



Managing Medicare Hospice Respite Care

Compliance for Hospice Providers Revised November 2016

DISCLAIMER

This Compliance Guidance has been gathered and interpreted by NHPKO from various resources and is provided for informational purposes. This should not be viewed as official policy of CMS or the Medicare Administrative Contractors (MACs). It is always the provider's responsibility to determine and comply with applicable CMS, MAC and other payer requirements.

WHAT IS RESPITE CARE?

Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may not be reimbursed for more than five consecutive days at a time, including the date of admission but not including the date of discharge. More than one respite period (of no more than 5 days each) is allowable in a single billing period (CMS, Chapter 11, Sec 30.1, 2011) There is no written guidance from the Centers for Medicare & Medicaid Services (CMS) which restricts the use of respite to one time per benefit period.

WHERE CAN RESPITE CARE BE PROVIDED?

Inpatient respite can only be provided in the following facilities:

- A Medicare-certified inpatient hospice facility
- A contracted Medicare-certified hospital or a skilled nursing facility that has the capability to provide 24-hour nursing if the patient's plan of care required that type of nursing intervention. (See section below: *CONSIDERATIONS WHEN CONTRACTING FOR RESPITE CARE*)

WHERE RESPITE CARE CANNOT BE PROVIDED?

The respite level of care under the Medicare Hospice Benefit is inpatient, which means that the patient is cared for in a Medicare designated inpatient facility. Therefore:

- Respite care **may not** be provided in an assisted living facility (ALF) or a residential care facility because these facilities are regulated at the state level and do not meet the requirement of being a Medicare or Medicaid certified hospital or nursing facility.
- Respite care **may not** be provided in a patient's private residence.

WHEN IS RESPITE CARE APPROPRIATE?

Respite care is for short term caregiver relief, so there needs to be a caregiver involved in the patient's care. The Centers for Medicare and Medicaid Services (CMS) does not furnish a list of scenarios or examples appropriate for respite care, so it is at the hospice provider's discretion to determine the merit of the caregiver's need. Some examples for provision of respite care may include:

- The caregiver is physically and emotionally exhausted from caring 24/7 for the patient and requires a break.
- The caregiver would like to attend a family event, such as a wedding, graduation, or other event.
- The caregiver is ill and needs a break from patient care to recover.

While the patient and their caregiver have the right to respite care under the Medicare Hospice Benefit, hospice providers should thoughtfully consider the reason of the caregiver for the respite stay. If a caregiver is requesting frequent respite care, then a change in patient care environment may be warranted. The interdisciplinary group (IDG) should review the patient/family situation to ensure appropriate care planning.

WHEN IS RESPITE CARE NOT APPROPRIATE?

Respite care may not be provided in the following circumstances:

- There is no identified caregiver
- Patient resides in a nursing facility or a facility that provides 24/7 care
- There is no clear reason for caregiver relief

★ **NOTE:** Continuous home care is not intended to be used as respite care

HOW OFTEN CAN A CAREGIVER ASK FOR RESPITE CARE?

- More than one respite period (of no more than 5 days each) is allowable in a single billing period.
- If the beneficiary dies under inpatient respite care, the day of death is paid at the inpatient respite care rate.
- Frequent use of respite care for one patient or unusual patterns of respite care may be a red flag to your Medicare Administrative Contractor (MAC). Documentation must justify the reason for the caregiver relief. (ie: 5 days of respite with a one day break and another 5 days of respite)
- Payment for inpatient respite care is subject to the requirement that it may not be provided consecutively for more than 5 days at a time. Payment for the sixth and any subsequent day of respite care is made at the appropriate home care rate. Counting respite care days example:
 - If the patient enters a respite period on July 1 and is returned to routine home care on July 6, the units of respite reported on the line item would be 5 representing July 1 through July 5, July 6 is reported as a day of routine home care regardless of the time of day entering respite or returning to routine home care.

CONSIDERATIONS WHEN CONTRACTING FOR RESPITE CARE

- **24 hour nursing** - The Medicare hospice Conditions of Participation (CoPs) no longer require that there be 24-hour nursing available when the respite level of care is contracted from a facility. The revised regulatory text at §418.108(b)(2) states that 24-hour nursing should meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. The contracted facility would provide room and board services and function as the patient's caregiver during the 5 days of inpatient respite per the contractual agreement language. (CMS, Hospice Conditions of Participation, 2008)

★ **NOTE:** Some state hospice licensure regulations have not eliminated the nursing requirement for respite care. Providers should check their state regulations to ensure that if 24-hour nursing is required, they only contract with facilities that meet the requirement.

- The hospice provider must ensure the following:
 - Provision of a copy of the patient’s plan of care and specify the inpatient respite services to be furnished.
 - That the inpatient provider has established patient care policies consistent with those of the hospice and agrees to abide by the palliative care protocols and plan of care established by the hospice for its patients.
 - That the hospice patient’s inpatient clinical record includes a record of all inpatient services furnished and events regarding care that occurred at the facility.
 - That a copy of the discharge summary be provided to the hospice at the time of discharge.
 - That a copy of the inpatient clinical record is available to the hospice at the time of discharge.
 - That the inpatient facility has identified an individual within the facility who is responsible for the implementation of the provisions of the agreement.
- A contract for respite services is required if respite care is not provided in the provider’s own facility, to meet the requirements of the Medicare Hospice Conditions of Participation to provide all four levels of care (§418.202 Covered services). The provider should document their efforts to secure a contract at the Medicare per diem respite rate and if a higher rate was negotiated, the reasons why.
 - Recommend referencing the regulations related to contract requirements for inpatient and SNF/IID (§ 418.112 (c) if the hospice provides respite in those settings.

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A word about physician orders

CMS does not specifically state that a physician order is required to change from routine home care level of care to inpatient respite level of care. Check your state hospice licensure regulations for possible requirements and in the absence of any requirements, obtaining a physician order is at your organization’s discretion.

Because of the increased scrutiny on physician orders, a best practice would be to have a physician order anytime there is a change in level of care.

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HOW SHOULD THE IDG DOCUMENT RESPITE LEVEL OF CARE?

A patient’s plan of care during an inpatient respite stay would be the same as if the patient were receiving care in their home. The established plan of care visit frequency is followed by the hospice interdisciplinary group (IDG) and the facility staff would give care that the caregiver would provide in the home setting. Documentation in the clinical record should include the following:

- Reason for respite care
- Dates of respite care provision
- Visits by any hospice discipline to the patient during the respite stay
- Orientation of facility staff to:
 - patient’s plan of care and advance directives
 - when and how to contact the hospice provider
 - hospice IDG visit schedule
 - how to contact patient’s caregiver

- Note that the documentation for each day of respite care provided should demonstrate continued eligibility for this level of service.

TRANSITIONING FROM GENERAL INPATIENT TO RESPITE CARE

CMS revised the respite guidance in Chapter 9, section 40.1.5 of the Medicare Benefit Policy manual in 2014 to include specific examples of when respite may be appropriate, one of which contemplates transitioning a patient directly from GIP to respite. The guidance states respite may be provided for "a few days immediately following a GIP stay if the usual caregiver has fallen ill". While this guidance appears to allow respite in instances where the patient is not currently residing at home, the qualifying language (underlined) is important and signals an expectation that these transitions will be unique and likely rare.

TRANSITIONING FROM ACUTE HOSPITAL INPATIENT TO RESPITE CARE

The guidance in Chapter 9, section 40.1.5 of the Medicare Benefit Policy manual states that "respite care cannot be provided to a hospice patient who resides in a facility (such as a long term care nursing facility)". In the description of the Q code for the type of service location, this includes both Q5003 and Q5004. This is a relatively broad prohibition and could be interpreted as not allowing a patient to be transitioned from hospital inpatient directly to hospice respite when there is no interceding GIP stay. Even if there were an interceding period of GIP, the appropriateness of respite in the hospital would be subject to the narrow limits discussed in Chapter 9.

RESPITE BILLING AND DATA REPORTING

Hospice providers are paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of 5 continuous days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate and the patient would be liable for room and board. Payment at the respite rate is made when respite care is provided at a Medicare or Medicaid certified hospital, SNF, hospice facility, or NF. (CMS, Medicare Claims Processing Manual, Chap. 11, 2011)

Visit Data: Medicare requires hospices to report additional detail for visits on their claims. For all Routine Home Care (RHC), Continuous Home Care (CHC) and Respite Care billing, Medicare hospice claims should report each visit performed by nurses, social workers, aides, homemakers, OT's, PT's, SLP's who are employed by the hospice, and their associated time per visit in the number of 15 minute increments, on a separate line. (CMS, Medicare Claims Processing Manual, Chap. 11, 2011)

- ★ Respite care visits of hospice staff only is recorded on the claim form in 15 minute increments.

RISK AREAS IN RESPITE CARE

- Provision of respite services outside of the specified Medicare guidelines as an incentive for referrals or facility contracts is prohibited. To avoid the appearance of inducement, providers should:

- Ensure that documentation for each day of Respite level of care evidences the reason for the caregiver relief
- Ensure that contractual agreements do not contain language which may indicate a kickback or inducement arrangement
- It may be difficult in some areas to secure an inpatient respite care contract with a Medicare or Medicaid certified hospital or nursing facility. Facilities may require the hospice provider to contract at a higher reimbursement rate than the per diem rate the provider receives from Medicare.

RESPITE CARE AND THE INPATIENT CAP

The total number of inpatient days, including both general inpatient and inpatient respite care, used by Medicare beneficiaries who elected hospice coverage in a 12-month period in a particular hospice may not exceed 20 percent of the total number of hospice days for which these patients had elected hospice care. (42 CFR 418.302(f))