National Hospice and Palliative Care Organization

CMS Issues Questions and Answers
April 12, 2012

CMS has released Q&As for clarifications requested by NHPCO and NAHC in recent weeks. The Q&As were covered in the Home Health/Hospice/DME Open Door Forum on April 11, 2012 and were posted to the CMS website on April 12. The Q&As can be found by going to https://questions.cms.gov/ , choose Medicare Fee for Service Payment on the left hand column, then choose "hospice." The most recent questions are the last four at the bottom of the list.

Can a hospice face-to-face encounter occur on the same day that the new hospice benefit period begins?

> Yes. The hospice face-to-face encounter must occur prior to, but no more than 30 calendar days prior to, the 3rd benefit period recertification, and every benefit period recertification thereafter. The face-to-face encounter is one part of a hospice recertification, so a recertification is not complete until it occurs. Therefore, by definition, a face-to-face encounter always occurs prior to recertification. We also require that each benefit period (after the first one) be recertified, and recertifications are to occur no more than 15 days prior to the start of the benefit period. This timeframe does not preclude the hospice face-to-face encounter from occurring on the same day that the new benefit period starts. We allow hospice providers the flexibility to complete the face-to-face encounter during the first day of the new benefit period.

If a veteran who is on hospice decides to go to a VA hospital for care, and doesn't revoke the hospice benefit, can the hospice use condition code 52 to discharge him or her?

> CR 7677, which becomes effective July 1, 2012, requires hospices to use new NUBC condition code 52 to indicate a discharge due to the patient's unavailability/inability to receive hospice services from the hospice which has been responsible for the patient. In such a circumstance, the patient is considered to have moved out of the hospice's service area.
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> If a duly 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. The hospice is unable to serve the veteran while he or she is in a VA owned and operated inpatient facility, and Medicare is not allowed to pay for those services for which another federal entity is primary payer. As of July 1, 2012, CR 7677 allows the hospice to discharge the veteran using condition code 52 if the beneficiary does not revoke the hospice benefit.

When a hospice patient goes to a hospital for care for the terminal illness or related conditions without the hospice arranging for it, who is responsible for the bill?

> For the duration of an election of hospice care, an individual waives all rights to Medicare payments for any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected, or a related condition. If a beneficiary seeks hospital care for the

terminal illness or related conditions without the hospice arranging it, then the beneficiary is liable for the cost of that hospital stay.

Can a hospice discharge a patient who is in a hospital for care for the terminal illness or a related condition if it doesn't have a contract with that hospital?

If the hospice does not have a contract with the hospital, then the hospice is unable to serve the beneficiary there. As of July 1, 2012, CR 7677 allows a hospice to discharge a patient who moves out of its service area, using condition code 52; receiving care in a hospital that the hospice doesn't contract with is considered moving out of the service area. The hospice will have to consider the beneficiary's length of stay in the hospital, and how it affects the plan of care, in deciding whether or not to discharge the patient.

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