The Medicare Hospice Benefit

What You Should Know About Eligibility and Elections

Today's Presenter

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- Provider Outreach and Education
- Syracuse, NY

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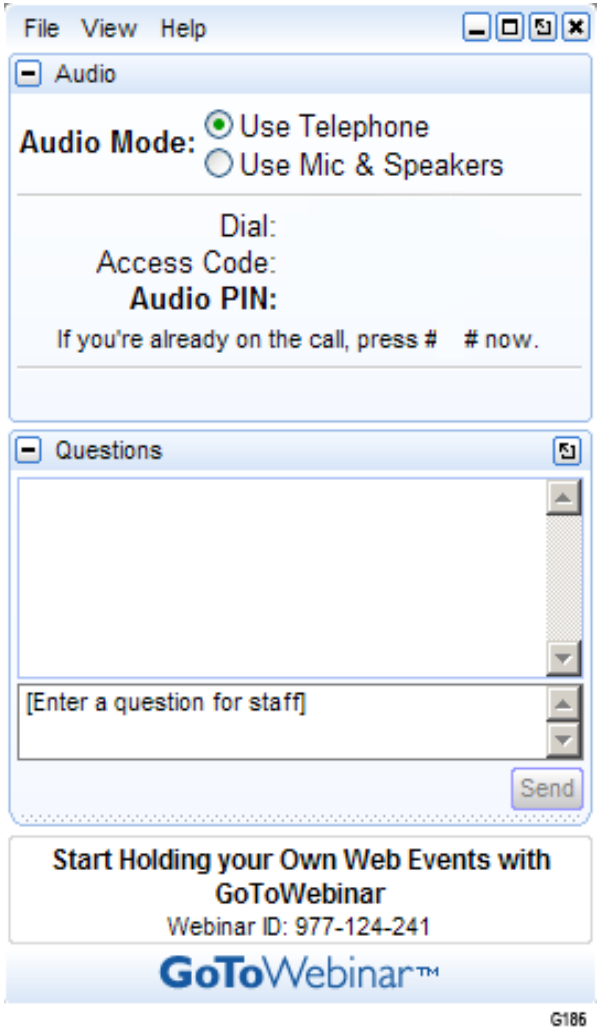

Objective

To provide a basic understanding of the Medicare Hospice program including:

- Eligibility and certification requirements
- Election and revocation requirements
- VA, MSP, MAO, and stays in a SNF as they relate to the hospice benefit

Agenda

Eligibility requirements

Benefit periods

Certification/recertification requirements

Election requirements

Pre-election evaluation and counseling service

Discharge, revocation, and transfers

Verifying eligibility

General Information

When did the Medicare hospice benefit begin?

- Program began on 11/01/1983

What is a hospice?

- Public agency or private organization that provides care and support to terminally ill

What is hospice care?

- Care that combines medical, spiritual bereavement, and psychosocial services, designed to help both the patient and the family with an emphasis on pain control, symptom management, and emotional support

Covered Hospice Services

Nursing care

Medical social services

Physicians' services

Counseling services

Short-term inpatient care

Medical appliances and supplies

Aide services

PT, OT, and SLP

Other Items and Services

Any other item/service which is included in the POC and for which payment may otherwise be made under Medicare 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

Other Items and Services

Bereavement Counseling

- Required hospice service
  - Provided up to one year following patient's death
  - Consists of counseling services provided to individual's family after their death

Special Modalities

- A hospice may use chemotherapy, radiation therapy, and other modalities for palliative purposes if it determines that these services are needed

Noncovered Hospice Services

Under the hospice benefit, Medicare will not pay for:

- Treatment intended to cure terminal illness
- Care from any provider not set up by elected hospice
- Care from another provider that is same as what is received from hospice
- Services not medically reasonable and necessary
- Services not covered by Medicare

How Payment Rates are Set

Medicare payment for hospice care is made at one of four predetermined rates for each day that a beneficiary is under the care of the hospice

- Daily payments are made regardless of amount of services furnished on a given day
- Rates are determined based on the level of care

Levels of Care

Routine home care

- Paid for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care
  - Paid without regard to the volume or intensity

Levels of Care

Continuous home care

- Provided only during periods of crisis to maintain the beneficiary at home
  - Beneficiary requires “continuous care” for at least 8 hours in a 24-hour period (midnight to midnight)
    - More than 50% of care must be nursing by RN, LPN, or LVN
  - Care need not be continuous
  - Homemaker or hospice aide may supplement nursing

Levels of Care

Inpatient respite care

- Provided only when necessary to relieve the family members or other persons caring for individual at home
  - Only on an occasional basis
  - May not be reimbursed for more than five consecutive days at a time

Levels of Care

General inpatient care

- Provided only when beneficiary requires an intensity of care directed towards pain control and symptom management that cannot be managed in any other setting
  - Can be provided in acute hospital, SNF or NF if they meet special hospice standards

Eligibility Requirements

To be eligible to elect hospice care under Medicare, an individual must:

- Be entitled to Medicare Part A coverage
- Be certified as being terminally ill
  - Prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course

Eligibility Requirements

In order for an eligible individual to receive covered hospice services:

- Certification must be completed
- Face-to-face encounter must occur prior to the beginning of the patient's third and each subsequent benefit period
- POC must be established
  - Services must be consistent with the POC
- Services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions

Benefit Periods

There are an unlimited number of benefit periods of hospice care

Benefit periods consist of:

- Two 90-day periods (not renewable)
- A series of 60-day periods (unlimited)

Benefit Periods

Hospice care is considered continuous from one benefit period to another, until beneficiary revocation or hospice/physician discharge

- Upon revocation or discharge, the beneficiary must forfeit any remaining days in that benefit period
- If the beneficiary meets the hospice coverage criteria, they can re-elect the hospice benefit at any time and begin with the next benefit period

Certification

Hospice must obtain written certification of the terminal illness

- If written certification cannot be obtained timely, verbal certification can be used
- Must ensure the written certification is signed and on file prior to billing Medicare

Certifications/recertifications required at the start of every hospice benefit period

Certification

Timing

- No later than two days after the beginning of the benefit period (by the end of the third calendar day)
- Initial certification may be completed up to 15 days prior to the hospice election
- Recertifications may be completed up to 15 days before the next benefit period begins
- Written certification must be on file in the agency before submitting a claim to Medicare

Face-to-Face Encounter

Timeframe

- Must occur no more than 30 calendar days prior to the third benefit period and every subsequent benefit period

Exceptional Circumstances

- 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
  - In such documented cases, a face-to-face encounter which occurs within two days after admission will be considered to be timely

Face-to-Face Encounter

Late encounters

- Results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement
- Patient would cease to be eligible for the benefit
  - Hospice must discharge patient from the Medicare hospice benefit
    - Expectation is that hospice will continue to care for the patient at its own expense until the required encounter occurs
      - » CR 7478

Face-to-Face Encounter

Once face-to-face encounter occurs

- Hospice can re-admit the patient to the Medicare hospice benefit once the required encounter occurs, provided:
  - Patient continues to meet all of the eligibility requirements;
  - Patient (or representative) signs a new election statement;
  - New physician certification of terminal illness is completed; and
  - All other paperwork associated with an admission is completed

Election Requirements

Beneficiary (or authorized representative) must elect hospice care to receive it

- Must file an election statement with a particular hospice
- Must waive all rights to Medicare payments for services related to the terminal illness

Medicare will continue to pay for covered benefits not related to terminal illness

Election Statement

No Standard Form

Must include the following items:

- 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;
- 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

Election by SNF/NF Residents

Medicare beneficiary residing in a SNF or NF may elect hospice benefit if:

- Room and board is paid for by the beneficiary or another insurance; or
- Beneficiary is eligible for Medicaid and facility is reimbursed by Medicaid; and
- The hospice and the facility have a written agreement under which the hospice takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual

Election by MA Enrollees

MA enrollee may elect the hospice benefit; upon hospice election, payment reverts to fee-for-service Medicare

- MAC responsibility
  - Pays the hospice for hospice services
  - Pays other providers for services not related to the patient's terminal illness
- MAO responsibility
  - Continues to cover extra services not covered by Original Medicare (e.g., dental and vision)

Election by MA Enrollees

Duration of payment responsibility by MACs extends through the remainder of the month in which hospice is revoked

VA and Hospice

Medicare beneficiaries that are dually eligible veterans and reside at home, in a community nursing home, or a state home, may elect the Medicare hospice benefit and have hospice services paid for under the Medicare hospice benefit

VA and Hospice

If a dually eligible veteran who had been receiving Medicare hospice services in his/her home is admitted to a VA-owned and -operated inpatient facility, the beneficiary must revoke the Medicare hospice benefit

- Medicare is not allowed to pay for those services for which another federal entity is primary payer

Medicare Secondary Payer

Medicare may pay secondary to another insurance

- Medicare pays based on primary payer's payment
  - May pay in full, partially, or nothing to provider

MSP categories

- Medicare is not automatically secondary
- Each category has guidelines to determine if Medicare is secondary or primary

MSP Screening Process

Conduct MSP screening process

- Registrar discuss questions with patient
- Keep copy of answers either hardcopy or electronically
- Perform screening at start of care

Provider must compare information gathered with Medicare system information prior to billing

- MSP information is reported on claims

Did You Know…

When your facility signed a provider agreement with Medicare to give treatment to Medicare beneficiaries and receive payment from Medicare, they agreed to fulfill certain obligations as part of that provider agreement. So, any provider that bills Medicare for services rendered to Medicare beneficiaries must do two things:

- Determine whether or not Medicare is the primary payer for those services (known as identifying MSP) and the provider must
- Bill the other primary payers before Medicare

Changing Hospice/Transfers

Patient may change hospices once in each benefit period

Patient must file a transfer statement

- With original hospice and newly designated hospice
- Include 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

Both hospices must communicate to coordinate billing

- Transfers can occur on the same day or next day
  - There cannot be a gap in service dates between

Changing Hospice/Transfers

Transfers can occur on the same day or the next day

- There cannot be a gap in service dates between the two agencies
  - Example:
    - Beneficiary is transferring from Hospice A on 01/15/2014, the transfer admission date for Hospice B must occur on 01/15/2014 or 01/16/2014

Did You Know…

Two hospices may bill for the same day when there is a discharge/admission involved

A change in ownership of a hospice is not considered a change in the individual's designation of a hospice, and requires no action on the beneficiary's part

Revocation

Individual or representative may revoke benefit any time

- To seek active treatment
- Moving out of service area and does not want any hospice benefits
- Individual does not want hospice any longer

General coverage under Medicare is reinstated at the time the patient revokes the benefit

Revocation

Revocation must be in writing

No standard form

- Statement must include an effective date for the revocation
  - Cannot be earlier than the date the revocation is made
- Statement must be signed by patient or representative

Day of revocation is a payable day

Discharge from Hospice

Hospice may discharge individual if:

- Patient moves out of service area
- Patient's condition improves and is no longer terminal
- The hospice determines, under hospice policy, that the patient's behavior is disruptive, abusive, or uncooperative to the extent that delivery of care is seriously impaired

General coverage under Medicare is reinstated at the time the patient is discharged

Out of Service Area Discharges

Examples

- Patient moves to another part of the country
- Patient leaves the area for a vacation
- Patient is receiving treatment for a condition unrelated to the terminal illness
- Patient is receiving treatment for related conditions in a facility with which the hospice does not have a contract, and thus is unable to provide hospice services to that patient
  - Medicare's expectation is that the hospice provider would consider the amount of time the patient is in that facility before making a determination that discharging the patient from the hospice is appropriate

Did You Know…

A hospice can “discharge” a patient and a patient can “revoke” hospice. These two terms are not used interchangeably

Pre-Election Evaluation and Counseling Services

One-time only payment

Services are comprised of:

- Evaluating the individual's need for pain and symptom management;
- Counseling the individual regarding hospice and other care options; and may include
- Advising the individual regarding advanced care planning

Services must be furnished by physician who is either medical director or employee of hospice

Pre-Election Evaluation and Counseling Services

Beneficiary must be terminally ill with life expectancy of six months or less if disease or illness runs its normal course

Beneficiary must not have submitted a hospice election

Beneficiary must not have previously received pre-election hospice services

Verifying Medicare Eligibility

Patient presents insurance information and/or cards

Provider verifies Medicare eligibility and determines proper order of insurance

- Use MSP screening process

Verifying Medicare Eligibility

Medicare eligibility information is maintained in CWF

- Hospice staff can access beneficiary eligibility information using the provider self-service tools to verify eligibility
  - NGSConnex
  - IVR
  - HIQA

Common Working File

Maintains national beneficiary records

- Entitlement, date of birth, and date of death
- Recent benefit periods
- MAO enrollment
- Hospice enrollment
- MSP information
  - Information available through NGSConnex, IVR, and HIQA is pulled from CWF

NGSConnex

Free web application that provides

- Claim status
- Beneficiary eligibility
- Financial data
- Provider demographics
- Ability to order remittances

http://www.NGSConnex.com

- Free NGSConnex webinars occur throughout the year to walk providers through the NGSConnex system

IVR

Uses natural language and text-to-speech technology that responds to your voice.

- Touch tone is also available throughout the application, as needed

Obtain information such as patient eligibility, claim status, check and remittance information, and some general information

IVR

Available 24-hours a day, seven days a week for general questions

- Menu options that require system access are limited to system availability
  - Monday – Friday: 6:00 a.m. – 7:00 p.m. ET
  - Saturday: 7:00 a.m. – 3:00 p.m. ET

IVR Telephone Numbers

HH+H State/Region	Telephone Number
Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Washington, American Samoa, Guam, Northern Mariana Island	866-277-7287
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	866-275-7396
Michigan, Minnesota, New York, New Jersey, Wisconsin, Puerto Rico, U.S. Virgin Islands	866-275-3033

HIQA

CWF assists in verifying patient's eligibility

- Providers access through online claims system

Maintains national beneficiary records

Comprised of nine (9) host regions

Providers access CWF information through FISS via HIQA

- Utilize the Health Insurance Query Access Manual for detailed instructions

RESOURCES

CMS Resources

CMS Web site, Hospice Center

- http://www.cms.gov/center/hospice.asp

CMS Transmittals

- http://www.cms.gov/Transmittals/

CMS Internet-Only Manuals

- http://www.cms.gov/manuals
  - Publication 100-02, Medicare Benefit Policy Manual, Chapter 9
  - Publication 100-04, Medicare Claims Processing Manual, Chapter 11

National Government Services Resources

http://www.NGSMedicare.com

- HHH portal
  - Provider Resources > Acronym Search
  - Education > Job Aids & Manuals
    - Hospice Job Aids
  - Claims & Appeals > Top Claim Errors
  - Claims & Appeals > Claims: Medicare Secondary Payer
  - Education > Webinars, Teleconferences & Events
    - Upcoming education sessions
  - Education > Past Events
    - Presentation materials and event summaries

CERT A/B MAC Outreach & Education Task Force

CERT A/B MAC Outreach & Education Task Force

- A joint collaboration of the A/B MACs to communicate national issues of concern regarding improper payments to the Medicare Program
- Shared goal of reducing the national improper payment rate as measured by the CERT program
- Partnership to educate Medicare providers on widespread topics affecting most providers and complement ongoing efforts of CMS, the MLN and the MACs individual error-reduction activities within its jurisdictions

Disclaimer

The CERT A/B MAC Outreach & Education Task Force is independent from the CMS CERT team and CERT contractors, which are responsible for calculation of the Medicare fee-for-service improper payment rate.

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- CGS Administrators, LLC/J15
- First Coast Service Options, Inc./J9
- National Government Services, Inc./J6 and JK
- Noridian Healthcare Solutions, LLC/JE and JF
- Novitas Solutions, Inc./JH and JL
- Palmetto GBA/J11
- Wisconsin Physicians Service Insurance Corporation/J5 and J8

CERT A/B MAC Outreach & Education Task Force

The CERT Task Force educates on common billing errors and contributes educational Fast Facts to the CMS website

- CMS MLN Provider Compliance Fast Facts web page
  - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ ProviderCompliance.html
- In addition, the CERT Task Force section on the NGSMedicare.com website provides a link to the CMS MLN Provider Compliance Fast Facts

CERT A/B MAC Outreach & Education Task Force

CERT Task Force Web Page

- Go to our website, http://www.NGSMedicare.com; in the **About Me** drop down box, select your provider type and applicable state, click on **Next,** accept the Attestation. Choose the **Medical Policy & Review** tab, then choose **CERT**, the **CERT Task Force** link is located to the right of the web page.

Task Force Scenario's

- Insufficient documentation
- Documenting therapy and rehabilitation services

Look for new articles added to this page and provided in your Email Updates

CERT A/B MAC Outreach & Education Task Force

CMS works closely with the CERT A/B MAC Task Force and the CERT DME MAC Outreach & Education Task Force

- CMS has a web page dedicated to education developed by the CERT A/B MAC Outreach & Education Task Force
  - http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/CERT-Outreach-and-Education-Task-Force.html

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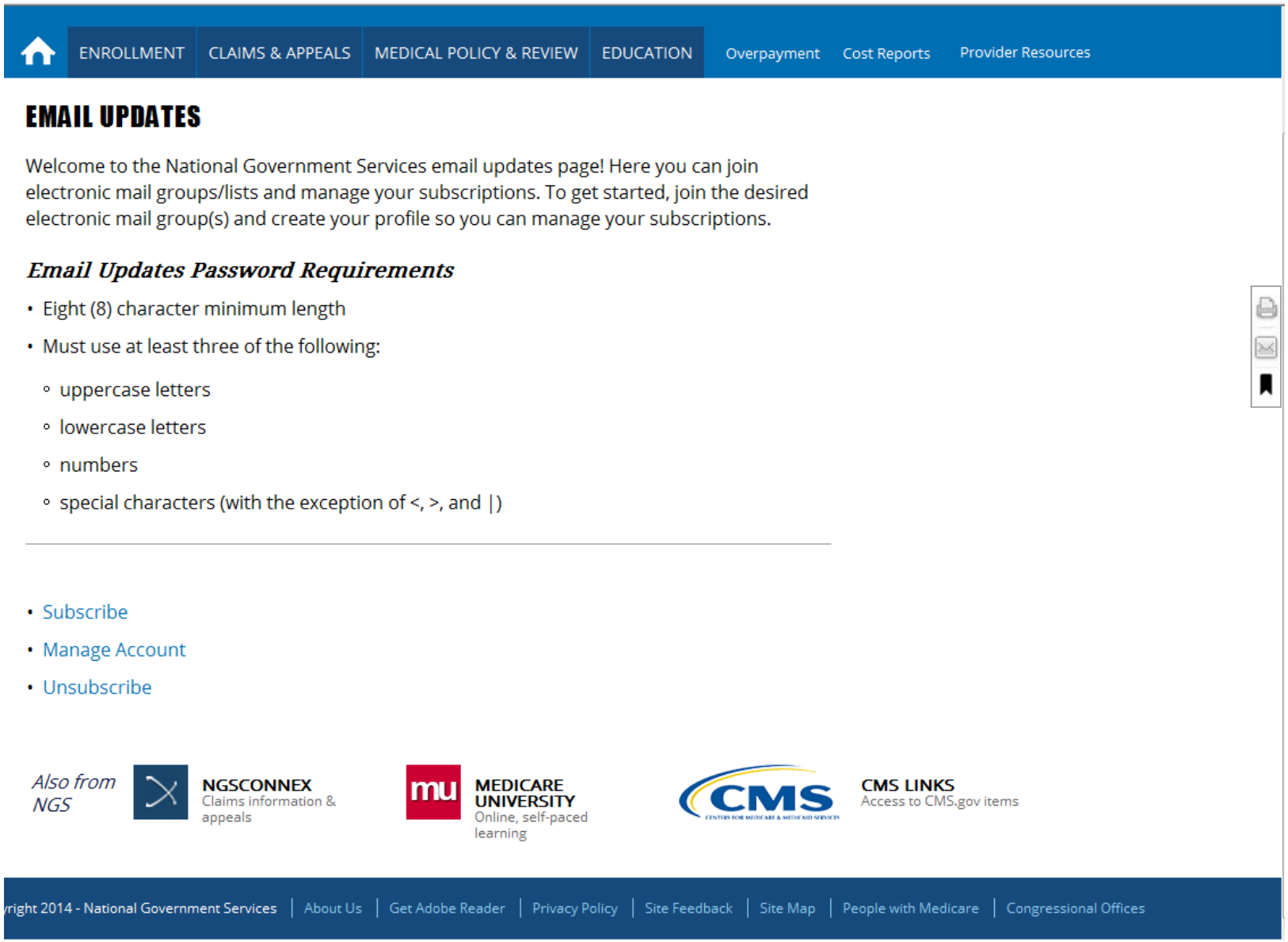

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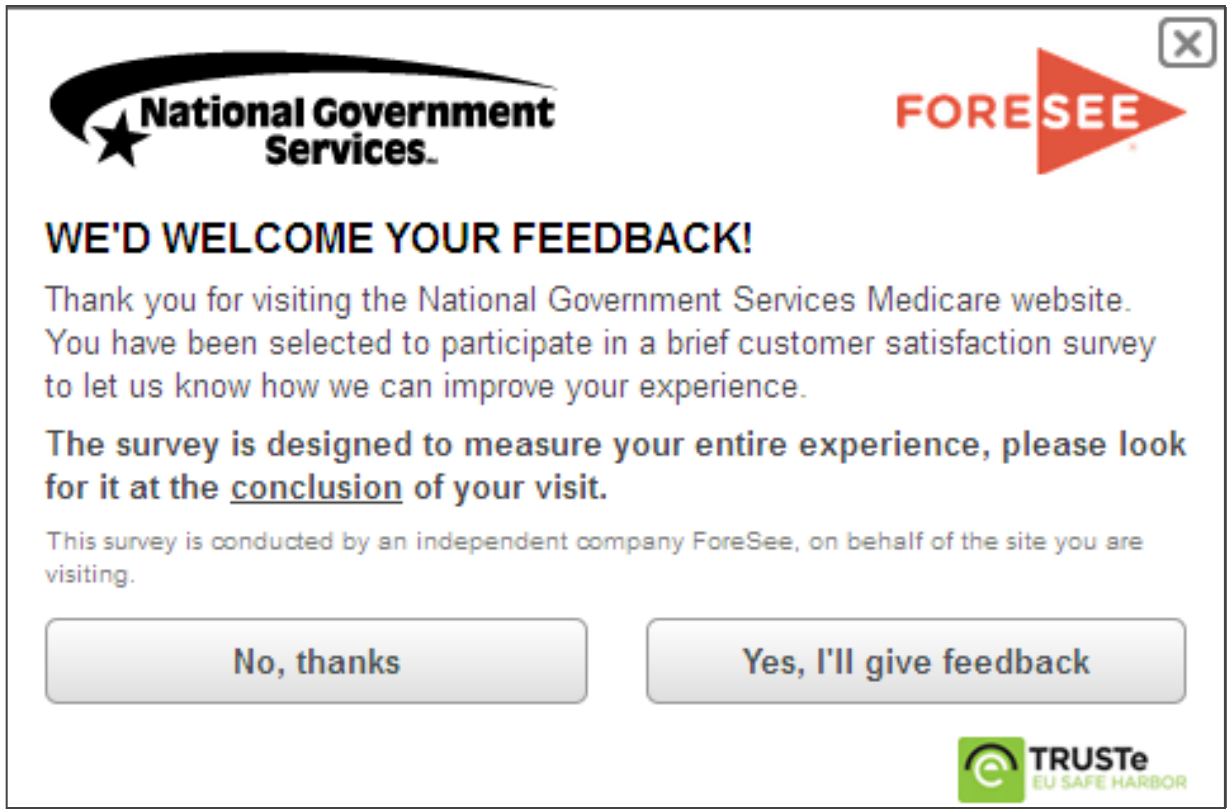
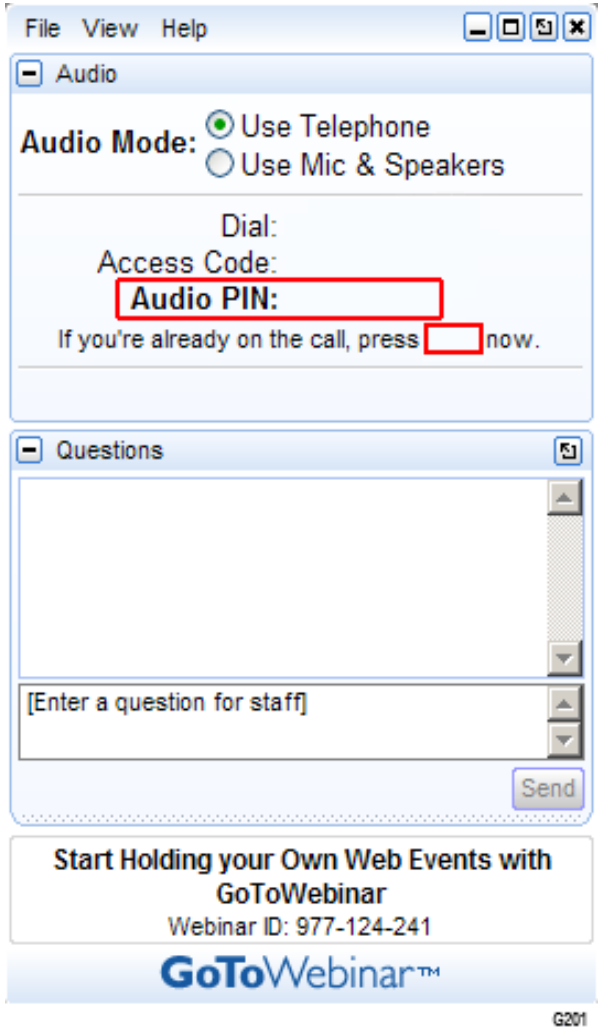


How to Participate Today



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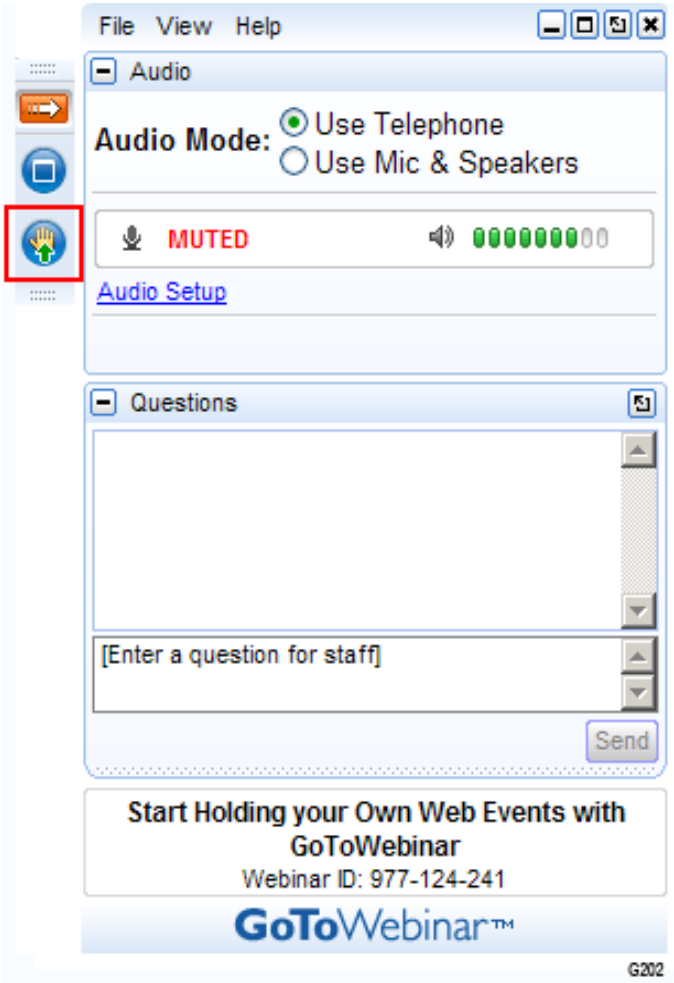
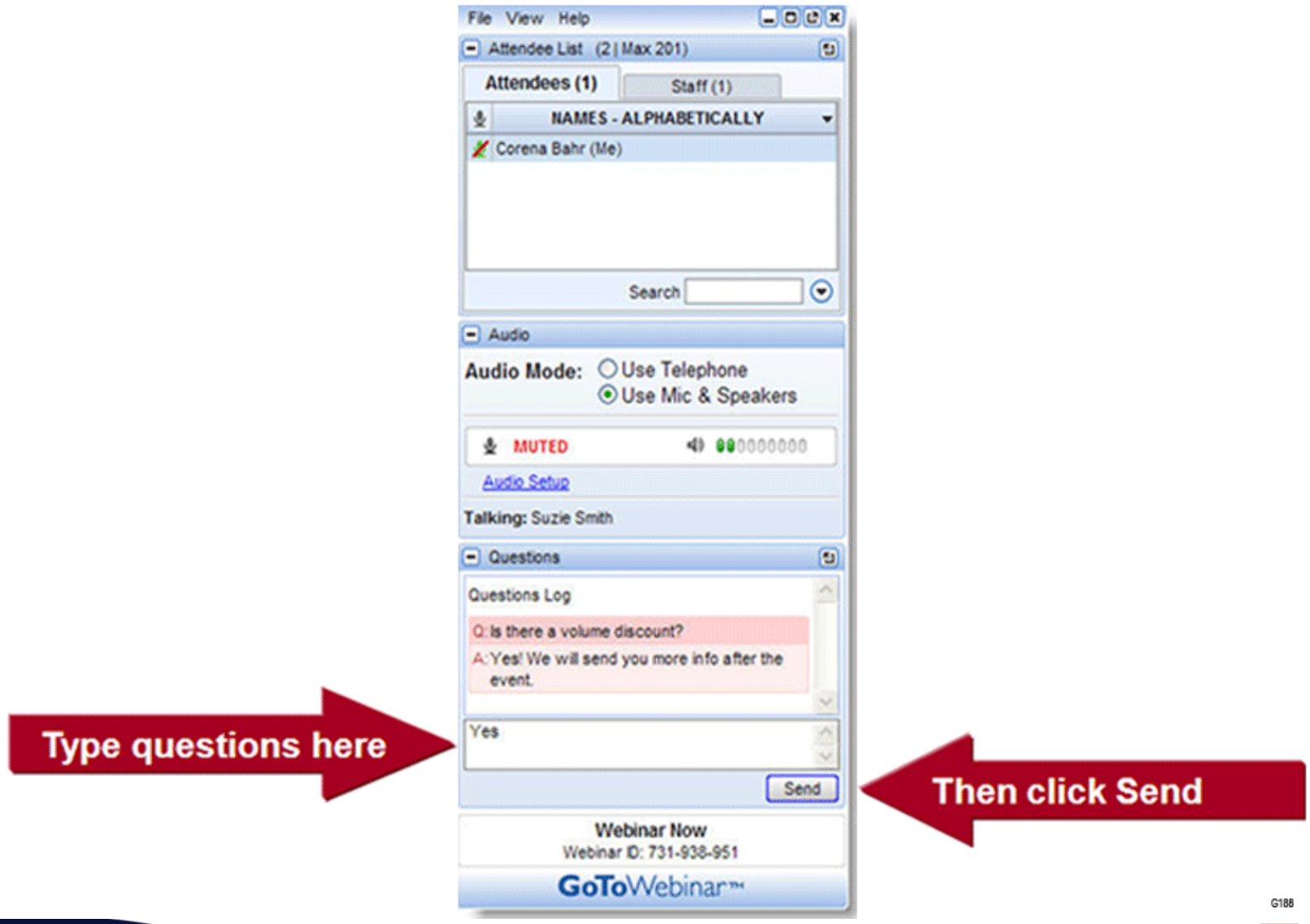
To Ask a Verbal Question: Raise your hand

- The **Green Arrow** means your hand is not raised (Click to raise your hand)
- The **Red Arrow** means your hand is raised (Click to lower your hand)



To Ask a Question
By Raising Your Hand

To Ask a Question
Using the Question Box



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Interactive online system available 24/7

Educational opportunities available

- Computer-based training courses
- Teleconferences, webinars, live seminars/face-to-face training

Self-report attendance

Website

- http://www.MedicareUniversity.com

Medicare University Self-Reporting Instructions

Log on to the National Government Services Medicare University site at http://www.MedicareUniversity.com

- Topic = **Hospice Eligibility and Election**
- Medicare University Credits (MUCs) = **1**
- Catalog Number = To be provided
- Course Code = To be provided
- Visit our website for step-by-step instructions on self-reporting. Click on the **Education** tab, then the **Get Credit** link. This will open the **Get Credit for Completed Courses** web page.

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Follow-up email

- Attendees will be provided a Medicare University Course Code

Questions?