Understanding and Managing Live Patient Discharge in Hospice Care

NHPCO
National Hospice and Palliative Care Organization

September 2022 | nhpco.org

Table of Contents

Introduction

The issue of live discharges is a source of confusion for hospice providers and an area of scrutiny for the Centers for Medicare and Medicaid Services (CMS). This toolkit will provide regulatory guidance and links to regulatory text, case scenarios and questions to assist with staff education and understanding, as well as suggestions for documentation for each type of live discharge, both patient-initiated (revocation) and hospice-initiated live discharges. This toolkit is intended to provide guidance related to live discharges of Medicare hospice patients only. Medicaid, private payers and state requirements may differ, and hospices should be aware of any differences and apply them as appropriate.

The information provided does not, and is not intended to, constitute legal advice. Hospice providers are encouraged to consult their legal counsel to obtain advice with respect to any particular legal matter. This tool is designed to provide general information to hospices on the different types of live discharges and how to plan for them. Because each patient discharge is different, hospices are encouraged to consult legal counsel to review the payment and coverage implications of any particular discharge. For example, unique legal and payment considerations may be raised if a hospice learns after the fact of an issue that may give rise to a discharge (e.g., missing or late face-to-face visits or an unknown admission to a hospital). This resource does not and should not be used to address these types of circumstances.

There are a ***limited number of reasons*** under the Medicare Hospice Benefit (MHB) for patient discharge. The regulations for discharge are included in the Medicare hospice regulations, 42 CFR §418.26.[1] Once a hospice chooses to admit a Medicare beneficiary (patient), it may not automatically or routinely discharge the beneficiary at its discretion, even if the care promises to be costly or inconvenient.[2] Discharges can be initiated by the patient/representative or the hospice provider. A patient-initiated discharge, known as a revocation or transfer (a discharge from your hospice but not from the MHB), is a decision made by the patient at any time during the hospice election, for any reason. A hospice-initiated discharge is a hospice provider decision and is initiated by the hospice only for the regulated allowable reasons.

CMS commented on revocation in the FY2019 Hospice Wage Index proposed rule by saying "nor is it appropriate for hospices to encourage, request, or demand that the beneficiary or his or her representative revoke his or her hospice election. Like the hospice election, a hospice revocation is to be an informed choice based on the beneficiary's goals, values and preferences for the services the person wishes to receive through Medicare.[3]

This NHPCO toolkit will provide resources for hospice providers for each reason for live discharge, including a description of the live discharge reason, regulatory references, case scenarios and questions that can be used for staff education, and suggestions for documentation of the live discharge in the medical record.

[1] 42 C.F.R. § 418.26.

[2] CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.2.3.

[3] Centers for Medicare and Medicaid Services. FY 2019 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements Proposed Rule. Published 5/08/18. https://www.federalregister.gov/documents/2018/05/08/2018-08773/medicare-program-fy-2019-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting

Types of Live Discharges

Discharge from the Medicare Hospice Benefit could occur because of one the following actions:

Patient Initiated Discharge[4]

- A patient or authorized representative chooses to revoke the hospice benefit and services.
- A transfer occurs when a patient or authorized representative chooses to continue hospice services, but requests services be provided by another hospice provider.
  - Even though a transfer moves the current benefit period from one hospice to another, the transfer represents a live discharge for your hospice but not from the MHB.

Hospice Initiated Discharge[5]

- The hospice determines that the patient is no longer terminally ill (i.e.; life expectancy is no longer 6 months or less).
- The patient moves out of the geographic area that the hospice defines in its policies as its service area. Some examples of moving out of the hospice's service area include:
  - The patient moves to another part of the country or leaves the area for an extended period not arranged for through a traveling contract.
    - A traveling patient can continue hospice services under arrangement with a hospice provider in their travel area. The home hospice maintains professional management responsibility for the patient during the travel period.[6]
  - The patient is receiving treatment for a condition related/unrelated to the terminal prognosis or related diagnoses in a facility with which the hospice does not have a contract, and the hospice is unable to access the patient to provide hospice services. In this example, Medicare's expectation is that the hospice provider would consider the amount of time the patient is in that facility and the effect of the stay on the plan of care before making a determination that discharging the patient from the hospice is appropriate.
- The patient is discharged for cause.
  - There may be extraordinary circumstances in which a hospice is 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. Certain actions are required by the hospice prior to discharging a patient for cause, including documenting in the medical record the problems and efforts made to resolve the problems.[7]

[4] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 8/29/18: https://www.ecfr.gov/cgi-bin/text-idx?SID=0b265efa4b9e0bbb4f3b755641cf3deb&mc=true&node=se42.3.418_126&rgn=div8

[5] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 8/29/18: https://www.ecfr.gov/cgi-bin/text-idx?SID=0b265efa4b9e0bbb4f3b755641cf3deb&mc=true&node=se42.3.418_126&rgn=div8

[6] NHPCO Medicare Hospice Benefit Guide to Patient Travel. Retrieved on February 21, 2020.:https://www.nhpco.org/wp-content/uploads/2019/05/Medicare_Hospice_Benefit_Guide_to_Patient_Travel.pdf

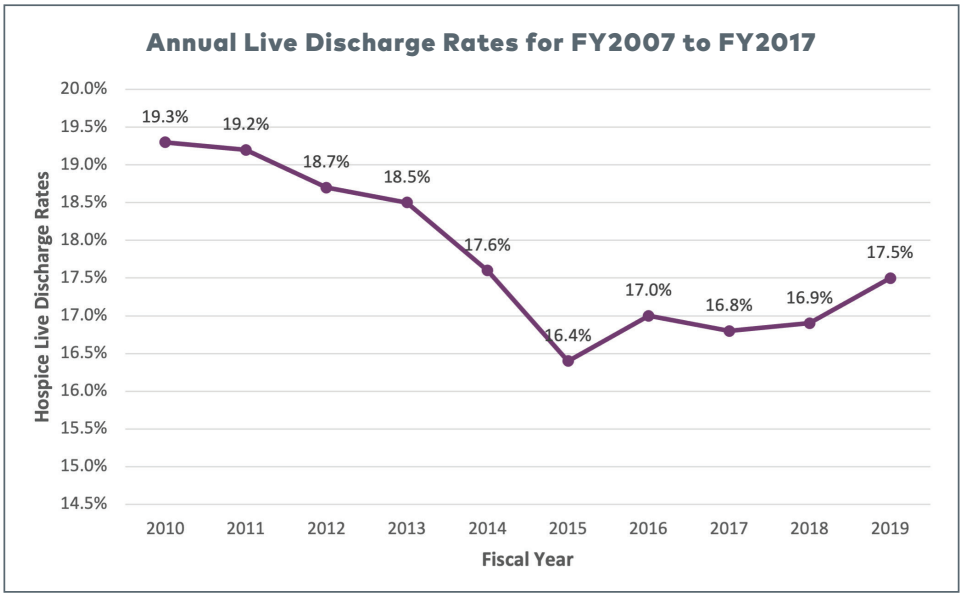
[7] 42 C.F.R. § 418.26(a)(3).

- Upon discharge from the hospice (except transfers), the patient:
  - Is no longer covered under Medicare for hospice care and forfeits hospice coverage for any remaining days in that election period.
  - Resumes coverage of the Medicare benefits waived.
  - May at any time elect to receive hospice coverage from any hospice for any other hospice election periods that he or she is eligible to receive.[8]
  - If under Medicare Advantage, they resume Medicare fee for service until the first day of the next month, when Medicare Advantage resumes.

What does CMS Claims Data Say about Live Discharges?

CMS has been monitoring the live discharge rate since 2007. See Figure 1 for details on the national live discharge rate. In 2012, a new code was established for patient revocation, so that revocations can be separately tracked from other reasons for a live discharge. In 2019, the last year for which detailed data is available, 37.5% of live discharges were patient revocations, 51% were hospice-initiated discharges because the patient was no longer terminally ill, and 12.9% were transfers from one hospice to another.

FIGURE 1



Source: FY2022 Hospice Wage Index Proposed Rule

CMS. (2021, April 14). Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update; Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Proposed Rule (CMS-1754-P). Retrieved from https://www.govinfo.gov/content/pkg/FR-2021-04-14/pdf/2021-07344.pdf

In the FY2022 Hospice Wage Index proposed rule, CMS stated that there is "The proportion of live discharges occurring between the length of stay intervals was relatively constant from FY 2016 to FY 2019 where approximately 25 percent of live discharges occurred withing 30 days of the start of hospice care, and approximately 32 percent occurred after a length of stay over 180 days of hospice care."

[8] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 8/29/18: https://www.ecfr.gov/cgi-bin/text-idx?SID=0b265efa4b9e0bbb4f3b755641cf3deb&mc=true&node=se42.3.418_126&rgn=div8

FIGURE 2

	Live Discharge Rate by Days and Year			
Model	**2016**	**2017**	**2018**	**2019**
< 30 Days	25.10%	25.40%	25.50%	25.00%
31 - 60 Days	12.40%	12.30%	12.60%	12.40%
61 - 90 Days	12.50%	12.30%	12.00%	11.60%
91 - 180 Days	18.60%	18.60%	18.70%	18.60%
>= 181 Days	31.50%	31.40%	31.20%	32.50%

Source: Analysis of data for FY 2016 through FY 2019 accessed from the CCW on January 15, 2021.

CMS. (2021, April 14). Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update; Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Proposed Rule (CMS-1754-P). Retrieved from https://www.govinfo.gov/content/pkg/FR-2021-04-14/pdf/2021-07344.pdf

Three hospice-level patterns of live discharges were defined as problematic when the provider's live discharge rate was at the 90th percentile or higher. A hospice with a high rate of patients discharged, hospitalized, and readmitted to hospice was considered to have a problematic live discharge pattern, which we have referred to as burdensome transition. The two other problematic live discharge patterns examined were live discharge in the first seven days of a hospice stay and live discharge after 180 days in hospice.[9]

Hospice Program for Evaluating Payment Patterns Electronic Report (PEPPER)[10]

How does Hospice PEPPER apply to hospice live discharges? Live discharges have been identified by the PEPPER contractor as an area of interest. Published annually in the Spring (usually April), **Hospice PEPPER** is an excellent reference for definitions and industry standards. National hospice claims data are analyzed each year to identify areas within the hospice benefit which could be at risk for improper Medicare payment. These areas are referred to as "target areas". Target areas must be approved by CMS before inclusion in PEPPER each year. The PEPPER Hospice Target Areas related to live discharges will provide a great start to knowing which discharge rates to monitor, and provides benchmark data regarding:

- Live Discharges, No Longer Terminally Ill
- Live Discharges, Revocations
- Live Discharges, LOS 61-69 days

[9] J Pain Symptom Manage. 2015 Oct;50(4):548-52. doi: 10.1016/j.jpainsymman.2015.05.001. Epub 2015 May 21. Characteristics of Hospice Programs With Problematic Live Discharges. Teno JM1, Bowman J2, Plotzke M3, Gozalo PL2, Christian T3, Miller SC2, Williams C2, Mor V2.

[10] PEPPER is developed and distributed by TMF Health Quality Institute, under contract with the Centers for Medicare & Medicaid Services (CMS). https://www.pepperresources.org/

Hospices should also consider monitoring:

- % live discharges LOS 7 days or less
- % live discharges LOS greater than 180 days
- % overall live discharges (include all reasons for live discharge)
- Live discharge and readmission of discharged patients

Each hospice's claims data statistics (obtained from the UB-04 claims submitted to the Medicare Administrative Contractor (MAC)) are available for these target areas by downloading their PEPPER. The report shows how a hospice's data compares to national, jurisdiction (MAC region) and state statistics. The data tables, graphs and reports in PEPPER were designed to assist the hospice in identifying potentially improper payments. More information on the Hospice PEPPER can be found at **www.pepperresources.org**.

Patient Initiated Discharges

Revocation & Change of Designated Hospice (Transfer)

Patient Revocation

General Regulatory Requirements

- A patient or representative may choose to revoke their election of hospice care at any time and it must be done in writing.
- **A hospice cannot "revoke" a patient's/representative's election** or encourage, request or demand that a patient or representative revoke their benefits.
- Revocation is a patient right, and in addition to the hospice, no other providers may make a decision to "revoke" a patient/representative hospice election.

Automatic Revocation is NOT Allowed by Regulation

- Revocation of the Medicare hospice benefit is a patient right and a patient decision. Hospice providers may not revoke a patient's hospice benefit or consider a benefit "automatically revoked" based on a patient's action.

Example: A hospice provider cannot tell a patient that if they seek emergent care from a hospital that is related to their terminal prognosis, their hospice benefit is "automatically revoked". There is no such allowance in the federal hospice regulatory guidance. A patient must willingly sign a revocation form to formally revoke their hospice benefit. (Pub. 100-02, Medicare Benefit Policy Manual Chapter 9, Section 20.2.2)[11]

- A statement of automatic revocation in the election of benefit is **NOT** allowed by Medicare hospice regulations.

Contents of Revocation Form

The patient or representative must file a document with the hospice that includes:[12]

- A signed statement that the individual revokes (no longer wants to use) 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; i.e.; backdating a revocation is not permitted

- A verbal revocation of benefits is <u>NOT</u> recognized.[13]

Documentation for Patient Revocation

- Documentation to support education given to patient and family about the hospice benefit and options they have during the admission process and after.
- Signed revocation form.

[11] Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance. (Sections 20.2.2) Retrieved on 8/29/2018: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

[12] 42 C.F.R. § 418.28(b).

[13] Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance. (Sections 20.2.2) Retrieved on 8/29/2018: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

- Documentation explaining the reason for revocation (if patient/representative chooses to disclose it).
- Documentation of discharge planning as permitted by patient/representative:
  - Collaboration with facility/provider that will be taking over care of the patient.
  - Documentation of resources that patient will need, including discharge instructions and medication profile.
  - Documentation of coordination of care related to:
    - removal of durable medical equipment (DME) from the patient's home
    - change of pharmacy for provision of medications

Quality of Care Considerations

Care coordination and clear communication with external healthcare providers is a key consideration to ensuring continuity of care for the patient. Ideally the patient should seamlessly resume access to the care and coverage that they had prior to electing the Medicare hospice benefit. The hospice provider should ensure a smooth transition from hospice to non-hospice care which could include such considerations as ensuring the patient has a supply of medications, the DME they require, and scheduled appointments with their attending physician.

Patient Initiated Discharge Case Scenarios (Revocations)

The following are hypothetical scenarios that illustrate reasons why a patient may choose to revoke hospice care:

CASE SCENARIO 1: Hospice Revocation

Mr. F is 83 years old when admitted on October 15th with end stage COPD (Chronic Obstructive Pulmonary Disease). He lives at home with his wife.

- November 12: Mr. F moved to an ALF (Assisted Living Facility) as his wife could no longer provide the care he needed due to its impact on her frail health.
- December 31: Mr. F moved back to his home, as they could no longer afford the ALF.
- February 1: Mr. F's wife was hospitalized, and she wanted him to receive care in a facility while she was in the hospital. The hospice provider offered respite and he refused. Mr. F would not let the hospice provider tell his wife he was home alone.
- February 5: Mr. F. stated he wanted to try aggressive treatment with cardiologist and pulmonologist and he also wanted some physical therapy. He chooses to revoke his hospice benefit and signs the revocation on February 5th. The hospice provider tells him to "call if things do not work out the way he expects". It is never clear if he ever followed up with pulmonologist or cardiologist.

What could have been done differently here?

1. Try to understand what outcomes he expects from the "aggressive" care. Determine if this could be part of the hospice plan of care, i.e. does it change the prognosis?

2. Contact pulmonologist and cardiologist to ensure they know he has elected his hospice benefit and understand what "aggressive" care they may prescribe.

3. Determine what results he would expect to see from PT, i.e. why he thinks it would be helpful. Provide a PT evaluation.

CASE SCENARIO 2: Revocation for Unplanned Hospitalization in a Contracted Facility

Mrs. W is admitted to hospice care on October 3rd with ES CHF (End Stage Congestive Heart Failure) and COPD (Chronic Obstructive Pulmonary Disease). She resides in an ALF.

- December 2: The hospice nurse visits patient and finds Mrs. W. with her daughter. Her daughter is upset with the attending physician regarding medication changes, specifically, that there was a change to patient's sodium prescription from every day to every other day. The daughter found her mother's hand bruised, edematous, and painful.
- December 9: Next nursing visit. Mrs. W. is very SOB (short of breath) and reports she had nausea and vomiting. The nurse also assesses 3+ edema in her upper extremities. The nurse calls the daughter to report her findings and the daughter states she wants her mother transferred to an emergency room. The nurse facilitates the transfer to a contracted hospital for GIP for symptom management (SOB, nausea and vomiting) which could not be managed at the RHC level of care in the patient's home.
- Daily hospice nurse visits are made to the patient in the hospital to manage the patient's plan of care.
- December 12: Diagnostics reveal that Mrs. W has a mass in the left lobe of her lung and she scheduled for a lung biopsy. The nurse discusses goals of care with patient and daughter and that a lung biopsy would be outside the scope of the hospice plan of care. Daughter became upset, decided they wanted the lung biopsy and choose to revoke hospice care. The patient stated she may want hospice again after discharge from hospital.

What could have been done differently here?

1. Hospice could have responded to the change in patient status by increasing nursing visits after December 2nd, and not waited 7 days until there was a change in the patient condition, change in medications, and the daughter was upset. With increased visits, the hospice may have been able to manage the CHF without a hospitalization (identified increasing edema before it became very symptomatic). Social worker increasing involvement to help with daughter. Close nurse assessments are critical in proactively managing care.

2. Communication with attending physician as to why sodium was decreased and obtain orders to draw sodium levels.

3. Work with ALF to understand when to contact hospice with concern perhaps before contacting attending physician.

4. Before and after Mrs. W. was hospitalized, did the hospice advocate for Mrs. W's end of life treatment preferences? Were her preferences care planned? Who was responsible for discussions with daughter? What were the outcomes of the discussions?

CASE SCENARIO 3: Veteran's Administration (VA) Patient

- Mr. H was admitted to hospice care on October 28th. He has Medicare Part A and a VA benefit. Hospice services are being paid for under Medicare Part A.
- A few days after admission to hospice, the patient is transported per his choice to his designated VA hospital for a procedure.
- The hospice provider learns from the patient that the VA physician advises him to be admitted to the hospital as the procedure is not recommended on outpatient level.

- The patient revokes his Medicare hospice benefit related to seeking care at a hospital where the hospice provider does not have a contract.

Note: Hospice is not able to contract with a VA facility for GIP services if health care is covered under Medicare Part A as primary.

- The hospice billing department enters the 81B the day after the patient's revocation. After this was done, the billing department was informed by the team they had been notified the procedure failed and admission to the VA hospital did not occur.
- The patient returned to the hospice provider's service area, re-elected hospice care and was admitted to his next benefit period.
- Several problems arose upon trying to readmit the patient to hospice care.
  - The NOE was entered one day late due to the 81B taking several days to clear. A series of actions were taken to get the patient entered into the system and billed correctly.
  - A NOE request for exception was made twice with the second request being granted after 3 months of diligent work on the case. Payment continues to appeal for the second admission.
- The patient did receive services and had a peaceful death.

What could have been done differently here?

1. The hospice could have discharged for leaving the service area in this case.

Change of Designated Hospice (also known as Patient Transfer)

General Regulatory Requirements

- An individual or representative may transfer (change their designated hospice), once in each election period.[14] The change of the designated hospice is a transfer of care from one hospice provider to another hospice provider and the benefit period remains the same. Both hospice providers are paid for the patient's level of care on the date of transfer. Hospices should work together to coordinate and maintain continuity of care when a patient chooses to change hospice providers.
- The patient/representative should file a statement with the hospice from which care has been received and with the newly designated hospice that indicates their intent to change hospice providers.[15]
- The statement should include the following information:[16]
  - The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care.
  - The date the change is to be effective.

[14] CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.2.1.

[15] Id.

[16] Id.

Transfer Requirements[17]

Either the hospice provider transferring/discharging the patient or the provider receiving the patient may assist the patient/authorized representative with initiating the transfer. In either case, the following requirements should be met.

Communication Between Two Hospices

Contact should be made with the other hospice agency and the following information documented:

- The method of the communication (e.g., email, telephone, fax)
- Date/time of the contact with the other agency
- The name individual with whom you communicated at the agency

Note: Unanswered communications are not acceptable. Ensure that a hospice employee documents the response from the other agency to ensure both hospices agree with the terms of the transfer.

Additional Issues for Consideration

- **Transfer Date:** The transfer date should be agreed upon before the transfer takes place. Ideally, the transfer date is either the same day or the day after the patient leaves one hospice and is received by the other hospice.
- **Gap in Days:** As of July 1, 2022, there can be NO gap in care days, per MM 12619. The goal in a patient transfer is continuity of care for the patient/family. The patient remains in the same benefit period during a transfer and interdisciplinary group (IDG) visit frequency listed in the plan of care should be maintained. Also, the 24/7 requirement to provide nursing, physician, and drugs (§418.100(c) Standard: Services)[18] is assumed by the receiving hospice provider on the date of transfer. Therefore, there must not be a gap in care between the transferring and receiving hospice provider. The transfer of care must begin and end on the same day.
- **Executing the Transfer Statement:** Explain to the beneficiary or the authorized representative that he or she is required to sign and date the transfer statement form (hospices have the flexibility to design and create their own forms, but only one form is required).
- **Copies of the Transfer Agreement Form on File with Both Agencies:** Ensure that a copy of the transfer agreement form is on file with both agencies before the transfer takes place.
- **Transportation Cost:** A patient in an inpatient setting who changes hospice providers may require ambulance transport. While there is no federal hospice requirement related to which provider pays the cost of the transportation, it is recommended that speedy negotiation commences between the two providers as to not delay the provision of patient care.

Transferring Hospice Responsibilities for Patient Transfer

Care Management Steps for the Transferring (Sending) Hospice:

- Contact the receiving hospice if you are assisting the patient/authorized representative with initiating the transfer, and document the information outlined above in the transfer requirements section.
- Once the determination is made, a written discharge order from the hospice physician is required (418.26(b)).
- Provide a hospice discharge summary and clinical record, if requested (418.104(e)).

[17] Palmetto GBA. Hospice Transfer Requirements. Last Updated: 8/17/17. Retrieved on 8/29/18. https://www.palmettogba.com/palmetto/providers.nsf/ls/JM%20Home%20Health%20and%20Hospice~AQBG575688?opendocument&utm_source=JMHHHL&utm_campaign=JMHHHLs&utm_medium=email

[18] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 7/1/19: https://www.ecfr.gov/cgi-bin/text-idx?SID=0b265efa4b9e0bbb4f3b755641cf3deb&mc=true&node=se42.3.418_126&rgn=div8

- Provide the receiving hospice with patient documentation from the clinical record to facilitate continuity of care. The following documentation is suggested for sharing with the receiving hospice provider:
  - The current certification of terminal illness (CTI)
  - Current hospice election statement
  - Current plan of care
  - Current physician orders
  - Face-to-face visit documentation as applicable
  - Additional documentation as requested by receiving hospice

Receiving Hospice Provider Responsibilities for Patient Transfer

Care Management Steps for the Receiving Hospice:

- Contact the existing hospice agency to work out the transfer date if you are assisting the patient/authorized representative with initiating the transfer.
- Complete all assessments as needed in accordance with 42 CFR § 418.54.[19]
- Obtain copies of the hospice discharge summary and the patient's clinical record, including as appropriate the original election of benefits and applicable face-to-face visit documentation.[20]
- If the beneficiary is transferring hospices in the third or later benefit period, a face-to-face encounter is not required if the receiving hospice can ***verify*** that the originating hospice had the encounter. It is important for the receiving hospice to review the documentation received from the transferring hospice, as these documents will govern the receiving hospice's care and payment. For example, close review of the election form prior to transfer will be important. If sufficiency issues are identified, the hospice will want to consider how best to address such issues and may want to consult with legal counsel.
- Ensure that all transfer requirements listed above have been met.

Documentation for Transfer

To change the designation of hospice programs, the beneficiary or the authorized representative should 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 (Pub. 100-02, Medicare Benefit Policy Manual chapter 9, section 20.2.1)

Advisable: Ensure that the patient's name and date of birth is on the transfer statement and that the patient or representative signs and dates the transfer statement.

Patient Transfer Scenarios

The following are hypothetical scenarios that illustrate reasons why a patient may choose to transfer to another designated hospice:

[19] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 8/29/18: https://www.ecfr.gov/cgi-bin/text-idx?SID=0bff11618b8f45329511069e2cebe8c2&mc=true&node=se42.3.418_154&rgn=div8

[20] 42 C.F.R. § 418.104(e)(1).

CASE SCENARIO 1: Beneficiary Transfer

Mr. P chooses to transfer to a new hospice on 08/05, which is the same day he leaves the transferring agency and is admitted to the receiving agency.

- The transferring/discharging hospice submits their final claim (8X4) with dates of service 08/01 through 08/05 and a patient status code of 50 or 51.
- Receiving hospice submits their Notice of Change (8XC) with 08/05 as their 'Admit' and 'From' date. The date reported with occurrence code 27 is the start date of the benefit period in which the patient transferred.
- Once the 8XC is processed, the claim for dates of service 08/05 to 08/31 (assuming the patient is still on service at the end of the month) may be submitted.
- Both agencies will be paid for 08/05 at the level of care they provided.

What should the receiving hospice do?

- Communicate with the sending hospice to ensure that Mr. P was transferred, not discharged from care from the sending hospice.
- Ensure that the sending hospice has submitted their final claim.
- Communicate with the sending hospice about eligibility paperwork and face-to-face documentation.

CASE SCENARIO 2: Family Decision to Transfer to Another Hospice

The patient's daughter informs the hospice aide she is going to change to a hospice provider that her neighbor recommended, and she wants it to occur quickly. She has contacted the other hospice and they are on their way to get her mother admitted. The hospice aide completes her visit and leaves the home. She then contacts her hospice and lets them know of this request.

What could the hospice do?

Although not a regulatory requirement, the current hospice provider may consider contacting the daughter immediately, in person is best but whatever is the fastest, to determine reason for request. Prompt and effective communication may be possible to avoid the transfer, but if not, assist in a safe and efficient transition of care.

What should the sending hospice do?

- Obtain a signed document which includes the name of the sending hospice, the name of the receiving hospice, and the effective date of the transfer.[21] This can be obtained directly by the sending hospice or from the new hospice. The regulations and applicable CMS guidance are not specific about whose form to use. A suggested practice would be that the hospice may choose to use the form based on who is initiating the transfer.
- Forward, to the new hospice, a copy of the hospice discharge summary and, if requested, the patient's clinical record.[22] The following documentation from the clinical record is suggested for sharing with the receiving hospice: current CTI, hospice election statement, plan of care, physician orders, face to face documentation (as applicable), along with any other documentation requested.

[21] CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.2.1.

[22] 42 C.F.R. § 418.104(e)(1).

What should the receiving hospice do?

- Contact the sending hospice provider.
- Determine if this is the first transfer in the benefit period. If it is not, the patient loses the remaining days in that benefit period. In transfer situations, the receiving hospice should use their own admission date.
- Review the sending hospice's clinical record items (election of benefit, certification, and applicable face to face documentation) for compliance.

Hospice Initiated Discharges

Introduction

Discharge Order

Prior to discharging a patient for any reason other than a patient revocation or death, the hospice must obtain a written physician's discharge order from the hospice medical director.[23] 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 communication with the attending physician should be documented in the patient's clinical record (Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance; Section 20.2.3)

Discharge Planning

CMS expects that if there is indication of improvement in the patient's condition such that hospice care may soon be no longer appropriate, discharge planning should begin.[24] 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 views 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 considers that the patient's condition might stabilize or change as such that the patient cannot continue to be certified as terminally ill.[25]
- 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.[26]
- 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.[27]

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.

[23] 42 C.F.R. § 418.26(b).

[24] CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.2.3.

[25] 42 C.F.R. § 418.26(d)(1).

[26] 42 C.F.R. § 418.26(d)(2).

[27] CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.2.3.

Discharge and the Face-to-Face Encounter

When a required face-to-face encounter does not occur timely, CMS instructs hospices to discharge the patient and expects the hospice to continue to care for the patient at its own expense until the required encounter occurs. A hospice can re-admit once the face-to-face encounter occurs, assuming the patient continues to meet all the eligibility requirements and the patient (or representative) files an election statement.[28] The assessment and plan of care should be updated. In the event a hospice learns of a late or missing face-to-face encounter after the fact, it is advisable to consult with legal counsel to determine how the issue may impact payment and what remedial action may be needed.

Allowable Reasons for Patient Live Discharge from Hospice Services

Patient is No Longer Terminally Ill

General Regulatory Requirements

- When the hospice physician, with input from the interdisciplinary group (IDG), determines the patient no longer has a prognosis of 6 months or less, the patient should be discharged.
- Discharge when a patient is no longer terminally ill should never be a last-minute event for the IDG. Hospice will provide discharge planning prior to discharge.
- There should be ongoing eligibility evaluations leading 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.
  - Transitions in care may be emotionally challenging for patients and their families, especially if the expectation is that care would be provided from the hospice provider until the patient's death. Initiating discussion about the possibility of discharge at the beginning of hospice care (as appropriate) and updating the patient/family in a timely manner if discharge appears imminent may lessen their feelings of anxiety, anger, and abandonment.
- Hospice providers should consider adding information about potential discharge to patient handout materials. For example, the patient materials could state that:
  - i. patients will be discharged from hospice care if hospice physician determines the patient is no longer terminally ill in his/her medical judgment,
  - ii. that the patient has the right to appeal the discharge decision to their State's Quality Improvement Organization (QIO), and
  - iii. that the hospice will provide the name and contact information of the QIO to the patient/family upon request.
- Evaluation of eligibility should be part of the ongoing comprehensive assessment and discussion of eligibility should occur at every IDG meeting as applicable. **Hospices should NOT wait until the end of the benefit period to discharge, if it is determined that the patient is no longer clinically eligible.**

Discharge Notice to the Patient/Family

- A patient who is discharged for no longer meeting Medicare eligibility criteria is issued the **Notice of Medicare Non-Coverage (NOMNC) form CMS-10123** (Generic Notice) no later than **2 days** before the effective date of the end of the Medicare coverage.[29]

[28] CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.1.

[29] 42 C.F.R. § 405.1200(b)(1).

- The patient/representative is required to sign this form.[30] If the beneficiary refuses to sign the NOMNC, the provider should annotate the notice to that effect, and indicate the date of refusal on the notice.[31]
- If state regulations for discharge notice require more than 2 days' notice, the provider is required to follow the more stringent regulation.

Patient/Representative Appeal of Discharge[32]

If the beneficiary does not agree that coverage should end, they may request an expedited review of the discharge decision by the QIO in that State. The provider then must furnish the Detailed Explanation of Non-Coverage (Detailed Notice Form CMS-10124-DENC) to the beneficiary explaining why services are no longer covered. The QIO will contact the hospice provider to obtain the patient medical information to complete a review. Generally, the QIO's review will be completed within 72 hours of the QIO's receipt of the beneficiary's request for a review. The QIO will render a decision to the patient and hospice provider indicating validation of the hospice provider's discharge or disagreement with the patient discharge.

- **Issuing the NOMNC / Expedited Determination Notice**
  In cases where there is a complete cessation of all Medicare covered services by the hospice, the NOMNC / (DENC) notice must be the issued by hospice provider. CMS updated the Medicare Claims Processing Manual, Chapter 30, via CR 7903 with an effective date of **August 26, 2013** to update guidance about issuance and completion of the NOMNC and the DENC forms, and requirements for interaction with a Quality Improvement Organization. (Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections, section 50.15.3.1)

- **QIO Decision**
  A QIO's decision is not legally binding which means if their decision does not support discharge of the patient, the hospice is not legally obligated to continue hospice care if the hospice physician does not feel, in their medical judgment, that the patient meets eligibility. CMS, Chapter 30 states the following about this situation:

  260.6.2 - Effect of QIO Determination on Continuation of Care (Rev. 2711, Issued: 05-24-13, Effective: 08-26-13, Implementation: 08-26-13) If the QIO decision extends coverage to a period where a physician's orders do not exist, either because of the duration of the expedited determination process, or because the physician has already concurred with the termination of care, providers cannot deliver care. In the event of a QIO decision favorable to a beneficiary without physician orders, the ordering physician should be made aware the QIO has ruled coverage should continue and be given the opportunity to reinstate orders. The beneficiary may also seek other personal physicians to write orders for care as well as find another service provider. The expedited determination process does not override regulatory or State requirements that physician orders are required for a provider to deliver care.

- **Advance Beneficiary Notice of Non-Coverage (ABN)[33]**
  If the patient and family wish hospice services to continue after the discharge date and are willing to pay out of pocket for the services, and if the hospice is willing to provide such services, the hospice provider should issue the patient the Advance Beneficiary Notice of Noncoverage (ABN). A provider should issue an ABN prior to furnishing services that are usually paid for under Medicare Part A or B but may not be covered in this particular case because

[30] 42 C.F.R. § 405.1200(b)(3)(i).

[31] 42 C.F.R. § 405.1200(b)(4); CMS, Pub. No. 100-02, Medicare Claims Processing Manual, ch. 30, § 260.3.5.

[32] See 42 C.F.R. § 405.1202; CMS, Pub. No. 100-02, Medicare Claims Processing Manual, ch. 30, §§ 260.4 et seq.

[33] See CMS, Pub. No. 100-02, Medicare Claims Processing Manual, ch. 30, §§ 50 et seq.

they are not medically reasonable and necessary. Hospice providers should issue the ABN prior to providing hospice care to a patient who is not terminally ill. The Advance Beneficiary Notice of Noncoverage (ABN) should be completed by the provider and signed by the patient or his/her representative, before a service is rendered.

The ABN advises the patient that the service they are about to receive may not be covered by Medicare. The form includes a description of the service, along with the estimated out-of-pocket cost and the reason why Medicare may potentially deny the service. The services itemized on the form should be clearly explained to the patient (or his/her representative). Thus, the ABN allows the patient to make an informed decision regarding whether to proceed with service at their expense or continue with recommended treatment plan. **The patient or their representative is required to sign and date the form and must be given a copy for their records.** If the patient refuses to sign the ABN, the provider should annotate the form to that effect.[34] Providers should maintain the original ABN in the patient's record.

References:

- Issuance of the Generic **Notice of Medicare Non-Coverage** form (NOMNC- CMS-10123),
- **Detailed Notice of Medicare Non-Coverage** form (NOMNC- CMS-10124)
- **Advance Beneficiary Notice** (ABN-CMS-R-131). Click on links to access these tip sheets.

Documentation for No Longer Terminally Ill

- Documentation that supports consistent/ongoing assessment of the patient painting a picture of improvement or no longer terminally ill.
- An order for discharge was obtained and documented from the hospice medical director.[35]
- Document that the Notice of Medicare Provider Non-coverage (NOMNC) has been delivered received /signed.
- Well-defined documentation of resources that are needed by the patient/family and documentation on how these needs will be met.
- Documentation of discharge planning for patient/family.
- Discharge planning discussions that occurred involving the IDG team, attending physician, patient, and patient's family/caregiver.
- Discharge planning discussion involving the RN/SW and the patient/patient family or caregivers (this includes coordination with the nursing facility or assisted living). Discharge instructions could include instructions for safe care following the discharge and a reconciled list of medications.
- Discharge summary documentation.[36]
  - The Conditions of Participation at §418.104(e)(2) requires the hospice provider to forward to the patient's attending physician, a copy of the following:
    - The hospice discharge summary; and
    - The patient's clinical record, if requested.
  - In accordance with §418.104(e)(3), the discharge summary must include the following information:

[34] CMS, Pub. No. 100-02, Medicare Claims Processing Manual, ch. 30, § 50.6.5.B.

[35] 42 C.F.R. § 418.26(b).

[36] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 8/29/18: https://www.ecfr.gov/cgi-bin/text-idx?SID=0bff11618b8f45329511069e2cebe8c2&mc=true&node=se42.3.418_154&rgn=div8

- A summary of the patient's stay including treatments, symptoms and pain management
- The patient's current plan of care
- The patient's latest physician orders
- Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility.

Quality of Care Considerations

Care coordination and clear communication with external health care providers is a key consideration to ensuring continuity of care for the patient. Ideally the patient should seamlessly resume access to the care and coverage that they had prior to electing the Medicare hospice benefit. The hospice provider should ensure a smooth transition from hospice to non-hospice care which could include such considerations as ensuring the patient has a supply of medications, the DME they require, and scheduled appointments with their attending physician.

Patient Discharge Scenarios (No Longer Terminally Ill)

The following is a hypothetical scenario that illustrates reasons why a hospice may choose to discharge a patient for no longer being terminally ill:

CASE SCENARIO 1: No Longer Terminally Ill

Ms. Smith is 87 years old with a diagnosis of advanced Alzheimer's disease. She was admitted to hospice care on January 26th following three days of hospitalization due to a change in cognitive status. Ms. Smith currently lives with her daughter because she requires supervision and care throughout the day and night. Ms. Smith's daughter found her in the home non-responsive and called EMS for transport to the hospital. Lab work reported in the hospital showed Ms. Smith to have an albumin of 2.1 and she has bacteria in her urine. Her daughter states that she has lost 40 pounds in the last 6 months and has become weaker each month. Ms. Smith barely opens her eyes to stimuli.

- Jan 26: Ms. Smith is admitted to hospice care with a diagnosis of Alzheimer's disease.
- February 22: Ms. Smith's daughter reports that her urine does not have odor any longer and she is eating 40% of her meals and loves chocolate.
- March 12: Ms. Smith's nurse notes state that she has gained 4 pounds and is continuing to eat between 50-60% of all meals. Ms. Smith is alert, mumbles, and speaks nonsensical words.
- March 22: Ms. Smith has gained 3 more pounds and is continuing to eat between 50-60% of her meals with dessert being her favorite. She remains alert and mumbling.
- March 26: Interdisciplinary team meeting. The hospice medical director and IDG discuss Ms. Smith's status. The LCD (local coverage determination) for Alzheimer's Disease is reviewed. IDG decision is made that Ms. Smith is no longer terminally ill with a 6 month or less prognosis.
- March 26: RN case manager calls family to set up a time to meet the next day to discuss discharge and resources needed.
- March 28: NOMNC issued. Discharge planning took longer than expected; therefore the hospice was unable to bill Medicare for these days, so the patient's care was not funded.

What could the have done?

- Several weeks earlier the hospice could have begun to have discussions with the daughter about the potential for discharge and simultaneously should have been facilitating discharge planning until the final determination was made.

- Ensure a thorough assessment and communication of her disease trajectory.
  - What was her nutritional consumption, rather than 50% of meal?
  - Does she feed herself or does she require assistance with feeding?
  - Did Ms. Smith have urinary tract infections in the past?
  - Has there been a change in her albumin?

Patient Moves Out of the Hospice Provider's Service Area

General Regulatory Requirements

A hospice provider may discharge a patient who moves out of the geographic area that the hospice provider defines in its policies as its service area.[37] As described in CMS guidance, some examples of moving out of the hospice's service area include:

- Patient is admitted to a non-contracted facility for care that is related/unrelated to the terminal prognosis.[38]
- Patient moves to another part of the country or travels outside of the hospice's service area on a vacation.[39]

Patient Admission to Non-contracted Facility

- A hospice 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 deciding that discharging the patient from h ospice care is appropriate.[40]

Example: The hospice provider learns on a Monday that their patient sought care in a non-contracted facility emergency department on Friday night for shortness of breath and exacerbated pain, which are symptoms associated with the primary terminal diagnosis. The patient's discharge date from the hospital is unknown and the hospice provider decides to discharge the patient from hospice services.

CMS comment on discharge for admission to a non-contracted facility:

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 to discharge the patient.

[37] See 42 C.F.R. § 418.26(a)(1); CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.2.3.

[38] CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.2.3; CMS Pub. No. 100-04, Medicare Claims Processing Manual, ch. 11, § 30.3.

[39] CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.2.3.

[40] CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.2.3.

Documentation for Patient Who Leaves the Service Area

- An order for discharge was obtained and documented from the hospice medical director.
- Well-defined documentation of resources that are needed by the patient/family and documentation on how these needs will be met.
- Documentation of discharge planning for patient/family
- Discharge planning discussions that occurred involving the IDG team, attending physician, patient, and patient's family/caregiver
- Discharge planning discussion involving the RN/SW and the patient/patient family or caregivers (this includes coordination with the nursing facility or assisted living). Discharge instructions could include instructions for safe care following the discharge and a reconciled list of medications.
- Discharge summary documentation[41]
  - Under §418.104(e)(2), a hospice is required to forward to the patient's attending physician, a copy of the following:
    - The hospice discharge summary; and
    - The patient's clinical record, if requested.
  - Pursuant to §418.104(e)(3), the discharge summary must include the following information:
    - A summary of the patient's stay including treatments, symptoms and pain management
    - The patient's current plan of care
    - The patient's latest physician orders
    - Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility.

Quality of Care Considerations

Care coordination and clear communication between the hospice and external healthcare providers is key to facilitating continuity of care for the patient who leaves the hospice's service area.

Patient Discharge Scenarios (Patient Moves from Hospice Provider's Service Area)

The following is a hypothetical scenario that illustrates discharge situations related to a patient leaving the hospice provider's service area:

CASE SCENARIO 1: Patient Moves Out of Hospice Service Area

Mr. Jones is a 72-year-old male with end stage Chronic Obstructive Pulmonary Disease (COPD), who was admitted in his second 90-day benefit period and has been on hospice service for a week. The patient's spouse calls the hospice triage service at 11:30 pm on Thursday night to report the patient's experience of shortness of breath and anxiety symptoms previously relieved by current medication regime. The triage Registered Nurse (RN) instructs the spouse to administer specific drugs from the patient's comfort kit to relieve the exacerbated symptoms. The spouse decides she is not comfortable with administering drugs from the comfort kit after concluding the call with the hospice triage nurse and calls 911. Mr. Jones is transported to the nearest hospital emergency department (ED) which is not contracted with the hospice provider. Mrs. Jones informs the ED staff that Mr. Jones receives hospice care from Best Hospice. The

[41] Centers for Medicare and Medicaid Services. Electronic Code of Federal Regulations; updated daily. Retrieved on 8/29/18: https://www.ecfr.gov/cgi-bin/text-idx?SID=0bff11618b8f45329511069e2cebe8c2&mc=true&node=se42.3.418_154&rgn=div8

ED contacts the hospice triage RN and she informs the ED physician that the patient is currently receiving hospice care for COPD and his symptoms are managed by his plan of care. The ED physician states that they intend to admit the patient for symptom management and is unsure how long the patient will remain in the hospital.

The hospice provider works to negotiate a one-time agreement with the non-contracted facility, but the hospital declines. The hospice provider then discharges the patient from hospice service because they do not have access to provide palliative intervention. The hospice provider documents, they sought the one-time agreement to avoid a live discharge but were denied by the hospital.

What could the hospice do differently?

- The hospice provider could have scheduled a family visit during the first week and initiated anticipatory interventions and education to manage a possible exacerbation.
- On-call RN could have been scheduled proactively to do a visit follow up.
- On-call RN could have gone to the home as soon as the call came in.
- The hospice triage RN could have provided options to the patient and wife for transport to contracted hospitals or GIP units for symptom management.
- The hospice on-call RN could have met patient at the hospital to facilitate dialogue concerning goals and options of care.
- The hospice provider could have waited a few days to make the discharge decision depending on communication with the patient and his wife related to hospital discharge.

Discharge for Cause

General Regulatory Requirements

Discharging a patient for cause should be a hospice provider's **last resort**. Documentation must demonstrate the interventions tried and failed by the hospice provider to address the identified problem before considering discharge.[42]

- There may be extraordinary circumstances in which a hospice is unable to continue to provide hospice care to a patient.[43]
- 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.[44]
- The hospice should 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 should notify their State Survey Agency of the circumstances after the discharge and their Medicare Administrative Contractor (MAC) on the patient's claim form using condition code H2 to indicate a discharge for cause.[45] The hospice may also need to make referrals to other relevant state/community agencies (i.e., Adult Protective Services) as appropriate.[46]

[42] 42 C.F.R. § 418.26(a)(3).

[43] CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.2.3.

[44] CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.2.3.

[45] CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.2.3; Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual Chapter 11 - Processing Hospice Claims. (Section 30.3) Retrieved on 8/29/2018: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

[46] CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.2.3.

- The hospice must complete the following before discharging a patient for cause:[47]
  - Advise the patient that a discharge for cause is being considered;
  - Document the problem(s) and efforts made to resolve the problem(s) in the patient's clinical record.
  - Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services.[48]
- Discharge for cause should not be for financial reasons or because the hospice does not like the patient or family.

Documentation for Discharge for Cause

- Objective description(s) of behaviors, concerns, and risks creating potential discharge for cause.
- Interdisciplinary meeting(s) collaboration about the concerns and care planning with documented interventions, responsibility, and measurable goals.
- Communication with the attending physician (if one) about the issues and possibility of discharge from hospice care if no resolution.
- Notification of the patient and family of the possibility of discharge for cause if no resolution.
- Education provided to the patient or family in regard to the problems/concerns and expectations of care plan.
- Documentation of all efforts made by hospice to resolve the problems/concerns, and outcomes of interventions.
- Consultation with the attending physician before discharge.
- Discharge order obtained from the hospice medical director.
- Notification to Medicare Administrative Contractor (via patient claim form) and State survey agencies about discharge for cause.
- Discharge summary which includes instructions, including arrangements for resources needed for patient. This may include Adult Protective Services or State/Community resources.

Quality of Care Considerations

Care coordination and clear communication with external health care providers is a key consideration to ensuring continuity of care for the patient discharged from hospice care. Ideally the patient should seamlessly resume access to the care and coverage that they had prior to electing the Medicare Hospice Benefit. The hospice provider's responsibility is to ensure a smooth transition from hospice to non-hospice care which could include such considerations as ensuring the patient has a supply of medications, the DME they require, and scheduled appointments with their attending physician.

Patient Discharge for Cause Scenarios

The following are hypothetical scenarios that illustrate discharge situations related to patients discharged for cause:

[47] 42 C.F.R. § 418.26(a)(3).

[48] CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.2.3.

CASE SCENARIO 1: Discharge for Cause (Medication Diversion)

Mrs. T is a patient of XYZ Hospice; her diagnosis is ovarian cancer. Due to debilitating progression of her disease, Mrs. T moved into her daughter Debbie's home, where she would have more available support and care. Debbie and her husband have two sons living in the home, seventeen and ten years of age. Debbie shared with the nurse and social worker that her older son has an "addiction problem" and she is fearful of having "narcotics" in their home. The interdisciplinary team develops a plan of care to promote Mrs. T's comfort and pain management; a plan that includes physician orders for morphine. When the morphine order is received, the nurse and social worker schedule a family meeting with the patient and all members of the family to review the plan of care, and to provide education about the medications, including the dangers and risks of anyone other than the patient using the medications. The policy for evaluating the usage of the medications and monitoring frequency of refills is also reviewed. A plan for safe storage of the medications and a schedule for medication administration are devised with the patient and daughter as primary her caregiver. The RN describes what medication diversion is and informs the patient and family that if medications are found to be missing, hospice policy would require a more restrictive plan and cooperation of the family, or discharge from hospice care. Mrs. T and her family all state they understand the plan and the consequences if medications are found missing. The nurse and social worker document in detail the plan for medication management and the education provided.

Two weeks following the family meeting, the nurse is told that the Roxanol™ order that was to be delivered to the home never arrived. Investigation reveals that the medication left the pharmacy as scheduled and the medication was "signed for" by the elder grandson. The nurse visits the patient and caregiver and shares her concern that the Roxanol™ was diverted. A Medication Safety Contract is signed, a lock box for the medications is provided, and the pharmacy is alerted to send limited quantities of Roxanol™. Additionally, the nurse informs Mrs. T and Debbie that further diversion may result in discharge from hospice. Again, detailed documentation of the plan and education is entered into the record, including the signed contract. The nurse notifies the attending physician of the possible diversion, and nurse and social worker visits are increased in frequency to monitor for adherence to the medication management plan.

Over the next week, despite multiple and varying efforts on the part of the interdisciplinary team and collaboration with the patient, family, and attending physician, evidence of medication diversion continues, compromising the safety of the patient and all family members. The team makes the difficult decision to discharge the patient for cause. The drug diversion protocol failed. The hospice provider documents that discharge for cause is the only course of action at this point.

Questions to ask:

- Does the patient need the medication? If no, obtain an order to stop the medication.
- If yes, is there a less desirable version (abuse deterrent formulation) that the patient could take?

Note: In this case scenario, diversion of the opioids prescribed and provided by the hospice impacted the management of the patient's comfort and quality of life, as well as endangered the health and safety of the family in the home and possibly members of the community. The hospice provider should exhaust all possible means for influencing and managing these situations, and document carefully all the interventions and subsequent outcomes, prior to deciding to discharge for cause.

CASE SCENARIO 2: Discharge for Cause (Guns in the Home)

Mr. Duck is an 83-year-old war veteran admitted to hospice for end stage COPD and comorbidities of CHF, Alzheimer's dementia and other health conditions of anxiety and PTSD. His wife reports that he has always been anxious, but it has gotten worse with his increased shortness of breath and need for increased oxygen. One of the things he likes to do is reminisce about his war days and show off his treasured gun collection. During the assessment the nurse notices that he dozes off frequently and is disoriented upon waking.

During one visit, wife reports that Mr. Duck has loaded a gun and is now sleeping with it because he hears noises at night. When asked if he will put it away, he says no. We ask the family members if they can remove the gun when he is asleep. The wife says she cannot because this is the only time he seems lucid. Talking about the war gives him pleasure. The hospice staff repeatedly explain the dangers, but family does not want to deprive him of this simple pleasure.

Based on the family's refusal to remove the bullets or place the gun in a lock box or gun safety box, the staff determine that is it is unsafe for them to continue seeing the patient and discharge for cause.

Questions to ask:

- Are guns loaded; can they be stored in another area of the house; can they be locked up during hospice visits?

Other questions / issues:

- Do you report to APS; If the family calls another hospice, how do you handle reporting the danger to them?
- Do the police need to be notified of the potential risk?

Billing Guidance

In General

Billing Reference in Hospice Regulations (§418.302 - Payment Procedures for Hospice Care)

- Generally, payment is made to the hospice for each day during which the beneficiary is eligible and under the care of the hospice, regardless of the amount of services furnished on any given day.
- For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

NOTR

The Notice of Termination/Revocation (NOTR) must be submitted and accepted by the Medicare contractor within 5 days.

Change of Ownership

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.[49] See the Hospice Change of Ownership job aid[50] and Hospice Billing the 8XE Job Aid[51] for more information.

Billing Information by Discharge Type

Use the table in Figure 3 on page 31 to ensure that the proper discharge code is used on the claim form.

Revocations[52]

- Post-revocation administrative functions:
  - Notify the Medicare Administrative Contractor (MAC) within 5 calendar days after the effect date of the revocation, following the guidelines for the Notice of Termination or Revocation (NOTR)[53]
  - Arrange for equipment to be removed
  - Contact pharmacy
  - Update collaborating care providers of change in hospice status
- Notice of Termination/Revocation (NOTR)
  - If a hospice beneficiary is discharged alive or if a hospice beneficiary revokes the election of hospice care, the hospice should submit a timely-filed Notice of Termination/Revocation (NOTR) unless the hospice has already filed a final claim. A timely-filed NOTR is one that is submitted to and accepted by the Medicare contractor within 5 calendar days after the effective date of discharge or revocation. Hospices continue to have 12 months from the date of service in which to file their claims.[54] Note that posting to the CWF/HETS may not occur within that same timeframe. The date of posting to the CWF/HETS is not a reflection of whether the NOTR is considered timely-filed.

---

[49] CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.2.1.

[50] Palmetto GBA. Hospice Change of Ownership. Last Updated: 4/9/18. Retrieved on 8/29/18. https://www.palmettogba.com/Palmetto/Providers.nsf/docsCat/JM%20Home%20Health%20and%20Hospice~Learning%20Education~Job%20Aids~Hospice%20Change%20of%20Ownership?open&Expand=1

[51] Palmetto GBA. Notice of Change of Ownership (TOB 8XE) Job Aid. Last Updated: 4/10/18. Retrieved on 8/29/18. https://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~JM%20Home%20Health%20and%20Hospice~Learning%20Education~Job%20Aids~AUAQVN6748?open

[52] Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual Chapter 11 - Processing Hospice Claims. Retrieved on 7/1/2019. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

[53] 42 C.F.R. § 418.28(d).

[54] CMS, Pub. No. 100-02, Medicare Benefit Policy Manual, ch. 9, § 20.2.4.

- When a new hospice admission occurs after a hospice revocation, the new admission date cannot be the same as the date of revocation.[55]

No Longer Terminally Ill

- **Billing:** At the point at which the hospice determines the patient is no longer eligible, the hospice should no longer bill the payer, even if the IDG is still completing discharge planning.
- **Timing of NOMNC:** The hospice can bill for two days from the date the NOMNC is issued, but no billing is allowable after that time even if discharge planning is not complete.

Discharge for Cause

- Billing reference §418.302 - Payment procedures for hospice care
- Generally, payment is made to the hospice for each day during which the beneficiary is eligible and under the care of the hospice, regardless of the amount of services furnished on any given day.

Hospice Transfers

Steps in the Billing Process:

- For the Transferring Hospice Provider:
  - Submit your final claim (8X1 or 8X4) with Patient Status Code 50 or 51 to indicate transfer to another hospice.
  - Ensure the dates of service on the claim are correct and align with the transfer date.

Note: There can be no gap in days for the transfer or the change in hospice provider will be considered a discharge and readmission. The receiving hospice's claim "from" date must be the same as the transferring hospice claim's "through" date. Both hospices will be paid for the date of transfer.[56]

- For the Receiving Hospice Provider:
  - Document in the record that you accessed the patient's eligibility records. CMS's HETS Eligibility Transaction System is one tool for checking Medicare beneficiary eligibility data in real time.
  - Ensure that the transferring/discharging hospice has already submitted their final claim (8X1 or 8X4) with Patient Status Code 50 or 51 to indicate transfer to another hospice, and then submit the Notice of Change (8XC) to Medicare.
  - After the Notice of Change (8XC) is processed, subsequent claims may then be submitted.
  - When a hospice patient transfers to a new hospice, the receiving hospice should file a new Notice of Election. (Pub. 100-04, Medicare Claims Processing Manual, chapter 11, section 20.1.1)[57]

Discharge Codes on the Patient Claim Form[58]

The table below summarizes how hospice discharge reasons 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.

---

[55] CMS, Pub. No. 100-02, Medicare Claims Processing Manual, ch. 11, § 20.1.1.

[56] Centers for Medicare and Medicaid Services. MedLearn Matters article MM12619, Gap Billing Between Hospice Transfers. https://www.cms.gov/files/document/mm12619-gap-billing-between-hospice-transfers.pdf,

[57] Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual Chapter 11 - Processing Hospice Claims. (Section 20.1.1) Retrieved on 8/29/2018: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

[58] Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual Chapter 11 - Processing Hospice Claims. (Section 30.3) Retrieved on 8/29/2018: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

FIGURE 3

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

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

Condition Codes

The hospice enters any appropriate NUBC approved code(s) identifying conditions related to this bill that may affect processing. Codes listed below are only those most frequently applicable to hospice claims. For a complete list of codes, see the NUBC manual.

Code	Description	Details
07	Treatment for non-terminal condition for hospice	Code indicates the patient has elected hospice care, but the provider is not treating the terminal condition, and is, therefore, requesting regular Medicare payment.
20	Beneficiary Requested Billing	Code indicates that the provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination.
21	Billing for Denial Notice	Code indicates the provider realizes series are at a noncovered level of care or excluded but requests a denial notice from Medicare in order to bill Medicaid or other insurers.
H2	Discharge by a Hospice Provider for Cause	Discharge by a Hospice Provider for Cause. **Note:** Used by the provider to indicate the patient meets the hospice's documented policy addressing discharges for cause.
52	Out of Hospice Service Area	Code indicates the patient is discharged for moving out of the hospice service area. This can include patients who relocate or who go on vacation outside of the hospice's service area, or patients who are admitted to a hospital or SNF that does not have contractual arrangements with the hospice.
85	Delayed recertification of hospice terminal illness	Code indicates the hospice received the recertification of terminal illness later than 2 days after the first day of a new benefit period. This code is reported with occurrence span code 77, which reports the provider liable days associated with the untimely recertification.

Transitions of Care

Transitions of Care

CMS cites transitions of care as patient movement across health care settings, including between providers of care and to and from home.[59] The Institute of Medicine described care transitions as particularly vulnerable events for patients. If transitions are poorly coordinated and managed, they can cause poor health care outcomes for patients and waste health care dollars.[60] CMS states that care transitions at the end of life are burdensome to patients, families, and the health care system at large because they can be associated with adverse health outcomes.[60, 61] It is important that hospice providers consider the impact a discharge, transfer, and revocation has on care transitions for their patients and their family. When appropriate, hospice providers may avoid patient care transitions by working with the patient and family to develop a workable plan of care and provision of high-quality patient and family care by the hospice team.

Hospice is under increasing scrutiny relative to live discharge rates, making it important for hospice providers to know what their internal rates are and to compare them to available industry benchmarks. CMS is watchful of live discharge rates, regardless of the reason, making it important to monitor and track all reasons individually as well as an overall percentage. Live discharges within 7 days may indicate inadequate evaluation of eligibility. A high rate of discharged patients with a LOS over 180 days may indicate the provider is trying to avoid external scrutiny. Readmission following recent live discharge may represent a burdensome transition for the patient and family, and might be an indicator the provider should review their process for determining ineligibility or examine patient reasons for choosing revocation.

Hospice providers should consider tracking and analyzing their live discharge data to determine if there is a pattern in the type of discharges, revocations, or transfers. Consistently assessing live discharge data can lead a hospice provider to identification of areas for performance improvement which will lead to provision of higher quality of care for patients and their families. This includes those instances where a live discharge, for whatever reason, is warranted.

[59] The Joint Commission. "Hot Topics in Health Care: Transitions of Care". Available from: https://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf 2

[60] "Improving Care Transitions, " Health Affairs Health Policy Brief, September 13, 2012. DOI: 10.1377/hpb20120913.327236

[61] Aldridge, M. D. P., MBA; et al. (2016). "The Impact of Reported Hospice Preferred Practices on Hospital Utilization at the End of Life" Medical Care 54(7): 657-663.

[62] Phongtankuel, V., et al. (2015). "Why Do Home Hospice Patients Return to the Hospital? A Study of Hospice Provider Perspectives." Journal of Palliative Medicine 19(1): 51-56

References

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. (2016, August 5). Pub. 100-04, Medicare Claims Processing Manual, chapter 11. Retrieved July 14, 2017 from Medicare Internet Only Manuals: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

CMS. (2017, July 14). Coverage of Hospice Services Under Hospital Insurance, chapter 9, section 20.2. Retrieved July 14, 2017 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-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

Hospice Care Amendments: November 22, 2005: https://www.gpo.gov/fdsys/pkg/FR-2005-11-22/pdf/05-23078.pdf

CMS. (2021, April 14). Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update; Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Proposed Rule (CMS-1754-P). Retrieved from https://www.govinfo.gov/content/pkg/FR-2021-04-14/pdf/2021-07344.pdf

CMS (2022, February 25). MLN Matters 12619 Gap Billing Between Hospice Transfers. Retrieved August 24, 2022 from https://www.cms.gov/files/document/mm12619-gap-billing-between-hospice-transfers.pdf

NHPCO
National Hospice and Palliative Care Organization

1731 King Street
Alexandria, VA 22314

tel. 703.837.1500 | **fax.** 703.837.1233
nhpco.org