, and their enforcement, are adequate to protect the health and safety of individuals under hospice care. The hospice CoPs were originally published on December 16, 1983, (48 FR 56008) and were amended on December 11, 1990, (55 FR 50831) largely to implement provisions of section 6005(b) of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101–239). On May 27, 2005, CMS proposed changes to the hospice CoPs (70 FR 30840), and finalized those changes in the June 5, 2008, Hospice Conditions of Participation Final Rule (73 FR 32088). The changes became effective on December 2, 2008. The revised CoPs affect specifics in the policy manual related to bereavement, the establishment of the plan of care, personnel requirements, physician contracting requirements, core services, and non-core services.

In October 2008, the Medicare Payment Advisory Commission (MedPAC) convened an expert panel of hospice providers; the panel noted that while many hospices comply with the Medicare eligibility criteria, some are enrolling and recertifying patients who are not eligible. The panel noted that in some cases there was limited medical director engagement in the certification or recertification process. As a result, in their March 2009 Report to Congress, MedPAC recommended that CMS require that certifications and recertifications include a brief narrative describing the clinical basis for the patient’s prognosis. This recommendation was proposed in 2009, and after considering public comments, was finalized in the August 6, 2009, Hospice Wage Index Final Rule (74 FR 39384). This new requirement became effective October 1, 2009.

With passage of the Affordable Care Act in March 2010, Congress required hospice physicians or hospice nurse practitioners to have a face-to-face encounter with Medicare hospice patients prior to the 180th-day recertification and every recertification thereafter, and to attest that the encounter occurred. CMS proposed and implemented policies related to this new requirement in the Home Health Prospective Payment System Rate Update for CY 2011; Changes in Certification Requirements for Home Health Agencies and Hospices Final Rule (75 FR 70372). This new face-to-face encounter requirement became effective on January 1, 2011.

B. Policy: CMS is revising Pub. 100-02, Medicare Benefit Policy Manual, chapter 9, to include the existing policies described above, which were implemented through notice-and-comment rulemaking, and to make minor technical corrections to the chapter.

CMS is including the existing hospice CoP policies related to bereavement, clarifying the purpose of the service and the timeframe for its performance (from admission through 12 months after the patient’s death). CMS is also including the personnel requirements for hospice aides and homemakers, requiring these individuals to receive appropriate education, training, and skills assessment prior to performing patient care duties. Furthermore, CMS is clarifying that all physicians, whether they are direct employees or under contract with a hospice, must provide services under the supervision of the hospice’s medical director. Additionally, CMS is including the list of core services that must be routinely provided by hospice employees as well as the circumstances under which a hospice may contract for these services (extraordinary circumstances and highly specialized nursing services). A hospice must maintain professional management responsibility for all services

furnished under contract. Moreover, CMS is including a list of non-core services that may be provided directly by hospice employees or under contract, as well as information about a waiver for providing certain non-core services on a 24-hour basis.

Hospice certifications and recertifications must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less, either as part of the form or as an addendum. Physicians must briefly synthesize the clinical information supporting the terminal diagnosis, and attest that they composed the narrative after reviewing the clinical information, and where applicable, examining the patient. The narrative must reflect the patient’s individual clinical circumstances. Narratives associated with the third and later benefit period must also include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.

A hospice physician or hospice nurse practitioner must have a face-to-face encounter with patients prior to the third benefit period recertification and each subsequent recertification. This encounter can occur up to 30 calendar days prior to recertification, and the hospice physician or nurse practitioner must attest that the visit occurred. The certification or recertification must include the benefit period dates to which it applies, and be signed and dated by the certifying or recertifying physician. Initial certifications may be prepared no more than 15 calendar days prior to the effective date of election. Recertifications may be prepared no more than 15 calendar days prior to the start of the subsequent benefit period.

Finally, technical edits were made to the manual. References to other sections of the manual that were either outdated or incorrect have been corrected. CMS noted that in electing the hospice benefit, the patient should have a full understanding of the palliative rather than curative nature of the treatment. Language was removed that referred to the “treatment of the patient’s medical condition or to the patient’s rate of recovery” and replaced it with language referring to the “palliation and management of the patient’s terminal illness and related conditions.” Policy describing ambulance transports which occur on the effective date of election was clarified to note that they must be to a patient’s home to be covered by the ambulance benefit. A continuous home care (CHC) example to increase the hours of continuous care provided by a nurse has been corrected so that the total CHC hours were predominantly nursing hours, in keeping with existing CHC policy. Additionally, outdated language related to the establishment of the plan of care was removed. Also, terminology was updated, as home health aides are now known as hospice aides, and licensed vocational nurses (LVNs) are a type of licensed nurse not previously mentioned. Finally, references to intermediaries, RHHIs, and carriers have been removed and replaced with “Medicare contractor”.

II. BUSINESS REQUIREMENTS TABLE

Use “Shall” to denote a mandatory requirement

Number	Requirement	Responsibility (place an “X” in each applicable column)									
		A / B M A C	D M M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
						F I S S	M C S	V M S	C W F		
7337.1	Medicare contractors shall make providers aware of the clarifications provided in the updated manual sections attached to this instruction.	X		X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B M A C	D M M A C	F I I E R	C A R I E R	R H I S S	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
7337.2	<p>A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>	X		X		X				

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Conditions of Participation: Mary Rossi-Coajou (mary.rossicoajou@cms.hhs.gov); Certification Requirements and all other sections: Anjana Patel (anjana.patel@cms.hhs.gov) or Katie Lucas (katherine.lucas@cms.hhs.gov)

Post-Implementation Contact(s): Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For *Medicare Administrative Contractors (MACs)*, include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Benefit Policy Manual

Chapter 9 - Coverage of Hospice Services Under Hospital Insurance

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 - 40.4.2 - Waiver for *Certain* Core *Staffing Requirements*
 - 40.4.2.1 - *Waiver for Certain Core Nursing Services*
- 40.5 - *Non-Core Services*

10 - Requirements - General

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

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 6 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 *medical director or* physician *member of the interdisciplinary group (IDG)* and the individual's attending physician, if he/she has one, 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 *40.1.3.1*.

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 *Medicare contractor*, 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 (*NP*) 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.

20.1 - Timing and Content of Certification

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

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 *IDG*, 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 *Medicare contractor*.

Initial certifications may be completed up to *15 days* 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, recertifications may be completed up to 15 days before the next benefit period begins. For subsequent periods, the hospice must obtain, no later than 2 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 *IDG*. If the

hospice cannot obtain written certification within 2 calendar days, it must obtain oral certification within 2 calendar days. A written certification must be on file in the hospice patient's record prior to submission of a claim to the *Medicare contractor*.

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 6 months or less; and
3. The signature(s) of the physician(s), *the date signed, and the benefit period dates that the certification or recertification covers.*

4. As of October 1, 2009, the physician's brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms.

- *If the narrative is part of the certification or recertification form, then the narrative must be located immediately above the physician's signature.*
- *If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.*
- *The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his or her examination of the patient.*
- *The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients. The physician must synthesize the patient's comprehensive medical information in order to compose this brief clinical justification narrative.*
- *For recertifications on or after January 1, 2011, the narrative associated with the third benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.*

5. Face-to-face encounter. For recertifications on or after January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient prior to the beginning of the patient's third benefit period,

and prior to each subsequent benefit period. Failure to meet the face-to-face encounter requirements specified in this section results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement. The patient would cease to be eligible for the benefit.

The face to face encounter requirement is satisfied when the following criteria are met:

- a. Timeframe of the encounter: The encounter must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to every subsequent benefit period thereafter (refer to section 20.1.5.d below for an exception to this timeframe).*
- b. Attestation requirements: A hospice physician or nurse practitioner who performs the encounter must attest in writing that he or she had a face-to-face encounter with the patient, including the date of the encounter. The attestation, its accompanying signature, and the date signed, must be a separate and distinct section of, or an addendum to, the recertification form, and must be clearly titled. Where a nurse practitioner performed the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of 6 months or less, should the illness run its normal course.*
- c. Practitioners who can perform the encounter: A hospice physician or a hospice nurse practitioner can perform the encounter. A hospice physician is a physician who is employed by the hospice or working under contract with the hospice. A hospice nurse practitioner must be employed by the hospice. A hospice employee is one who receives a W-2 from the hospice or who volunteers for the hospice.*
- d. Timeframe exceptional circumstances for new hospice admissions in the third or later benefit period: In cases where a hospice newly admits a patient who is in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period. For example, if the patient is an emergency weekend admission, it may be impossible for a hospice physician or NP to see the patient until the following Monday. Or, if CMS data systems are unavailable, the hospice may be unaware that the patient is in the third benefit period. In such documented cases, a face to face encounter which occurs within 2 days after admission will be considered to be timely. Additionally, for such documented exceptional cases, if the patient dies within 2 days of admission without a face to face encounter, a face to face encounter can be deemed as complete.*

The hospice must retain the certification statements.

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

20.2 - Election, Revocation, and Change of Hospice

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

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, *particularly the palliative rather than curative nature of treatment*;
- 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 Medicare contractor assigned the hospice specialty workload* maintain payment responsibility for hospice services and *may pay* for other claims *if that contractor is the geographically assigned Medicare contractor for the* managed care enrollees who elect hospice; *for specifics, see* regulations at [42 CFR 417](#), Subpart P, [417.585](#), Special Rules: Hospice Care (b), and [42 CFR 417.531](#) Hospice Care Services (b). *Institutional* claims for services not related to the terminal illness would otherwise be the responsibility of another *geographically assigned Medicare contractor*.

Managed care enrollees *who* 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 *Pub. 100-04*, Medicare Claims Processing Manual, Chapter 2, “Admission and Registration” and Chapter 11, “*Processing Hospice Claims*,” for requirements for hospice reporting to the *Medicare contractor*.

20.2.1 - Hospice Discharge

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

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 *Medicare contractor* 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 or 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 *Medicare contractor* 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.

40 - Benefit Coverage

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

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.

A nurse practitioner serving as an attending physician should participate as a member of the *IDG* 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 §40.1.5 and §40.2.2); and
- General inpatient care (refer to §40.1.5).

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 *Pub. 100-04*, Medicare Claims Processing Manual, Chapter 11, "*Processing Hospice Claims*," for a description of billing procedures.

40.1.1 - Nursing Care

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

To be covered as nursing services, the services must require the skills of a registered nurse, a licensed practical nurse (*LPN*) or a licensed vocational nurse (*LVN*) under the supervision of a registered nurse, *and* 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 *an NP*, 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 *an RN*, which could also be provided by *an NP*, 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 *an NP*, *an RN* 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 *an NP*, *an RN* would assess the patient.
- c. Administration of medications through intravenous (e.g., PICC, central, etc.), intrathecal or any other means. In the absence of *an NP*, *an RN* would administer the medication.
- d. Family counseling. In the absence of *an NP*, *an RN*, social worker or counselor would provide this service.
- e. Providing a home visit for assessment or provision of care to a patient who is not his/her patient. In the absence of the *NP*, the service would be provided by *an RN, LPN* or *LVN*. Therefore the NP cannot bill separately for the service.

40.1.2 - Medical Social Services

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

Medical social services must be provided by a *person who meets the criteria given in the Conditions of Participation at [42CFR418.114\(b\)\(3\)](#)*.

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 *palliation and management of the patient's terminal illness and related conditions*. 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. Medical social services to address general problems that do not clearly and directly impede treatment, 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. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

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 40.1.3.2.

40.1.3.2 - Nurse Practitioners as Attending Physicians

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

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 6 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.

Hospice nurse practitioners may conduct face-to-face encounters as described in §20.1(5) as part of the certification process, but are still prohibited by statute from certifying the terminal illness.

40.1.4 - Counseling Services

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

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. *Bereavement counseling is available to the patient and his or her immediate family to provide emotional, psychosocial, and spiritual support and services before and after the death of the patient and to assist with issues related to grief, loss, and adjustment for up to 1 year after the patient's death.* Also, see §40.5 regarding waivers under certain conditions for making dietary counseling available.

40.1.7 - Hospice Aide and Homemaker Services

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

A hospice aide is a person who meets the requirements described in the Conditions of Participation. Hospice 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. Hospice aides are assigned to a specific patient by a registered nurse who is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide.

CMS' Conditions of Participation define a qualified homemaker as an individual who meets the requirements described in [42CFR418.202\(g\)](#) and who has successfully completed hospice orientation addressing the needs and concerns of patients and families coping with a terminal illness. Homemaker services may include assistance in maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

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

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

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 [§40.5](#) regarding waivers available under certain conditions for provision of these services.

40.1.9 - Other Items and Services

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

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 *to a patient's home* 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 *to their home*, 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 *an existing* 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.

40.2.1 - Continuous Home Care (CHC)

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

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 8 hours of care during a 24-hour day, which begins and ends at midnight. This care need not be continuous, e.g., 4 hours could be provided in the morning and another 4 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 *an RN, an LPN, or an LVN*. Services provided by a nurse practitioner that, in the absence of a nurse practitioner, would be performed by *an RN, LPN, or LVN*, 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 *an RN, LPN, or LVN*. Homemaker or *hospice* aide services may be provided to supplement the nursing care.

NOTE: When fewer than 8 hours of 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 *is* 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 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 *hospice* 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 *hospice* 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 *and* 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 *hospice* 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 *hospice* 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 5 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, *17* hours of care (*i.e., 9 hours of nursing care and 8 hours of aide 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 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 *hospice* 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 *hospice* 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 *hospice* aide. In addition, it would not be correct to discount any portion of the *hospice* 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 *hospice* aide provides care during 1 hour of this period. The nurse leaves and the *hospice* 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 hours of direct skilled nursing care; the aide provided 4 hours of direct care resulting in a total of 10 hours of registered nurse and *hospice* 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 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, 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.

40.2.3 - Bereavement Counseling

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

Bereavement counseling consists of counseling services provided to the individual's family *before and* after the individual's death. Bereavement counseling is a required hospice service, provided for a period up to 1 year following the patients' death. It is not separately reimbursable.

Bereavement specifics are found in *Pub. 100-07*, State Operations Manual, Appendix M, [42CFR 418.64\(d\)\(1\)](#), L596.

40.3 - Contracting With Physicians

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

[Section 1861\(dd\)\(2\)](#) of the Act allows hospices to contract for physician services. Medical directors and physician members of the 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 [42CFR 418.64\(a\)](#), [418.100\(e\)](#), and [418.102\(a\)](#) 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. *All physician employees and those under contract must function under the supervision of the hospice medical director.* 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. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

With the exception of physician services, substantially all core services must be provided directly by hospice employees on a routine basis. These services must be provided in a manner consistent with acceptable standards of practice. The following are hospice core services:

- *Physician services.*
- *Nursing services, (routinely available and/or on call on a 24-hour basis, 7 days a week) provided by or under the supervision of an RN functioning within a plan of care developed by the hospice IDG in consultation with the patient's attending physician, if the patient has one.*
- *Medical social services by a qualified social worker under the direction of a physician.*
- *Counseling (including, but not limited to, bereavement, dietary, and spiritual counseling) with respect to care of the terminally ill individual and adjustment to death. The hospice must make bereavement services available to the family and other individuals identified in the bereavement plan of care up to 1 year following the death of the patient.*

The hospice may contract for physician services as specified in the Conditions of Participation.

40.4.1 - Contracting for Core Services

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances.

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.

A hospice that has a written agreement with another agency, individual, or organization to furnish any services under arrangement must retain administrative and financial management, and oversight of staff and services for all arranged services, to ensure the provision of quality care. Arranged services must be supported by written agreements that require that all services be--

- (1) Authorized by the hospice;*
- (2) Furnished in a safe and effective manner by qualified personnel; and*
- (3) Delivered in accordance with the patient's plan of care.*

40.4.1.1 - Contracting for Highly Specialized Nursing Services (Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

A hospice may contract for the services of a registered nurse if the services are highly specialized, provided non-routinely, and so infrequently that the provision of such services directly would be impracticable and prohibitively expensive. Highly specialized services are determined by the nature of the service and the nursing skill level required to be proficient in the service. For example, a hospice may need to contract with a pediatric nurse if it cares for pediatric patients infrequently and if employing a pediatric nurse would be impracticable and expensive. Continuous care is not a highly specialized service, because while time intensive, it does not require highly specialized nursing skills.

40.4.2 - Waiver for Certain Core Staffing Requirements (Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

Hospices are prohibited from contracting with other hospices and non-hospice agencies on a routine basis for the provision of the core services of nursing, medical social services and counseling to hospice patients. A hospice may, however, enter into arrangements with another hospice program or other entity for the provision of these core services in extraordinary, exigent, or other non-routine circumstances. An extraordinary circumstance generally would be a short-term temporary event that was unanticipated. Examples of such circumstances might include unanticipated periods of high patient loads, caused by an unexpectedly large number of patients requiring continuous care simultaneously, temporary staffing shortages due to illness, receiving patients evacuated from a disaster such as a hurricane or a wildfire, or temporary travel of a patient outside the hospice's service area. The hospice that contracts for services must maintain professional management responsibility for all services provided under arrangement or contract at all times and in all settings. Regulations at [42CFR418.100\(e\)](#) discuss the professional management responsibilities of the hospice for services provided under arrangement.

Hospices must maintain evidence of the extraordinary circumstances that required them to contract for the core services and comply with the following:

(a) *The hospice must ensure that contracted staff is providing care that is consistent with the hospice philosophy and the patient's plan of care and is actively participating in the coordination of all aspects of the patient's hospice care.*

(b) *Hospices may not routinely contract for a specific level of care (e.g., continuous care) or for specific hours of care (e.g., evenings and week-ends).*

40.4.2.1 - Waiver for Certain Core Nursing Services

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11; Implementation: 03-23-11)

The Conditions of Participation allow CMS to waive the requirement that a hospice provide nursing services directly, if the hospice is located in a non-urbanized area. The location of a hospice that operates in several areas is considered to be the location of its central office. The hospice must provide evidence to CMS that it has made a good faith effort to hire a sufficient number of nurses to provide services. CMS may waive the requirement that nursing services be furnished by employees based on the following criteria:

- *The location of the hospice's central office is in a non-urbanized area as determined by the Bureau of the Census.*
- *There is evidence that the hospice was operational on or before January 1, 1983, including the following:*
 - *Proof that the organization was established to provide hospice services on or before January 1, 1983;*
 - *Evidence that hospice-type services were furnished to patients on or before January 1, 1983; and*
 - *Evidence that hospice care was a discrete activity rather than an aspect of another type of provider's patient care program on or before January 1, 1983.*
- *By virtue of the following evidence that a hospice made a good faith effort to hire nurses:*
 - *Copies of advertisements in local newspapers that demonstrate recruitment efforts;*
 - *Job descriptions for nurse employees;*
 - *Evidence that salary and benefits are competitive for the area; and*
 - *Any other recruiting activities (e.g., recruiting efforts at health fairs 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.

40.5 - Non-core Services

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

In addition to the hospice core services (physician services, nursing services, medical social services, and counseling), the following services must be provided by the hospice, either directly or under arrangements, to meet the needs of the patient and family:

- *Physical and occupational therapy and speech-language pathology services.*
- *Hospice aide services. A hospice aide employed by a hospice, either directly or under contract, must meet the qualifications required by [§1891\(a\)\(3\)](#) of the Act and implemented at [42CFR418.76](#).*
- *Homemaker services.*
- *Volunteers.*
- *Medical supplies (including drugs and biologicals on a 24-hour basis) and the use of medical appliances related to the terminal diagnosis and related conditions.*
- *Short-term inpatient care (including respite care and interventions necessary for pain control and acute and chronic symptom management) in a Medicare/Medicaid participating facility.*

Section [1861\(dd\)\(5\)](#) of the Act allows CMS to permit certain waivers of the requirements that the hospice make physical therapy, occupational therapy, speech language pathology services, and dietary counseling available (as needed) on a 24-hour basis. CMS is also allowed to waive the requirement that hospices provide dietary counseling directly. These waivers are available only to an agency or organization that is located in an area which is not an urbanized area (as defined by the Bureau of Census) and that can demonstrate to CMS that it has been unable, despite diligent efforts, to recruit appropriate personnel.

80.2 - Payment

(Rev. 141, Issued: 03-02-11, Effective: 01-01-11: Implementation: 03-23-11)

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. *CMS* intends 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 *is* 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 amounts for this service for FY 2005 *was* \$54.57. Future changes in the rate will be identified in the Physician Fee Schedules. See Pub 100-04, *Medicare Claims Processing Manual*, chapter 11, section 10.1, for claims processing instructions.