



Discharge from the Medicare Hospice Benefit (Includes Revocation, and Transfer) *A Compliance Guide for Hospice Providers* *Revised August, 2014*

There are a limited number of reasons under the Medicare Hospice Benefit for patient discharge. The regulations for discharge are included in the Medicare hospice regulations, 42 CFR 418, Subpart B, §418.26. 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 or inconvenient, or the State allows for discharge under State requirements.¹ Discharge is a hospice decision and is initiated by the hospice provider only for the regulated allowable reasons.

Upon discharge from the hospice, the patient:

- Is no longer covered under Medicare for hospice care and **the patient loses the remaining days in the benefit period.**
- Resumes Medicare coverage of the benefits waived.
- May at any time elect to receive hospice **coverage for any other hospice election periods that he or she is eligible to receive.**

(The **bold text** is the update to this requirement outlined in CR 8727 issued on May 1, 2014 with an effective date of August 4, 2014).

Updates to the regulations

- **FY2015 Hospice Wage Index Final Rule:** An update to the regulatory text was issued by CMS and posted to the Public Inspection page of the *Federal Register* on August 4, 2014 and will publish in the *Federal Register* on August 22, 2014. The FY2015 Hospice Wage Index Final Rule, officially called the *Medicare Program; FY 2015 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements and Process and Appeals for Part D Payment for Drugs for Beneficiaries Enrolled in Hospice (CMS-1609-F)*. This rule is effective October 1, 2014.
- **CR8727:** An update was published in CR 8727 amended the content portion of this requirement and was effective August 4, 2014.
- **CR7677:** The regulations for this requirement were reviewed and updated in December 11, 1990 and amended on November 22, 2005. The last update to the regulatory text occurred on March 23, 2011 via Change Request (CR) 7677 issued by the Centers for Medicare and Medicaid Services (CMS). The update in 2011 amended the content portion of the requirement.

Reasons for hospice discharge

Discharge from the Medicare Hospice Benefit will occur as a result of one the following:

- **Patient Revocation:**
 - A patient or authorized representative decides to revoke the hospice benefit.
- **Transfer:**
 - A patient or authorized representative decides to transfer to another hospice.
- **Death:**
 - The patient dies.
- **Hospice discharge:**
 - The patient moves away from the geographic area that the hospice defines in its policies as its service area.
 - The patient's condition stabilizes or improves and they are no longer considered terminally ill.
 - The patient is discharged for cause.

Filing of Notice of Termination/Revocation (NOTR)

- **Effective October 1, 2014, providers will have a maximum of 5 days to have the Notice of Termination/ Revocation (NOTR) submitted and accepted by their Medicare contractor (if a final claim has not been submitted).**
- **CMS strongly encourages hospices to file the NOTR as soon as possible after the election or the revocation/discharge, not waiting until the fifth day.**

The **bold text** is the update to this requirement outlined in the FY2015 Hospice Wage Index Final Rule (CMS-1609-F) posed on August 4, 2014 and published in the Federal Register on August 22, 2014. The implementation date is October 1, 2014

Revocation of the Medicare Hospice Benefit

- A patient or representative may revoke the election of hospice care at any time in writing; **a hospice cannot "revoke" a patient's election.**
- Documentation required :
 - The patient or representative must file a document with the hospice that includes:
 - A signed statement that the individual revokes the election for Medicare coverage of hospice care for the remainder of that election period.
 - The effective date of the revocation.
 - **NOTE:** An individual may not designate an effective date earlier than the date that the revocation is made.
- A verbal revocation of benefits is **NOT** acceptable.

(The **bold text** is the update to this requirement outlined in CR 8727 issued on May 1, 2014 with an effective date of August 4, 2014).

Transfer to another Hospice Provider

- A patient may change, once in each election period, the designation of the particular hospice from which he or she elects to receive hospice care.
- The change of the designated hospice is not considered a revocation of the election, **but is a transfer.**
- Documentation required:

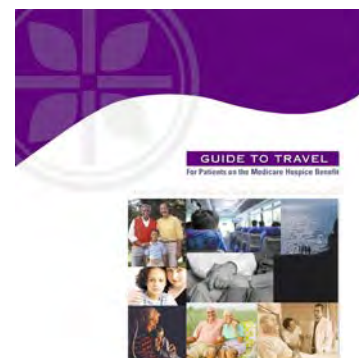
- the patient must file, with the hospice from which he or she has received care and with the newly designated hospice, a signed statement that includes the following information:
 - The name of the hospice from which the individual has received care,
 - The name of the hospice from which they plan to receive care, and
 - The date the change is to be effective.
- **As described in Pub. 100-04, [Medicare Claims Processing Manual, chapter 11, section 20.1.1](#), when a hospice patient transfers to a new hospice, the receiving hospice must file a new Notice of Election; however, the benefit period dates remain the same.**
- **The receiving hospice must complete all assessments required by the hospice Conditions of Participation as described in 42 CFR 418.54.**
- **Face-to-face encounter: If the patient is in the third or later benefit period and transfers hospices, a face-to-face encounter is not required if the receiving hospice can verify that the originating hospice had the encounter.**
- A change of ownership of a hospice is not considered a change in the patient's designation of a hospice and requires no action on the patient's part.

(The **bold text** is the update to this requirement outlined in CR 8727 issued on May 1, 2014 with an effective date of August 4, 2014).

Patient Moves Away From the Hospice Provider's Geographic Area

- Leaving the service area:
 - A hospice provider may discharge a patient who moves out of the provider's service area.
 - I.e.: **hospice patient moves to another part of the country.**
- Patient is traveling:
 - A provider may also discharge a patient when they leave the area for a vacation, but discharge for travel is optional and not required per regulation.
 - The Medicare Modernization Act of 2003 allows a hospice provider to keep the patient on service and contract with another hospice provider in the patient's travel destination.
 - The amount of time and the location of the patient's vacation should be considered by the hospice provider in determining discharge versus treating the patient as a traveler. The *NHPCO Guide to Travel Toolkit* suggests that if a patient will be traveling for a time greater than 14 days, the hospice provider should consider discharge as they will not be able to complete and update to the comprehensive assessment as the patient's care manager per the requirement in the Medicare hospice Conditions of Participation at §418.54(d).

This resource from NHPCO is available for purchase in our Marketplace
<http://www.nhpc.org/resources/marketplace>



- Patient in a non-contracted facility:
 - A provider may discharge a patient if they are admitted to a hospital or SNF that does not have a contractual arrangement with the hospice. CMS expects the hospice **would consider the amount of time the patient is in that facility and the effect on the plan of care before making a determination that discharging the patient from the hospice is appropriate.**

CMS related FAQ:

Question: 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?

Answer: 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. (CMS [FAQ 6105](#))

(The **bold text** is the update to this requirement outlined in CR 8727 issued on May 1, 2014 with an effective date of August 4, 2014).

No Longer Terminally Ill

- Discharge when a patient is no longer terminally ill should never be a last minute event for the interdisciplinary group (IDG).
- There should be consistent evaluative lead up to the determination to discharge the patient for this reason. When the hospice provider observes indications of disease plateau, there should be discussion with the patient and family about the possibility of discharge if the plateau continues.
- Hospice providers should consider adding information about potential discharge to patient handout materials that include:
 - Patient will be discharged if hospice physician deems patient as no longer terminally ill in their medical judgment
 - Patient has the right to appeal the discharge decision to their state Quality Improvement Organization
 - Hospice will provide discharge planning prior to discharge
- This information should be reviewed with the patient and family at the start of care at intervals throughout the service period.
- **The patient/ representative can ask the Quality Improvement Organization (QIO) for an expedited review of the discharge (see [Pub. 100-04, chapter 30, section 260](#) for more information)**
- Please refer to the following NHPCO tip sheets related to issuance of the Generic Notice of Medicare Non-Coverage form (NOMNC- CMS-10123), the Detailed Notice of Medicare Non-Coverage form (NOMNC- CMS-10124), and the Advance Beneficiary Notice (ABN- CMS-R-131). Click on links to access these tip sheets.
 - [Advance Beneficiary Notice \(ABN\)](#)
 - [Notice of Non-Medicare Coverage \(NONMC\)](#)

(The **bold text** is the update to this requirement outlined in CR 8727 issued on May 1, 2014 with an effective date of August 4, 2014).

Discharge for Cause

- There may be extraordinary circumstances in which a hospice is be unable to continue to provide hospice care to a patient.
- **When a 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 can consider discharge for cause.**
- The hospice must make every effort to resolve these problems satisfactorily before it considers discharge an option. All efforts by the hospice to resolve the problem(s) must be documented in detail in the patient's clinical record and the hospice must notify the Medicare contractor and State Survey Agency of the circumstances surrounding the impending discharge. The hospice may also need to make referrals to other relevant state/community agencies (i.e., Adult Protective Services) as appropriate
- **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 behavior or situation;**
 - **Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and**
 - **Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into the patient's medical records.**

(The **bold text** is the update to this requirement outlined in CR 8727 issued on May 1, 2014 with an effective date of August 4, 2014).

Discharge order

Prior to discharging a patient for any reason other than a patient revocation, transfer, or death, the hospice 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 or her review and decision included in the discharge note.

(The **bold text** is the update to this requirement outlined in CR 8727 issued on May 1, 2014 with an effective date of August 4, 2014).

Discharge planning

CMS expects that if there is indication of improvement in the patient's condition that causes them to be no longer eligible for hospice services, discharge planning should begin. Discharge planning should be a process, and planning should begin before the date of discharge. CMS does not provide prescriptive guidance regarding the timeframe for discharge planning, but rather view the issue as one requiring physician/interdisciplinary group judgment that is supported by documentation in the medical record indicating the reason why hospice should continue if there seems to be improvement such that discharge is under consideration.

- Discharge planning requirements:
 - The hospice must have in place a discharge planning process that takes into account that the patient's condition might stabilize or change as such that the patient cannot continue to be certified as terminally ill.
 - The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.
 - Once a patient is no longer considered terminally ill with a life expectancy of 6 months or less if the disease runs its normal course, Medicare coverage and payment for hospice care should cease. Medicare does not expect that a discharge would be the result of a single moment that does not allow time for some post-discharge planning. Rather, it would be expected that the hospice's interdisciplinary group is following the patient, and if there are indications of improvement in the individual's condition such that hospice may soon no longer be appropriate, then planning should begin. If the patient seems to be stabilizing, and the disease progression has halted, then it could be the time to begin preparing the patient for alternative care. Discharge planning should be a process, and planning should begin before the date of discharge.
 - In some cases, the hospice must provide Advanced Beneficiary Notification (ABN) or a Notice of Medicare Non-Coverage (NOMNC) to patients who are being discharged. See Pub. 100-04, Medicare Claims Processing Manual, [Chapter 30 "Financial Liability Protections", Section 50.15.3.1](#), for information on these requirements.

(The **bold text** is the update to this requirement outlined in CR 8727 issued on May 1, 2014 with an effective date of August 4, 2014).

- Discharge planning may include:
 - Provision of information for hired caregivers to family.
 - Referral to home health agency if needed.
 - Referral to appropriate community resources for ongoing support to the patient and family.
 - Confirmation that attending physician will resume medical care of patient.
 - Confirmation that caregivers have been educated about self-care medication administration.

Discharge and the face-to-face encounter

When a required face-to-face encounter does not occur timely, the beneficiary is not considered terminally ill for Medicare purposes due to lack of recertification, and therefore is not eligible for the hospice benefit. A hospice must discharge the patient but can re-admit once the face-to-face encounter occurs, the patient continues to meet all of the eligibility requirements, and the patient (or representative) files an election statement in accordance with CMS regulations. Where the only reason the patient ceases to be eligible for the Medicare hospice benefit is the hospice's failure to meet the face-to-face requirement, CMS would expect the hospice to continue to care for the patient at its own expense until the required encounter occurs, enabling the hospice to re-establish Medicare eligibility (CMS Change Request 7478).

NOTE: Occurrence span code 77 does not apply to the above described situations when the face-to-face encounter has not occurred timely.

Discharge Coding On Hospice Claims

The table below summarizes how hospice discharges should be coded on claims based on the changes in CR 7677, effective July 1, 2012. There are no changes to the coding for discharge revocation, or transfer.

Discharge Reason	Coding Required in Addition to Patient Status Code	Notes
Beneficiary revokes	Occurrence Code 42	ONLY for revocation
Beneficiary transfers to another hospice	Patient Status Code 50 or 51 No other indicator necessary	Does not terminate patient's current benefit period
Beneficiary no longer terminally ill	No other indicator necessary	This is applicable for a discharge related to a missed /late face-to-face visit
Beneficiary discharged for cause	Condition Code H2	Used when patient meets agency policy for discharge for cause
Beneficiary moves out of service	Condition Code 52	<ul style="list-style-type: none"> Moves out of service area On vacation Admitted to hospital or SNF where hospice does not have a contract

Reference: CMS. (2014, April 10). Pub. 100-04, [Medicare Claims Processing Manual, chapter 11](http://www.cms.gov/manuals/downloads/clm104c11.pdf). Retrieved from Medicare Internet Only Manuals: <http://www.cms.gov/manuals/downloads/clm104c11.pdf>

References

CMS. (2014, August 22). Medicare Program; FY 2015 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements and Process and Appeals for Part D Payment for Drugs for Beneficiaries Enrolled in Hospice (CMS-1609-F). Retrieved from <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Regulations-and-Notices-Items/CMS-1609-F.html?DLPage=1&DLSort=3&DLSortDir=descending>

CMS. (2014, May 1). Transmittal, Change Request 8727: Updates and Clarifications to the Hospice Policy Chapter of the Benefit Policy Manual. Retrieved from <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R188BP.pdf>

CMS. (2014, April 10). Pub. 100-04, [Medicare Claims Processing Manual, chapter 11](http://www.cms.gov/manuals/downloads/clm104c11.pdf). Retrieved from Medicare Internet Only Manuals: <http://www.cms.gov/manuals/downloads/clm104c11.pdf>

CMS. (2014, August 4). Coverage of Hospice Services Under Hospital Insurance, chapter 9, section 20.2. Retrieved from CMS Internet Only Manuals:

<http://www.cms.gov/manuals/Downloads/bp102c09.pdf>

CMS. (2004). 42 CFR 418, *Subpart B— Eligibility, Election and Duration of Benefits*. Retrieved from edocket.gpo: [http://www.ecfr.gov/cgi-bin/text-](http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&rgn=div5&view=text&node=42:3.0.1.1.5&idno=42)

[idx?c=ecfr&rgn=div5&view=text&node=42:3.0.1.1.5&idno=42](http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&rgn=div5&view=text&node=42:3.0.1.1.5&idno=42)

CMS. (2011, October 7). Transmittal, Change Request 7478. Retrieved from CMS Transmittals:

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2316CP.pdf>