CMS Manual System

Pub. 100-07 State Operations Provider Certification

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

Transmittal 73 **Date: December 2, 2011**

SUBJECT: Revisions to Chapter 2, Sections 2082 – 2089 - "Hospices"

I. SUMMARY OF CHANGES: Regulatory citations in these sections have been revised to consistently cite a reference in the Code of Federal Regulations (CFR) using title, part and section number and omitting the word section. Thus 42 CFR 418.3 refers to title 42, part 418, section 3. Sections 2080A, 2080C, 2080C.1, 2080D, 2081, 2082, 2083, 2084, 2084A, 2084B, 2086, 2086B, 2086C and 2089 have all been revised to consistently cite the CFR regulations. Sections 2082A-2082D has been deleted. The information for 2082A-2082C is now contained in Appendix M of the SOM under the regulations and interpretive guidelines at 42 CFR 418.112. The information for 2082D is now contained in Section 20.3 of the Medicare Benefit Policy Manual. Section 2084C has been deleted. The information for 2084C is now contained in Section 2084B.

NEW/REVISED MATERIAL - EFFECTIVE DATE: December 2, 2011
IMPLEMENTATION December 2, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	2080A/Citations
R	2080C/Hospice Core Services
R	2080C.1/Waiver of Certain Staffing Requirements
R	2080D/Hospice Required Services
R	2081/Revoking Election of Hospice Care
R	2082/Discharge from Hospice Care
D	2082A/Compliance With SNF/NF Requirements
D	2082B/Professional Management
D	2082C/Provision of Non-Core Services to SNF/NF Residents or Residents of an ICF/MR or Other Non-Certified Facility
D	2082D/SNF/NF Residents and Dually-Eligible Beneficiaries
R	2083/Hospice Regulations and Non-Medicare Patients
R	2084/Hospice Inpatient Services

R	2084A/Hospice Provides Inpatient Care Directly
R	2084B/Hospice Provides Inpatient Services Under Arrangements
D	2084C/Hospice Provides Inpatient Services in Space Shared with Medicare-Approved Hospital or SNF at Same Location
R	2086/Hospice Change of Address
R	2086B/Administrative Review
R	2086C/Move after Certification Survey
R	2089/Survey Requirements When the Hospice Provides Care to Residents of a SNF/NF or ICF/MR

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

IV. ATTACHMENTS:

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

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

Hospices

2080 - Hospice - Citations and Description
(Rev. 1, 05-21-04)

2080A - Citations
(Rev.73, Issued: 12-02-11 Effective: 12-02-11, Implementation: 12-02-11)

Section 1861(u) of the Act establishes hospices as a provider of services. Section 1861(dd) of the Social Security Act (the Act) defines hospice care and the hospice program. 42 CFR 418 sets forth the Conditions of Participation (CoPs) that hospices must meet and applies to a hospice as an entity as well as to the services provided to each individual under hospice care. 42 CFR Part 418.110 is a condition applicable only to hospices that provide short-term inpatient care and respite care directly, rather than under arrangements with other participating providers. Section 1866(a)(1)(Q) of the Act requires hospices, among other providers, to file an agreement with the Secretary to comply with the requirements found in Section 1866(f) of the Act regarding advance directives.

The Centers for Medicare & Medicaid Services (CMS) has a Web site for survey and certification information including hospice policy memos, the State Operations Manual, §§2080-2089 relating to hospices, and Appendix M, "Hospice Survey Procedures and Interpretive Guidelines." This information is available at http://www.cms.hhs.gov/SurveyCertificationGenInfo/

Definition

A hospice is a public agency or private organization or a subdivision of either of these that is primarily engaged in providing care and services to terminally ill individuals, meets the CoPs for hospices, and has a valid Medicare provider agreement. The law governing the provision of Medicare hospice services is found at Section 1861(dd) of the Act. The law further clarifies that "terminally ill individuals" are individuals having a "medical prognosis that the individual's life expectancy is 6 months or less." This definition is further clarified at 42 CFR 418.3 to provide for a life expectancy of 6 months or less "if the illness runs its normal course." Although the law does not explicitly define its expectations for "primarily engaged," CMS has interpreted it to mean exactly what it says, that a hospice provider must be primarily engaged in providing hospice care and services (Section 1861(dd)(2)(A)(i)). "Primarily" does not mean "exclusively." This requirement does not preclude the hospice from providing services to terminally ill individuals who have not elected the hospice benefit or providing services to individuals who are not terminally ill, as long as the primary activity of the hospice is the provision of hospice services to terminally ill individuals and the hospice meets all requirements for participation in Medicare.

Hospice Benefit Periods

An individual may elect to receive Medicare hospice benefits for two periods of 90 days and an unlimited amount of periods for 60 days each. (See 42 CFR 418.21.)

Eligibility Requirements

In order 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. (See *42 CFR* 418.20.) An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

Referrals may come from any source, but patients must be assessed by the hospice medical director for appropriateness of admission in consultation with the patient's attending physician (if the individual has one). The hospice medical director must consider the diagnosis of the terminal condition of the patient, other health conditions, whether related or unrelated to the terminal illness, and current clinically relevant information supporting all diagnoses. The medical director may consult with the attending physician directly or through information obtained indirectly. Information could be obtained through the hospice nurse or others who would bring the attending physician's knowledge of the patient to the medical director when the admission decision is being made.

The hospice must obtain written certification of terminal illness within 2 calendar days for each of the benefit periods listed in *42 CFR* 418.21, even if a single election continues in effect for an unlimited number of periods. If the hospice cannot obtain the written certification within 2 calendar days, after a period begins, it must obtain oral certification within 2 calendar days and written certification before a claim for payment is submitted.

For the initial 90-day period, certification of terminal illness must be obtained from the medical director of the hospice or the physician member of the hospice interdisciplinary group (IDG) and the individual's attending physician (if the individual has one). Recertification for subsequent periods only requires the certification of the hospice medical director or the physician member of the IDG. Certification statements must be on file and dated by the physician before the hospice submits a claim for payment. (See *42 CFR* 418.22.)

2080C - Hospice Core Services

(Rev.73, Issued: 12-02-11 Effective: 12-02-11, Implementation: 12-02-11)

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 a registered nurse (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; and

- 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 *42 CFR* 418.64(a).

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.

2080C.1 - Waiver of Certain Staffing Requirements

(Rev.73, Issued: 12-02-11 Effective: 12-02-11, Implementation: 12-02-11)

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 *42 CFR* 418.100(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:

- The hospice must assure 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, and

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

2080D - Hospice Required Services

(Rev.73, Issued: 12-02-11 Effective: 12-02-11, Implementation: 12-02-11)

Requirement for 24-Hour Services

The hospice is required by the CoPs at *42 CFR* 418.100 to make nursing services, physician services, drugs, and biologicals routinely available on a 24-hour basis, 7 days a week. It also has to make all other covered services available on a 24-hour basis, 7 days a week, when reasonable and necessary to meet the needs of the patient and family.

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 Section1891(a)(3) of the Act and implemented at *42 CFR* 418.76;

- 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; and

- Continuous home care provided during a period of crisis. Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis, as necessary to maintain the patient at home. *42 CFR* 418.204(a) defines a crisis as the period in which an individual requires continuous care for as much as 24 hours to achieve palliation or management of acute medical symptoms. The care provided must require at least 8 hours of care in a 24 hour period, and the

care must be provided predominantly by a licensed nurse (RN, LVN, LPN). Homemaker or hospice aide services or both may also be covered if needed.

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. These waivers are codified at *42 CFR 418*.74.

2081 - Revoking Election of Hospice Care

(Rev.73, Issued: 12-02-11 Effective: 12-02-11, Implementation: 12-02-11)

The hospice patient or representative may revoke the patient's election of hospice care at any time during the election period according to *42 CFR* 418.28. Revocation is a voluntary action taken by the patient or representative. 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. It is important for the hospice to educate the patient and family before the start of care that hospice entails certain limits in the way care will be provided, including restrictions on obtaining care outside the care arranged for or provided by the hospice, and the patient's liability for care received without the hospice's involvement. The hospice should neither request nor pressure the patient/family or representative in any way to revoke his/her election.

2082 - Discharge from Hospice Care

(Rev.73, Issued: 12-02-11 Effective: 12-02-11, Implementation: 12-02-11)

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, inconvenient, or the State allows for discharge under State law. The situations under which a hospice may discharge a patient are addressed in the regulation at *42 CFR* 418.26 and include the following situations:

- The patient moves out of the hospice's service area or transfers to another hospice;
- The hospice determines that the patient is no longer terminally ill; and

- The hospice determines under a policy set by the hospice for the purpose of addressing discharge for cause, that the patient's (or other persons in the patient's home) 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.

The hospice must do the following before it seeks to discharge a patient for cause:

- Advise the patient that a discharge for cause is being considered;
- Make a serious effort to resolve the problem(s) presented by the patient's (or other persons in the patient's home) behavior or situation;
- Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and
- Document in the clinical record, the problem(s) and efforts made to resolve the problem(s).

Prior to discharging a patient for any reason stated above, the hospice IDG must obtain a written physician's discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his/her review and decision included in the discharge note.

The hospice notifies its Medicare administrative contractor (MAC) and SA of the circumstances surrounding the impending discharge. The hospice should also consider referrals to other appropriate and/or relevant state/community agencies (i.e., Adult Protective Services) or health care facilities before discharge.

2083 - Hospice Regulations and Non-Medicare Patients

(Rev.73, Issued: 12-02-11 Effective: 12-02-11, Implementation: 12-02-11)

The hospice CoPs apply to all patients of the hospice (Medicare and non-Medicare), with the exception of the following regulations, which apply only to Medicare beneficiaries:

- *42 CFR* 418.100(d) - the continuation of care requirement, and
- *42 CFR* 418.108(d) - the 80-20 inpatient care limitation.

In addition, the following CoPs regarding the certification and recertification of terminal illness are necessary to determine eligibility for Medicare and Medicaid patients and may or may not be a requirement by other payment sources:

- *42 CFR* 418.102(c);
- *42 CFR* 418.104 (a)(5); and
- *42 CFR* 418.112 (e)(3)(iii).

2084 - Hospice Inpatient Services

(Rev.73, Issued: 12-02-11 Effective: 12-02-11, Implementation: 12-02-11)

Hospices must make inpatient care available for pain control, symptom management, and respite purposes. This inpatient care may be provided directly by the hospice or indirectly under arrangements made by the hospice. If services are provided under

arrangements, the hospice must ensure that the services are in full compliance with all applicable standards relating to inpatient care found at *42 CFR* 418.110 and *42 CFR* 418.108.

2084A - Hospice Provides Inpatient Care Directly

(Rev.73, Issued: 12-02-11 Effective: 12-02-11, Implementation: 12-02-11)

When the hospice provides inpatient care directly, it may do so either in space that it owns or leases or in space shared with a Medicare certified hospital, SNF, or Medicaid certified nursing facility (NF).

- If the hospice provides care in its own inpatient facility, the care may be provided in space that the hospice either owns or leases from another facility or building. The inpatient unit may consist of several beds, a group of beds, or a wing and must meet all applicable Federal and State requirements and be surveyed for compliance with *42 CFR* 418.110 prior to providing inpatient care to patients. This survey includes a Life Safety Code survey (which has currently adopted the 2000 edition of the Life Safety Code of the National Fire Protection Association) that must be done both at the time of initial certification of the inpatient facility and at the time of recertification surveys.

- If the hospice provides care directly with hospice staff in space shared with a Medicare-certified Hospital, SNF, or a Medicaid certified NF (for respite care only), the SA reviews the agreement and patient files for compliance with *42 CFR* 418.110(b) and *42 CFR* 418.110(e) since the location already meets the remaining requirements of *42 CFR* 418.110 as a Medicare/Medicaid participating facility.

2084B - Hospice Provides Inpatient Services Under Arrangements

(Rev.73, Issued: 12-02-11 Effective: 12-02-11, Implementation: 12-02-11)

When the hospice provides inpatient services under arrangements with a Medicare participating hospital or SNF, a Medicaid participating NF (for respite care only), or an inpatient unit of another Medicare-certified hospice, a separate survey of each site is not required. In these cases, the SA reviews the agreement and patient files to assure that the standards in *42 CFR* 418.110(b) regarding 24-hour nursing service and *42 CFR* 418.110(e) regarding comfort and privacy of patient and family members are satisfied. However, if in reviewing contracts and other documentation (e.g., clinical records, plans of care), questions arise concerning the contract arrangements, the SA conducts an onsite visit to the institution providing the inpatient services to review the care provided under arrangements, not to inspect the facility. This includes hospitals that are accredited by The Joint Commission or the American Osteopathic Association that are providing inpatient services under arrangements.

Applicability of Inpatient Care CoP *42 CFR* 418.110

Location Where Inpatient Care is Provided	Applicability of Condition
Hospice freestanding inpatient facility	Survey for compliance with *42 CFR 418.110*.
Medicare certified hospital or SNF and/or Medicaid certified NF (for respite care only.)	Survey for compliance with *42 CFR* 418.110(b) and *42 CFR* 418.110(e). The institution already meets the remaining requirements of *42 CFR* 418.110 as a Medicare/Medicaid certified hospital or SNF/NF.

A hospice freestanding inpatient facility is defined in this context as a facility that is not a part of another Medicare/Medicaid certified facility (e.g., hospital or SNF/NF).

2086 - Hospice Change of Address

(Rev.73, Issued: 12-02-11 Effective: 12-02-11, Implementation: 12-02-11)

It is inherent in the provider certification process that a provider notifies CMS of its intent to change the location or site from which it provides services. Absent such notification, CMS has no way of carrying out its statutorily mandated obligation of determining whether the provider is complying with applicable participation requirements at the new site or location. It is a longstanding CMS policy that there is no basis for a provider to bill Medicare for services provided from a site or location that has not been determined to meet applicable requirements of participation. This guidance is contained in Chapter 3, section 3224 of Publication 100-07.

When an existing hospice intends to move from its surveyed, certified location to a new site or location, it notifies CMS either directly or through the SA, and, if deemed, it notifies its approved national accreditation organization (AO), in writing of the proposed change of location. The provider also notifies its MAC and submits all required documentation including an amended Form CMS-855A before CMS approval can be granted. The provider obtains CMS' approval of the new address before it provides Medicare services from the new address.

Upon receipt of a provider's notice and request for approval of the move to the new site or location, the RO will carefully evaluate the information, together with any supporting documentation from the provider and any other relevant information known to the RO in making its decision. If a decision can be made on the written application and supporting documentation, CMS will grant or deny an approval without requiring a survey. If, however, the RO concludes that circumstances warrant a survey to establish whether the new address complies with all applicable requirements, CMS will advise the provider and will make no further findings until a survey has been completed and submitted to CMS for its review. In either event, CMS will notify the provider of its decision in writing, as appropriate.

CMS generally will not approve a change of location of a primary hospice with one or more previously approved multiple locations if the new location increases the distance between the primary hospice location and its previously approved multiple location(s) to a point that prevents the hospice from exerting the supervision and control necessary at each multiple location to assure that all hospice care and services continue to be responsive to the needs of the patient/family at all times and in all settings. In that event, the application for approval of the new location would usually be denied without a survey, and the provider would apply for a new certification number for the new location. Request for approval of a proposed change of location of an approved multiple location is handled as a request for approval of a new multiple location, in accordance with the regulations and guidelines at *42 CFR* 418.100(f).

NOTE: CMS will not approve a change of location for a hospice's own inpatient facility without a survey to assure that the facility meets all requirements specified at *42 CFR* 418.110.

2086B – Administrative Review

(Rev.73, Issued: 12-02-11 Effective: 12-02-11, Implementation: 12-02-11)

CMS's decision on a request for approval of a change of address does not qualify as an initial determination subject to administrative review under *42 CFR* 498.3. Such a determination does not affect the existing provider agreement, which continues in effect at the surveyed, certified location until voluntarily terminated by the provider pursuant to *42 CFR* 489.52 or involuntarily terminated by CMS pursuant to *42 CFR* 489.53. In the event approval of the new change of address is denied, the provider has the option of formally applying for initial certification of the new site or location as a separate Medicare provider of hospice services. In that event, an initial certification survey by CMS or the SA (or accreditation based on survey by a national AO with deeming authority) would be required.

2086C – Move after Certification Survey

(Rev.73, Issued: 12-02-11 Effective: 12-02-11, Implementation: 12-02-11)

Requests for initial certification cannot be processed to completion if a prospective provider moves to a new location after it is surveyed and/or deemed to meet the CoPs by a national AO with deeming authority. If a prospective provider moves after its location has been surveyed and/or accredited but prior to a certification determination by CMS, the prospective provider's application for certification becomes incomplete. Absent a survey of the new location to which the prospective provider has moved, CMS is unable to determine whether applicable program requirements are met at the new location, and therefore is prevented from completing its review of the pending application. In these circumstances, CMS advises the prospective provider that its application is incomplete. Such an incomplete application is held in abeyance pending receipt of a report of survey of the current location from the SA or a national AO with deeming authority meeting the

requirements of and approved by CMS. The decision to hold an incomplete application in abeyance does not qualify as an initial determination as defined in *42 CFR* 498.3.

2089 – Survey Requirements When the Hospice Provides Care to Residents of a SNF/NF or ICF/MR

(Rev. Rev.73, Issued: 12-02-11 Effective: 12-02-11, Implementation: 12-02-11)

When a SNF or NF is the hospice patient's residence for purposes of the hospice benefit, the SNF or NF must comply with the requirements for participation in Medicare or Medicaid. The Medicare/Medicaid regulations for long term care facilities regarding the completion and submission of the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) data do not change when the resident elects the Medicare Hospice Benefit. This means the SNF or NF must assess the hospice resident using the RAI, and have a care plan and provide the services required under the plan of care. This can be achieved through cooperation between the hospice and facility staff with the consent of the resident. In these situations, the hospice IDG should participate with the facility in completing the RAI.

Similarly, the SNF/NF must complete the RAI for any hospice patient who receives short term inpatient care in a Medicare/Medicaid participating SNF/NF if the hospice patient resides in the facility for more than 14 days. For further information on the hospice requirements when it provides care in these settings, see 42 CFR 418.112.