Continuous Home Care in the Medicare Hospice Benefit

Compliance for Hospice Providers
Revised March 2021

What is Continuous Home Care?

Continuous home care (CHC) is one of the four levels of hospice care in the Medicare Hospice Benefit and required by the Medicare hospice regulations. The regulatory definition of continuous home care is meant to include predominately nursing care, covered for at least 8 hours, and up to 24 hours in a 24-hour period, beginning and ending at midnight. Either homemaker or hospice aide services or both may be covered on a 24-hour continuous basis during periods of crisis, but the care must be predominantly nursing care. The purpose of continuous home care is to achieve palliation and management of acute medical symptoms. Continuous home care is only furnished during brief periods of crisis as described in Sec. 418.204(a) and only as necessary to maintain the terminally ill patient at home. (CMS, 2009)

Continuous home care (CHC) day is a day in which an individual who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care for at least 8 hours in a 24-hour period at home. Hospice aide or homemaker services may also be provided on a continuous basis to supplement the nursing care.

Which Staff Hours Count Towards CHC Calculation?

- Predominately nursing care provided by an RN or an LPN/LVN employed by the hospice.
- Services provided by a nurse practitioner that, in the absence of a nurse practitioner, would be performed by an RN or LPN/LVN, are nursing services.
- Homemaker or hospice aide services to supplement the nursing care.
- Services of social workers and pastoral counselors would be expected during these periods of crisis, if warranted as part of hospice care, and are included in the provisions of routine hospice care. These services are not included in the statutory definition of continuous home care and are not counted towards total hours of continuous home care and may not be billed as continuous home care hours.

Contracting for Continuous Home Care

One of the major challenges hospices face in providing this level of care is having an adequate number of staff available when continuous home care is needed. Added to the challenge is the fact that nursing care is considered a hospice core service. Hospice core services must be provided by hospice employees.

Consequently, **hospices are not allowed to routinely contract** with nurses to provide continuous home care.

A hospice may, however, enter into arrangements with another hospice program or other entity for the provision of 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 unexpected increase in the number of patients requiring continuous home care simultaneously or temporary staffing shortages due to illness. 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 Section 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 must actively participate 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 home care) or during specific hours of care (e.g., evenings and weekends). (CMS, 2010)

★ The Centers for Medicare and Medicaid Services (CMS) recognizes there is a nursing shortage in some areas of the United States and has a temporary measure in place to allow individual hospices to contract for nurses if the hospice can demonstrate that the nursing shortage is creating an extraordinary circumstance that prevents it from hiring an adequate number of nurses directly. This temporary measure, which allows hospices to contract for nursing services, does not extend to counseling services and medical social services, which are the other core hospice services**.** Every two years CMS issues a memo with guidance for the Nursing Shortage as an "Extraordinary Circumstance" per 42 CFR 418.64 Core Services.

★ The October 2020 memo is summarized by CMS below:

- **Extraordinary Circumstances as Related to Hospice Staffing Requirements:** 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. The regulation allows the hospice to utilize these services temporarily without a waiver or exemption from the State Survey Agency (SA) or the CMS Location.

- **Compliance Determination:** CMS is updating previous guidance that the hospice agency must notify the CMS of its use of contracted staff during extraordinary circumstances and submit justification for such use to its SA or CMS Location. This notification/justification is not required by 42 CFR 418.64. Compliance with the regulation for use of contracted staff is reviewed as a part of the routine survey process.

- **Hospice Responsibility:** When contract services are utilized, the hospice agency maintains all professional, financial, and administrative responsibility for the services

When is CHC Appropriate?

Continuous home care may be provided only during a period of crisis. A period of crisis is defined by the Centers for Medicare and Medicaid Services (CMS) as a period in which a patient requires continuous home care, which is primarily nursing care, to achieve palliation or management of acute medical symptoms. If a patient's caregiver has been providing a skilled level of care for the patient and the caregiver is unwilling or unable to continue providing care, this may precipitate a period of crisis because the skills of a nurse may be needed to replace the services that had been provided by the caregiver. (CMS, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance, 2011)

CMS provides examples of circumstances that may qualify as CHC in the Medicare Benefit Policy Manual; Chapter 9 - Coverage of Hospice Services under Hospital Insurance .

When Is CHC Not Appropriate?

CMS states that CHC may be provided only during a period of crisis to manage pain and symptoms. (CMS, Subpart G, 2004) CHC is not appropriate:

- For a patient who is imminently dying with no acute skilled pain or symptom management needs.
- For caregiver breakdown with no acute skilled pain or symptom management needs. (As stated above, if a patient's caregiver has been providing a skilled level of care for the patient and the caregiver is unwilling or unable to continue providing care, this may precipitate a period of crisis because the skills of a nurse may be needed to replace the services that had been provided by the caregiver.)
- Continuous home care is not intended to be used as respite care.
- For safety concerns (for example, falls, wandering, etc.) in the absence of a need for skilled interventions.
- As an alternative to paid caregivers or placement in another setting.

Where Can CHC Be Provided?

CHC can be provided in the place where a patient resides such as:

- A private residence
- An Assisted Living Facility
- A long-term care facility (LTC) or non-skilled nursing facility (NF) (if the patient is not receiving a skilled level of care, i.e., Medicare Part A skilled benefit)
    - Providers need to be aware of how nursing facilities are licensed in their state as this will impact location of care codes on the hospice claim form. For example, all nursing facilities in Connecticut and New York are licensed as skilled nursing facilities.
    - This location of care would be coded on the claim form as Q5003, Hospice care provided in a nursing long term care facility (LTC) or non-skilled nursing facility (NF)

CHC MAY NOT be provided in an:

- Acute Care Hospital
- Skilled Nursing Facility (SNF) (where patient is receiving skilled care)
- Inpatient Hospice Facility

Source: CMS Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance, §40.2.1 - Benefit Coverage (Implementation: 08-04-14

How Should the IDT Document CHC Level of Care?

Medicare's requirements for coverage of CHC are that at least 8 hours of primarily nursing care are needed to manage an acute medical crisis as necessary to maintain the individual at home**.** When a hospice determines that a patient meets the requirements for CHC, documentation must be available to support the requirement that the services provided were reasonable and necessary and were in compliance with an established plan of care in order to meet a particular crisis situation. This would include the appropriate documentation of the situation and the need for continuous home care services consistent with the plan of care.

Documentation should include the following:

- Recommend process for documentation at least hourly
- Reason for continuous home care
- Vital signs (as appropriate)
- Observations of the patient's condition
- Interventions used to achieve palliation of physical or emotional symptoms
- Services provided to the patient
- Medications given and the patient's response
- Treatments completed and the patient's response
- Contacts made to the hospice and/or attending physician
- New or changed orders received
- Family response to care (as indicated)
- Detailed discharge planning to transfer the patient back to routine home care as soon as the crisis subsides.
- There is no specified frequency of documentation for CHC in the regulations or guidance. However, since CHC is for acute symptom management or some other crisis and billing occurs in 15-minute increments, the best practice standard is to document at least every hour.
- Suggest an MAR and narcotic count at each nursing staff shift change

Computation of CHC Hours

The following circumstances must be met in order to qualify and bill for CHC billing:

- The hospice must provide a minimum of 8 hours of care during a 24-hour day, which begins and ends at midnight.
- This care need not be continuous, e.g., 4 hours could be provided in the morning and another 4 hours in the evening. But a need for an aggregate of 8 hours of primarily nursing care is required.
- "Primarily nursing care" means that **greater than 50%** of the hours of care must be provided by an RN, LPN, or LVN.
- When fewer than 8 hours of care are provided, the services are reimbursed as a routine home care day rather than as continuous home care hours.
- The computation of the required 8 hours for the CHC level of care applies only to direct patient care provided by a nurse, a homemaker, or a hospice aide.

- **Calculation sample:**

Your Day 1 of Service	Nurse Hours	Aide Hours	8 Hour Aggregate Met?	50% of Aggregate Hours Nursing?	Can You Bill This Day at the CHC Rate?
24-hour day which begins and ends at midnight	5	9.5	Yes – 14.5 hours	No	No – only 5 hours of the aggregate were nursing. **To meet this requirement, nursing hours must be greater than 50% of the total of 14.5 hours, or greater than 7.25 hours.**
	4.75	12	Yes – 16.75	No	No – only 4.75 hours of the aggregate were nursing. **To meet this requirement, nursing hours must be greater than 50% of the total of 16.75 hours, or greater than 8.375 hours.**

Counting overlap of nurse and aide hours:

While in the majority of situations, one individual would provide continuous home care during any given hour, there may be circumstances where the patient's needs require direct interventions by more than one covered discipline resulting in an overlapping of hours between the nurse and hospice aide or homemaker. In these circumstances, the overlapping hours would be counted separately. The hospice would need to ensure that these direct patient care services are clearly documented and are reasonable and necessary.

Hours/services not counted in the 8-hour computation:

- Computation of hours of care should reflect the total hours of direct care provided for an individual that support the care that is needed. This means that all nursing and aide hours should be included in the daily computation for CHC. If the aide hours exceed the nursing hours on a given day, the provider would be paid as routine home care day rather than as a CHC.
- Deconstructing what is provided in order to meet payment rules is not allowed. In other words, hospices cannot discount any portion of the hospice aide and/or homemaker hours provided in order to qualify for a continuous home care day.
- Hospice aides or homemakers may not provide care as volunteers in order to meet the hours requirement for a continuous home care day.
- Documentation of care, modification of the plan of care and supervision of aides or homemakers would not qualify as direct care nor would it qualify as necessitating the services of more than one provider.

- The services provided by other disciplines such as medical social workers or pastoral counselors are an integral part of the care provided to a hospice patient**;** however, these services are not included in the regulatory definition of continuous home care and are not counted towards total hours of continuous home care. However, the services of social workers and pastoral counselors would be expected during these periods of crisis, if warranted, as part of hospice care and are included in the provisions of routine hospice care.

CHC Billing and Data Reporting

Billing: The amount of payment for CHC is determined based on the number of hours, reported in increments of 15 minutes of continuous home care furnished to the patient on that day. (These increments are used in calculating the payment rate) The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. (A minimum of 8 hours must be provided)

Payment is based upon the number of 15-minute increments that are billed for 32 or more units (4 units of 15 minutes equals one hour). Rounding to the next whole hour is no longer applicable. Units should only be rounded to the nearest increment. Billing for CHC should not reflect nursing shifts and non-direct patient increments (e.g., meal beaks, report, and education of staff). (CMS, Chapter 11, 30.3, 2010)

Location of care codes where CHC can be provided:

- **Q5001** – hospice care provided in patient's home/residence
- **Q5002** – hospice care provided in assisted living facility
- **Q5003** – hospice care provided in nursing long term care facility (LTC) or the non-skilled nursing facility (NF)
- **Q5009** - hospice care provided in a place not otherwise specified
- **Q5010** – hospice care provided in a hospice residential facility or a hospice facility which is also certified to provide inpatient care (CMS, Change Request 6905).

Location of care code where CHC cannot be provided:

- **Q5004 -** Hospice Care Provided in Skilled Nursing Facility (SNF)
  - CHC **cannot** be provided when the Q code location of care is Q5004 in a skilled nursing facility but can be provided when the patient is in a NF or long-term care facility (Q5003). Q5004 shall be used for hospice patients in a skilled nursing facility (SNF), or hospice patients in the SNF portion of a dually certified nursing facility. There are 4 situations where this would occur:
    1) If the beneficiary is receiving hospice care in a solely certified SNF.
    2) If the beneficiary is receiving general inpatient care in the SNF.
    3) If the beneficiary is in a SNF receiving SNF care under the Medicare SNF benefit for a condition unrelated to the terminal illness and related conditions and is receiving hospice routine home care; this is uncommon.
    4) If the beneficiary is receiving inpatient respite care in a SNF. If a beneficiary is in a nursing facility but does not meet the criteria above for Q5004, the site shall be coded as Q5003, for a long-term care nursing facility.

    CMS Chapter 11, Hospice Claims Processing:

CHC Risk Areas

Hospices across the country are experiencing increasing scrutiny of claims submitted for continuous home care. Payment of claims for continuous home care may be denied because:

- Documentation in the clinical record does not support the patient's initial and/or ongoing need for this level of care
- Computation of continuous home care hours is incorrect (for example, not eight hours within a 24-hour period beginning and ending at midnight; not predominantly nursing care)

CMS is monitoring CHC through targeted items on the hospice PEPPER report. Targets include:

- Continuous Home Care in Assisted Living Facility (ALF)
- Episodes with No General Inpatient Care (GIP) or Continuous Home Care.

CMS has concerns that some hospice providers are not providing access the full scope of services required by the Medicare Hospice Benefit. The federal hospice regulations require Medicare-certified hospices to be able to provide all four levels of care – including routine home care (RHC), general inpatient care (GIP), continuous home care (CHC), and inpatient respite care (IRC).

CMS is also monitoring CHC in assisted livings facilities related to a 2015 report from the Office of the Inspector General (OIG). The report stated that CHC is the level of hospice care with highest reimbursement rate and is seldom provided in ALFs. However, the OIG indicated that one large national for-profit chain stood out for its use of continuous home care in ALFs related to 2012 claims data. The OIG recommended that certain hospice providers be targeted for review. CMS concurred with the recommendation and supported the development of Fraud Protection System models targeting hospices that have a high percentage of beneficiaries who rarely receive visits, as well as considering hospices that provide high percentages of their beneficiaries at the continuous home care level of care.

There is also an increase in fraud investigations related to continuous home care. In 1999, the Office of the Inspector General identified "billing for a higher level of service than necessary" (for example, continuous home care or the general inpatient level of care) as an area where hospices might be vulnerable to fraud and abuse. Investigators are primarily concerned with providers who:

- Routinely offer continuous home care days to all patients and prospective patients residing in a facility when contracting with the facility. This is perceived as a violation of the Anti-Kickback Statute and as an inducement for referrals.
- Do not provide continuous home care to eligible patients. Medicare certified hospice providers are required to provide all levels of care, including CHC.
- Provide a significant amount of continuous home care to ineligible patients, particularly in nursing facilities.

CHC Compliance Monitoring

CHC is a challenging care level to manage. Hospices should continually audit and monitor its practices related to CHC as a component of their compliance and quality assessment performance improvement (QAPI) programs. Specifically, hospices should evaluate:

- Policies and procedures related to CHC that specify CHC eligibility and documentation requirements;
- Staffing levels to ensure the availability of continuous home care when needed;
- Processes for assessing and referring patients for CHC, obtaining physician orders, updating the patient's plan of care, and scheduling staff;
- Staff training regarding providing and documenting CHC;
- Training billing staff regarding CHC billing/coding requirements;
- Procedures related to ongoing discharge planning to ensure the patient returns to RHC as soon as feasible; and
- Ongoing audits of clinical records to ensure that documentation supports the patient's need for continuous home care on each day it is provided and that the care provided effectively addresses that need.

References:

CMS. (2020). CMS Medicare Claims Processing Manual Chapter 11 - Processing Hospice Claims – 30.3

CMS. (2014, AUG). CMS Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance – 40.2.1

CMS. (Feb 2021). Hospice Regulations Electronic Code of Federal Regulations, *Subpart G—Payment for Hospice.*

CMS. (2010, APR). Change Request 6905: New Hospice Site of Service

CMS. (2020). CMS State Operations Manual, Section 2080C.

HHS Office of Inspector General. (2015, JAN): Medicare hospices have financial incentives to provide care in assisted living facilities (OEI-02-14-00070).

HHS Office of Inspector General. (1999, OCT): Publication of the OIG Compliance Program, Guidance for Hospices