

Medicare Hospice Benefit Facts

- The Medicare hospice benefit consists of two 90-day benefit periods and an unlimited number of 60-day benefit periods (patient must continue to meet eligibility criteria).
 - For each benefit period, the patient must be certified as terminally ill (6 months or less to live if illness runs its normal course).
 - For the initial 90-day benefit period, both the hospice medical director (or the physician member of the interdisciplinary group) and the patient's attending physician (if they have one) must certify the patient. Nurse practitioners cannot certify the patient.
 - For all subsequent benefit periods, certification is only required from the hospice medical director (or the physician member of the interdisciplinary group).
 - The certification must include a physician narrative to support life expectancy of six months or less, and an attestation statement.
 - If the patient is entering/being admitted to their third or later benefit period, the hospice-employed/contracted physician, or hospice-employed nurse practitioner, must conduct a face-to-face encounter no more than 30 days prior to the start of the benefit period.
 - The certification/recertification must be completed within 15 days prior to, or by the end of the third day after, the start of the hospice benefit period. If written certification cannot be obtained within this time, a verbal certification must be obtained.
 - The certification/recertification must be signed and dated by the physician(s) before the services can be billed to Medicare.
 - The patient must be eligible for Medicare Part A benefits, and "elect" the hospice benefit by signing an election form.
 - When the patient elects hospice, they waive all rights to Medicare payments for the duration of their hospice election for the following services:
 - Care provided by a hospice other than the one designated by the patient (unless under arrangement).
 - Services related to the treatment of the terminal condition for which hospice was elected (or a related condition).
 - The hospice must submit a timely notice of election (NOE) (type of bill 81A or 82A) to notify Medicare of the election. NOEs must be submitted and accepted within 5 calendar days after the hospice admission date. See Change Request 8877 Web page at <http://www.cgsmedicare.com/hhh/education/materials/cr8877.html> for more information. The NOE must be processed (status/location P B9997) before any claims can be submitted.
 - Hospice agencies are paid based on the level of care the patient receives each day, regardless of whether a service is provided to the patient. The four levels of care are:
 - **Routine home care (RHC)** – when no other level of care is appropriate.
 - **Continuous home care (CHC)** – care provided during a crisis. Requires a minimum of 8 hours of direct patient care, including nursing and/or homemaker or aide services, in a 24-hour day, beginning at midnight. Care must be predominantly nursing (RN, LPN or LVN), and is billed daily in 15-minute increments.
 - **Respite care** – short-term inpatient care to relieve family members/caregivers. Provided occasionally. Reimbursed up to 5 consecutive days per respite period.
 - **General inpatient care (GIP)** – inpatient care needed to control/manage patient's symptoms and/or pain not feasible in other settings.
 - Physician and Nurse Practitioner (NP)* services are separately reimbursed by Medicare when the care provided is hands-on, professional care related to the terminal diagnosis.
 - If the physician/NP is employed, or contracted by the hospice or a hospice volunteer, the hospice bills their Medicare Administrative Contractor (MAC) for the services.
 - If the physician/NP is not employed or contracted by the hospice and is not a hospice volunteer, the physician/NP bills the Medicare Part B Carrier/MAC.
 - Patients may transfer from one hospice to another. Only one transfer is allowed per benefit period. The patient continues in their current benefit period.
 - A hospice may discharge a beneficiary from hospice when the patient is no longer terminally ill or the patient moves out of the hospice's service area, or in "extraordinary circumstances" such as patient or hospice staff safety.
 - Patients can continue to receive medical care (from other health care providers) for illnesses unrelated to the terminal diagnosis.
 - Patients can revoke hospice (by signing a revocation form) at any time. Any remaining days in the benefit period are forfeited.
 - Patients may re-elect the hospice benefit at any time, given they meet the eligibility criteria of the hospice benefit.
 - A new hospice benefit period will begin.
 - Once used, the two 90-day benefit periods are not renewable.
- * **Note:** The NP must be identified as the patient's attending physician.

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