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Medicare Hospice Benefit Basics

July 26, 2023

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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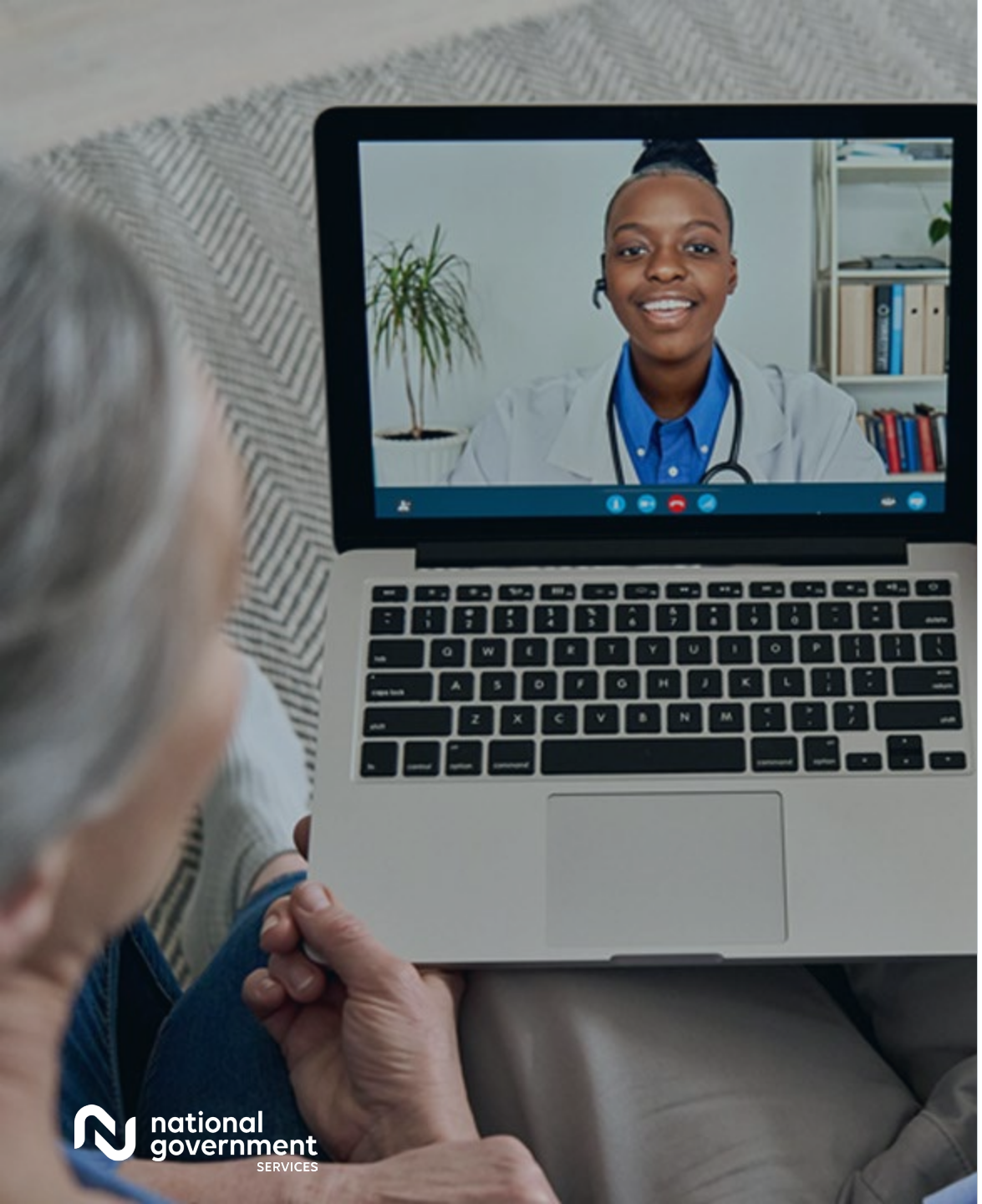

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Objective

After this session, attendees will understand the basics of the Medicare hospice benefit – patient eligibility, basic coverage guidelines, common terminology used and the different types of hospice care settings. In addition, attendees will know how to utilize self-service tools to determine Medicare eligibility and additional resources for hospice information.

Today's Presenter

Provider Outreach and Education Consultant

- Andrea Freibauer

Agenda

- Hospice Benefit Eligibility
- Hospice Benefit Coverage
- Provider Self-Service Tools
- References and Resources
- Q&A

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Hospice Benefit Eligibility

What is the Medicare Program?

- Federally-administered health insurance program for people
  - Age 65 or older
  - Under age 65 with certain disabilities
  - Of all ages with ESRD
- Medicare benefits offer coverage for
  - Part A – Hospital Insurance
  - Part B – Supplementary Medical Insurance (SMI)
  - Part C – Medicare Advantage Organization (MAO), including HMO
  - Part D – Prescription drugs

What is the Hospice Benefit?

- Hospice benefit under Medicare began in 1983
  - Part A Hospital Insurance Program
- Combination of home and inpatient care of the terminally ill that combines medical, spiritual bereavement and psychosocial services
  - Designed to help both the patient and the family
- “Whole person care” (physical, emotional, social, spiritual) with emphasis on pain control, symptom management, and emotional support rather than life-sustaining measures

Hospice Coverage Requirements

- Beneficiary must be entitled to Part A
- Beneficiary's doctor certifies as terminally ill with prognosis of life expectancy six months or less if illness runs its normal course
  - Initial certification must be done by hospice medical director or physician member of hospice IDG and beneficiary's attending physician if they have one
  - Subsequent certifications must be done by hospice medical director or physician member of hospice's IDG

Hospice Coverage Requirements

- Beneficiary must elect the benefit by signing Medicare hospice election statement
  - Waives all rights to traditional Medicare benefits for all services related to terminal illness
- Beneficiary receives all hospice-related care from Medicare-certified hospice
  - Can receive care for services not related to terminal illness under traditional Medicare
- If beneficiary enrolled in MAO plan, hospice benefit under Original Medicare assumes payment responsibility during hospice election

Common Medicare Hospice Terms

- Benefit period/Election period
  - Starts with election of the benefit and ends with the patient's discharge, revocation or death
- Election statement
  - Document prepared by the hospice agency and signed by the patient to indicate they chose that hospice agency and they understand what hospice care does/does not encompass
- Notice of Election (NOE)
  - Required transaction submitted to Medicare FFS to indicate hospice admission
- Hospice election
  - Encompasses one or more benefit periods in which the beneficiary has not revoked or discharged

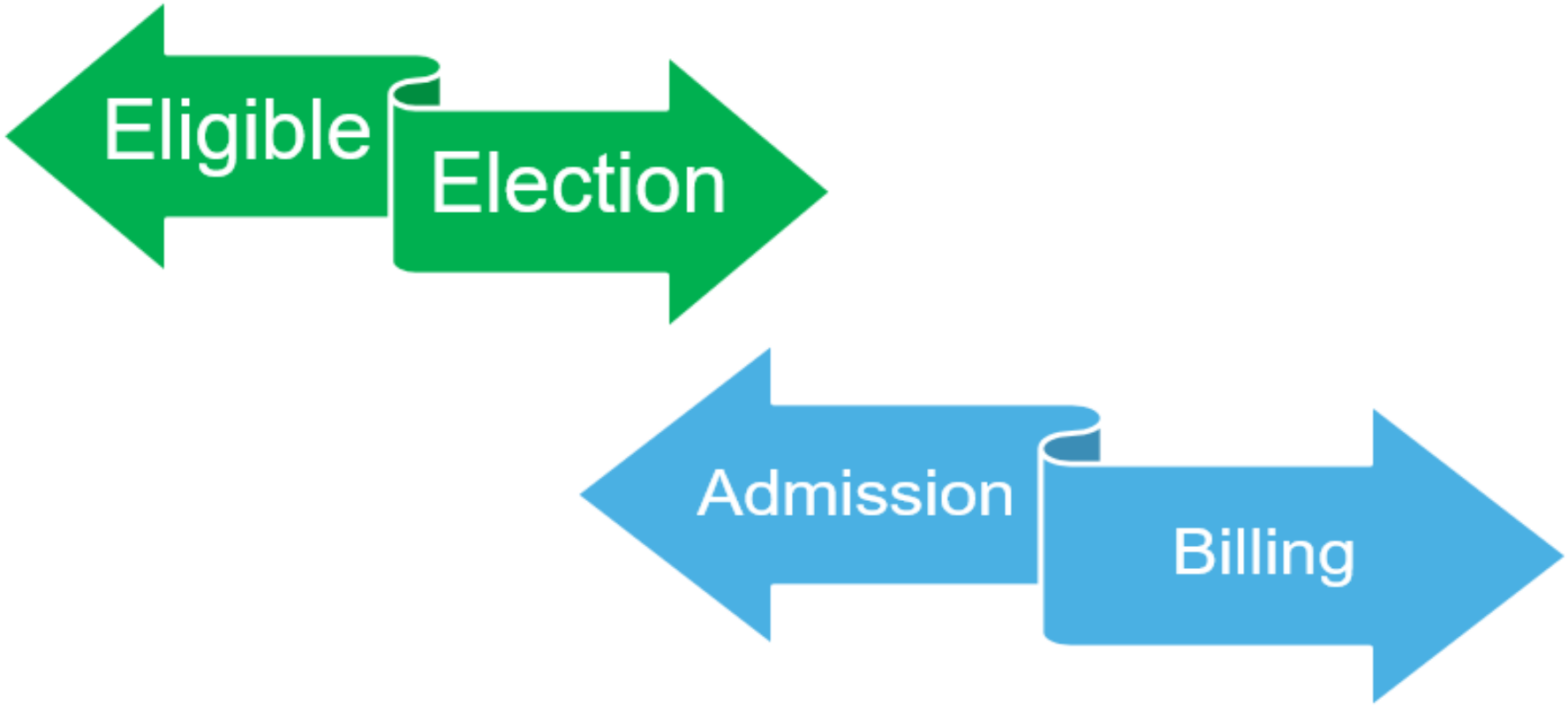
Common Medicare Hospice Terms

- Notice of Termination/Revocation (NOTR) –
  - Required transaction submitted to Medicare FFS to indicate patient was discharged alive from hospice or revokes hospice election
- Change of Provider/Transfer Notice –
  - Required transaction submitted to Medicare FFS to indicate patient changed hospice agencies with no gap in care or billing
- Cancellation of Election Notice –
  - Required transaction submitted to Medicare FFS to indicate patient will not be receiving services from the hospice agency but the admission date had already been entered into the system
- Change in Ownership Notice –
  - Required transaction submitted to Medicare FFS to indicate patient will remain with current hospice agency but that agency has been purchased or leased by another organization

Common Medicare Hospice Terms

- Certification of Terminal Illness (CTI)
  - Clinical certification that the patient meets the terminal illness requirements under the Medicare hospice benefit
- Admission
  - When the hospice agency begins rendering services to the patient; admission date is same date as the patient's effective hospice election date (except transfers)
- Recertification
  - Required for each hospice benefit period (after the initial), certification in the patient's medical record that the patient continues to meet the terminal illness requirements under the Medicare hospice benefit

Hospice Flow – Patient vs. Agency



Hospice Benefit/Election Periods

- Medicare hospice benefit consists of:
  - Two 90-day benefit periods (not renewable)
  - Unlimited number of 60-day benefit periods
- Beneficiary may
  - Change their hospice provider (transfer)
    - ✓ Only allowed once per benefit period
    - ✓ Does not end current benefit period
  - Voluntarily terminate/revoke hospice care at any time during any benefit period
    - ✓ Any remaining days in the current benefit period are forfeited
    - ✓ May re-elect the hospice benefit as long they remain eligible

Hospice Election Statement

- To admit patient, hospice must prepare hospice election statement
- No standard form, but all election statements required to have the following completed items
  - Identification of the particular hospice that will provide care to the individual
  - Beneficiary's (or authorized representative's) acknowledgment that they understand:
    - ✓ What hospice care consists of, particularly palliative rather than curative nature of treatment, and that hospice agency should be providing virtually all care needed
    - ✓ That certain Medicare services waived by the election and services unrelated to terminal illness/related conditions are exceptional/unusual
  - Effective date of the election
    - ✓ May be first day of hospice care or later date, but no earlier than date of the election statement
  - Information on individual cost-sharing for hospice services

Hospice Election Statement (cont.)

- If applicable, individual's designated attending physician and their identifying information
  - ✓ Can be physician, Nurse Practitioner (NP), or Physician Assistant (PA)
  - ✓ Full name, office address, NPI number, or any other detailed information to clearly identify attending physician
- Beneficiary/authorized representative's acknowledgment that they chose designated attending physician
- Notification of individual/representative's right to receive election statement addendum
  - ✓ Issued when there are conditions, items, services, and drugs the hospice has determined to be unrelated to the beneficiary's terminal illness/related conditions and would not be covered by the hospice
- Information on Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) – beneficiary's right to immediate advocacy and BFCC-QIO contact information
- Signature of beneficiary (or authorized representative)

After the Beneficiary Elects Hospice

- As with any election, the hospice agency must fulfill all other admission requirements, such as –
  - Certification/recertification of terminal illness
  - Any required face-to-face encounters
  - Conditions of Participation (CoP) assessments
- Election considered to continue through the initial election period and through subsequent election periods without break in care as long as the beneficiary:
  - Remains in the care of a hospice
  - Does not revoke the election
  - Is not discharged from the hospice
- Hospice must file Notice of Election (NOE) with Medicare FFS MAC

Face-to-Face Encounter

- Required prior to beginning of patient's third benefit period and each subsequent benefit period
  - Hospice physician or hospice nurse practitioner has face-to-face encounter with beneficiary and documents clinical findings supporting life expectancy of 6 months or less
- Must occur no more than 30 calendar days before third benefit period recertification and each subsequent recertification
  - May occur on first day of the benefit period and still be considered timely
- When not timely, recertification considered incomplete and Medicare will not cover/pay for hospice services
  - If only reason patient ceases to be eligible for Medicare hospice benefit
    - ✓ Discharge beneficiary from hospice benefit but continue to care for beneficiary (at hospice's expense) until FTF occurs
    - ✓ Readmit beneficiary once FTF completed and beneficiary (or their representative) files new election statement

Hospice Benefit Coverage

Medicare Hospice Services

- Hospice services must be arranged through hospice responsible for beneficiary
- Beneficiary liable for cost of services if seeks services for the terminal illness or related conditions without hospice agency arranging it
  - Applies for any services including, but not limited to, labs, diagnostics, IP stays and emergency room visits
- Medicare services for condition unrelated to the terminal condition for which hospice was elected can be paid by Medicare, if beneficiary eligible for such care

Plan of Care (POC)

- Must be created by hospice team and individualized depending on beneficiary's terminal illness and related conditions before any services provided
- Services must be reasonable and necessary for palliation or management of the terminal illness and related conditions
- Hospice not responsible for services provided outside of POC

Covered Hospice Services

- Doctor's services
- Nursing care
- Medical equipment (e.g., wheelchairs or walkers)
- Medical supplies (e.g., bandages or catheters)
- Prescription drugs for symptom control or pain relief
- Hospice aide and homemaker services
- Physical therapy services
- Occupational therapy services
- Speech-language pathology services

Covered Hospice Services (cont.)

- Social work services
- Dietary counseling
- Grief and loss counseling for the patient and family
- Short-term inpatient care for pain and symptom management
- Short term respite care
- Any other Medicare-covered services needed to manage pain and other symptoms related to the terminal illness and related conditions, as recommended by the patient's hospice team

Hospice Settings and Levels of Care

- Two settings (home or facility) and four billable levels of care
- Home
  - Routine Home Care
    - ✓ Most common, used when no other level of care is appropriate
  - Continuous Home Care (CHC)
    - ✓ Care provided at home during a crisis, more than 50% of care must be nursing by RN, LPN or LVN
    - ✓ Requires minimum of 8 hours of direct patient care, including nursing and/or homemaker or aide services, in a 24-hour day, beginning at midnight
    - ✓ Care must be billed daily in 15-minute increments

Hospice Settings and Levels of Care (cont.)

- Facility
  - General Inpatient Care (GIP)
    - ✓ Provided only when beneficiary requires intensity of care directed towards pain control and symptom management that cannot be managed in any other setting
    - ✓ Inpatient care provided in Medicare participating acute hospital, skilled nursing facility or hospice inpatient facility
  - Inpatient Respite Care
    - ✓ Short term inpatient care to relieve family members or others caring for hospice beneficiary at home
    - ✓ Must be arranged by hospice and provided in Medicare participating facility - hospital, hospice inpatient facility or nursing facility (includes facilities participating in Medicaid)
    - ✓ Cannot be covered by Medicare for more than 5 consecutive days at a time
    - ✓ Can be covered more than once per hospice benefit period

Deductible and Coinsurance

- No deductibles are applied to hospice services
- Coinsurance can only be charged in certain instances
  - Outpatient drugs and biologicals
    - ✓ 5% of reasonable cost of drug or biological, but not more than $5, for each prescription furnished
      - If hospice charges coinsurance on drugs/biologicals, must establish “drug copayment schedule” that specifies each drug and copayment to be charged and submit this schedule to A/B MAC (HHH) in advance for approval
  - Inpatient respite care
    - ✓ 5% coinsurance amount up to inpatient hospital deductible amount
      - Based on national Medicare respite care rate after adjusting national rate for local wage differences

Noncovered Hospice Services

- Treatment intended to cure the terminal illness
- Prescription drugs to cure the terminal illness
  - Does not refer to drugs for symptom control or pain relief
- Care from any hospice provider not set up by hospice medical team
- Room and board
  - Excluding short-term inpatient or respite care services arranged by hospice provider
- Care in an emergency room, inpatient facility care, or ambulance transportation
  - Unless arranged by hospice medical team or is unrelated to hospice terminal illness

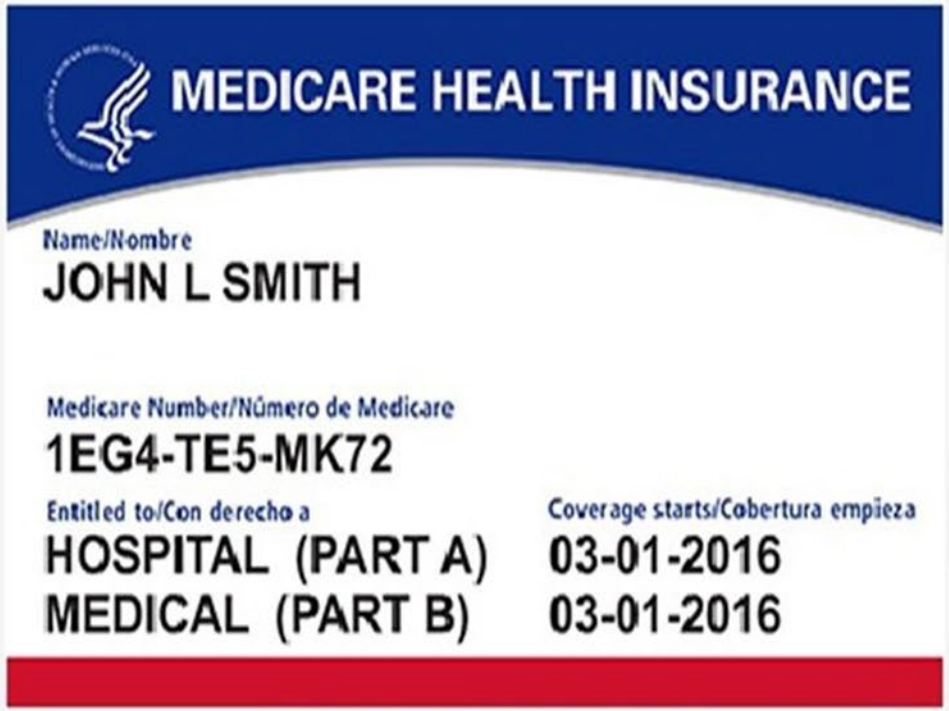
Provider Self-Service Tools

Medicare Card

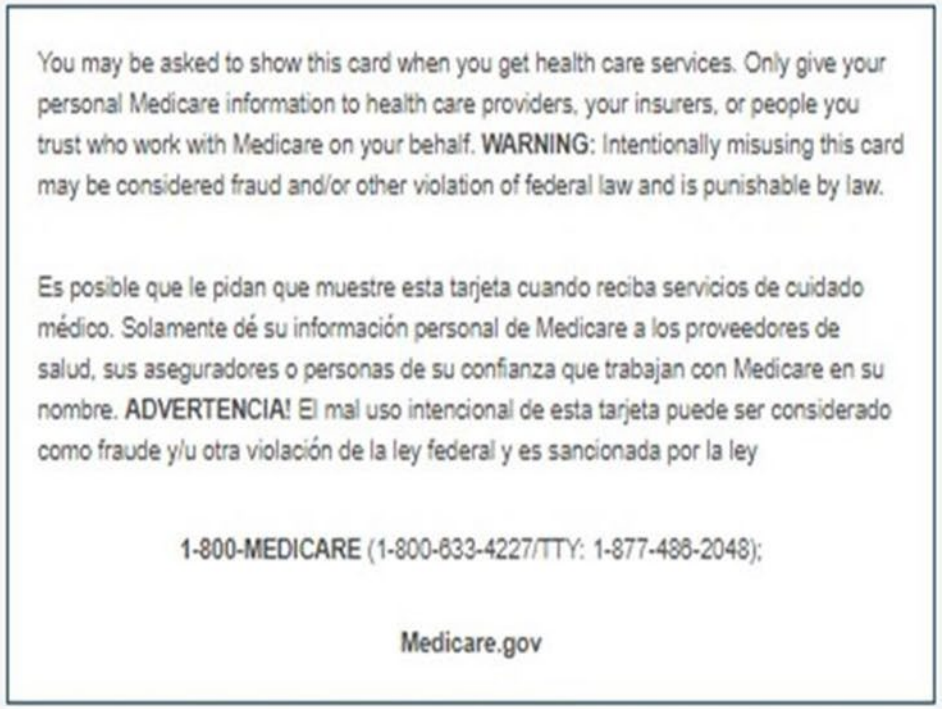
- Beneficiaries show as proof of Original Medicare enrollment
  - Full name
  - Medicare Beneficiary Identifier (MBI)
  - Effective date for Part A and Part B
- Card can be reissued if lost/stolen
  - Not reissued if only reason one of the following –
    - ✓ Part A or Part B terminated
    - ✓ Beneficiary enrolls in MA/HMO
      - MA/HMO plan enrollee issued different card
    - ✓ Patient elects hospice

Medicare Card

Front of card



Back of card



Provider Self-Service Tools

- Registration staff can quickly and accurately access beneficiary eligibility information using provider self-service tools (IVR, FISS/CWF and NGSConnex)
  - Prevent common eligibility-related claim error reason codes
  - Reduce time and money spent reviewing claim errors
  - Save cost of reprocessing claims unnecessarily
- CMS mandates providers utilize self-service tools instead of calling Provider Contact Center (PCC) to access certain information
  - Includes beneficiary eligibility and claim status
  - Providers who call PCC to request this information will be advised to use self-service tools

Interactive Voice Response Unit (IVR)

- Telephone-accessed research application used to provide general/common Medicare beneficiary and/or claim information
- Beneficial for different departments and varying shifts
  - No computer needed
  - No sign up required
  - Minimal “training” necessary
- Can type options using telephone keypad or use text-to-speech technology
  - Perform multiple inquiries during same call
  - Uses same system as PCC, NGSConnex, FISS DDE

Using the IVR

- IVR menu options that require system access limited to CWF's availability
  - Monday–Friday
    - ✓ 6:00 a.m.–7:00 p.m. ET
  - Saturday
    - ✓ 7:00 a.m.–3:00 p.m. ET
- "I Have a Question" option is available 24-hours per day, seven days per week

- Information available
  - Patient eligibility
  - Claims status
  - Checks
  - Check appeals status
  - Remittance statements
  - Provider enrollment status
  - Patient status
  - "I have a question"

Using the IVR

- Patient Eligibility Available Information
  - Part A and Part B effective and termination dates
  - HHH effective and termination dates
  - MSP type and insurer information
- Required to validate same elements as calls to PCC
  - Provider information (NPI, PTAN and last 5 digits of TIN)
  - Beneficiary information (MBI, first and last name, DOB)
- Have all information at hand before calling to maximize efficiency
  - Validation elements plus any applicable DOS, etc.

IVR Resources

- Visit Interactive Voice Response System on the NGS website to obtain
  - NGS Part A Provider IVR User Guide
  - Part A IVR Flow Chart
  - Part A IVR Navigation Guide
  - Part A Touch-Tone Card/Eligibility Checklist
  - Using the IVR to Avoid Top Claim Rejections and Return to Provider Errors
  - IVR Conversion Tools (name/number converters)

NGSConnex

- No-cost, secure self-service web application created and maintained by NGS
  - Need internet access and email address
- Similar to other options available (IVR, PCC, CWF/FISS, HETS)
- Options that require system access limited to CWF's availability
  - Monday – Friday: 6:00 a.m.–7:00 p.m. ET
  - Saturday: 7:00 a.m.–3:00 p.m. ET

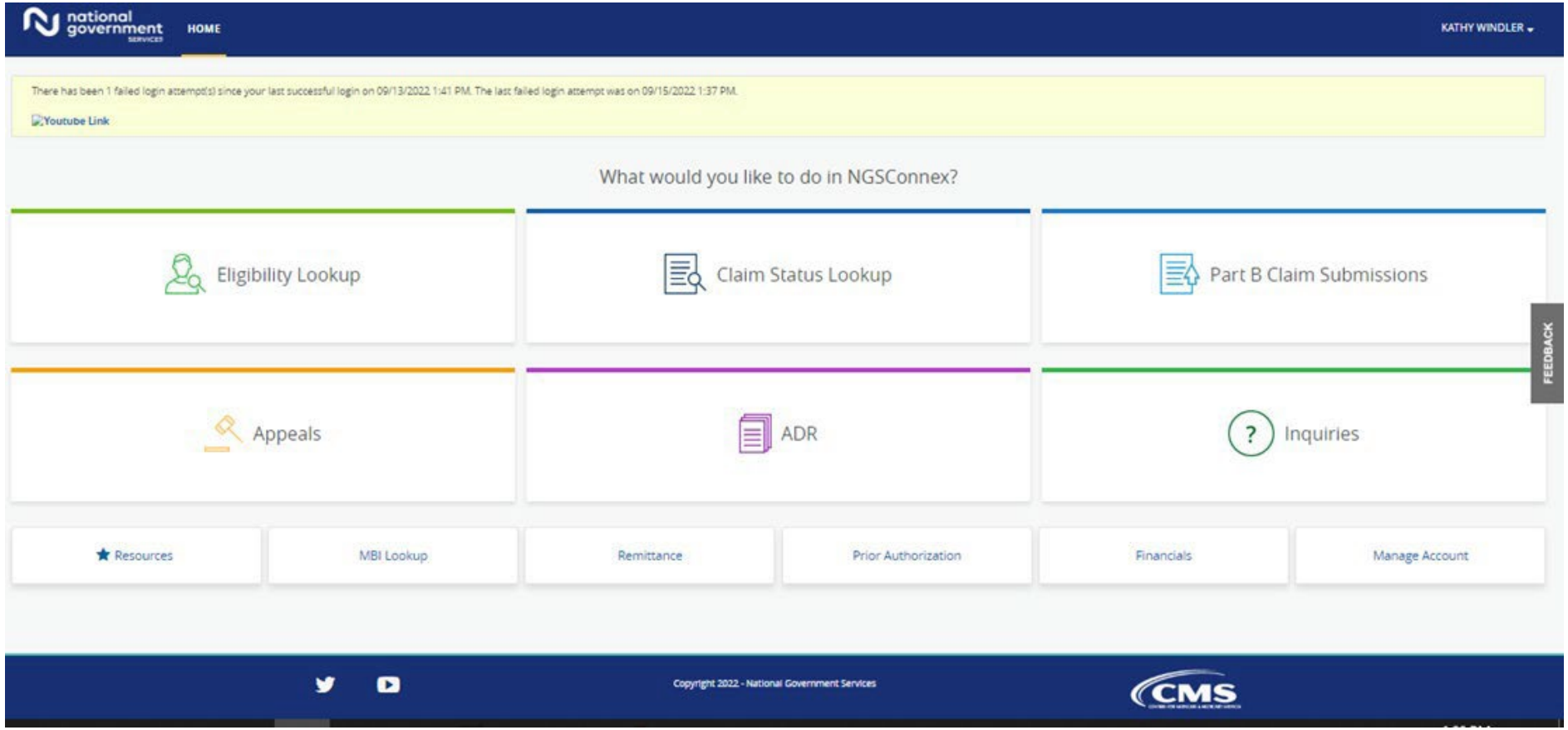
NGSConnex Capabilities/Features

- Including, but not limited to
  - Verify beneficiary eligibility
  - Obtain claim status
  - Initiate and check status of reopening/redetermination
  - Submit documentation in response to medical ADR
  - Query financial data
  - Submit credit balance report
  - Ability to order remittances

How to Access

- NGSConnex portal accessed through NGS website
- Prior to use, must have at least one authorized Local Security Officer (LSO)
- LSO grants access to individual Users based on business need
  - For example - admissions vs. finance dept
- Additional Information on NGS Website
  - NGSConnex in center of page
  - You Tube videos under “NGSConnex Videos”
- PCC handles NGSConnex support for issues with functionality
  - Monday through Friday
    - ✓ 8 a.m. – 4 p.m. ET
  - PCC phone numbers available on NGSMedicare.com
    - ✓ Contact Us > Provider Contact Center

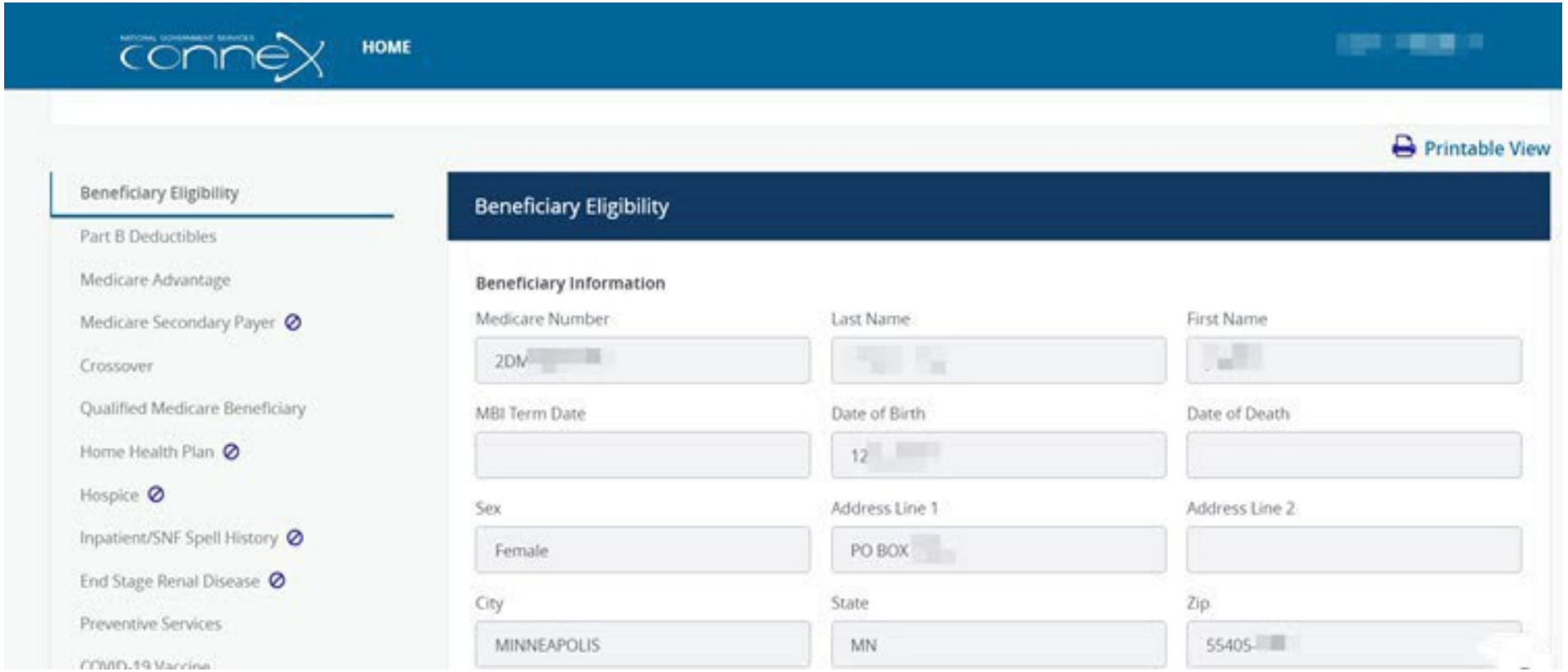
NGSConnex Main Screen



NGSConnex Eligibility

- Enter beneficiary information exactly as it appears on their Medicare card
  - Only need to enter first six letters of last name and first letter of first name

NGSConnex Eligibility



FISS DDE

- Inquiries submenu (01) > Beneficiary/CWF (10)
  - To view Eligibility Detail, key beneficiary's information in following FISS fields
    - ✓ MID (Medicare ID number/MBI)
    - ✓ LN (last name)
    - ✓ FI (first initial)
    - ✓ SEX (M – male; F – female)
    - ✓ DOB
    - ✓ ELIG FROM (from date of service)
    - ✓ ELIG THRU (thru date of service)

Beneficiary/CWF (10) Screen

- For field details and descriptions, refer to FISS DDE Provider Online Guide on NGS website

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MAP1751            NATIONAL GOVERNMENT SERVICES,#13001 UAT    ACMFA561 09/04/18
MXG9282   SC                ELIGIBILITY DETAIL INQUIRY         C2018400 13:50:25

MID XXXXXXXXXX      CURR XREF HIC                PREV XREF HIC 000000000000
TRANSFER HIC 000000000000       C-IND 9     LTR DAYS
LN XXXXXX                  FN X                  MI X  SEX M
DOB XXXXXXXX  DOD
ADDRESS: 1  123 ANYWHERE AVE                  2 SYRACUSE NY
         3                                    4
         5                                    6
     ZIP:   132000000

                          CURRENT ENTITLEMENT
PART A EFF DT 060111  TERM DT          PART B EFF DT 060111  TERM DT

 CURRENT                  BENEFIT PERIOD DATA
FRST BILL DT           LST BILL DT          HSP FULL DAYS     HSP PART DAYS
SNF FULL DAYS     SNF PART DAYS     INP DED REMAIN            BLD DED PNTS

                          PSYCHIATRIC
PSY DAYS REMAIN      PRE PHY DAYS USED      PSY DIS DT          INTRM DT IND

      PROCESS COMPLETED  ---   PLEASE CONTINUE
          PRESS PF3-EXIT  PF8-NEXT PAGE
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Provider Contact Center

- First option when contacting NGS for specific coverage or claims help
  - Information not available in NGSConnex or IVR
- Required to log and track all incoming inquiries
- Tiered system to respond accurately to all provider inquiries
- Contact numbers specific to geographic location
  - Resources > Contact Us > Provider Contact Center

PCC – To Call or Not to Call?

- YES
  - Clarify why claim processed (paid, rejected, denied) the way it did
  - Obtain assistance with general Medicare information/billing questions
  - How to use the IVR system, NGSConnex or NGSMedicare.com website
  - Other complex issues that cannot be addressed through self-service tools
- NO
  - Obtain beneficiary eligibility, claim status, or any other information available through self-service tools
  - Ask what modifiers, diagnosis codes, CPT codes or HCPCS to use for specific claims or beneficiaries
  - Note - PCC not allowed to answer inquiries from beneficiaries or their representatives

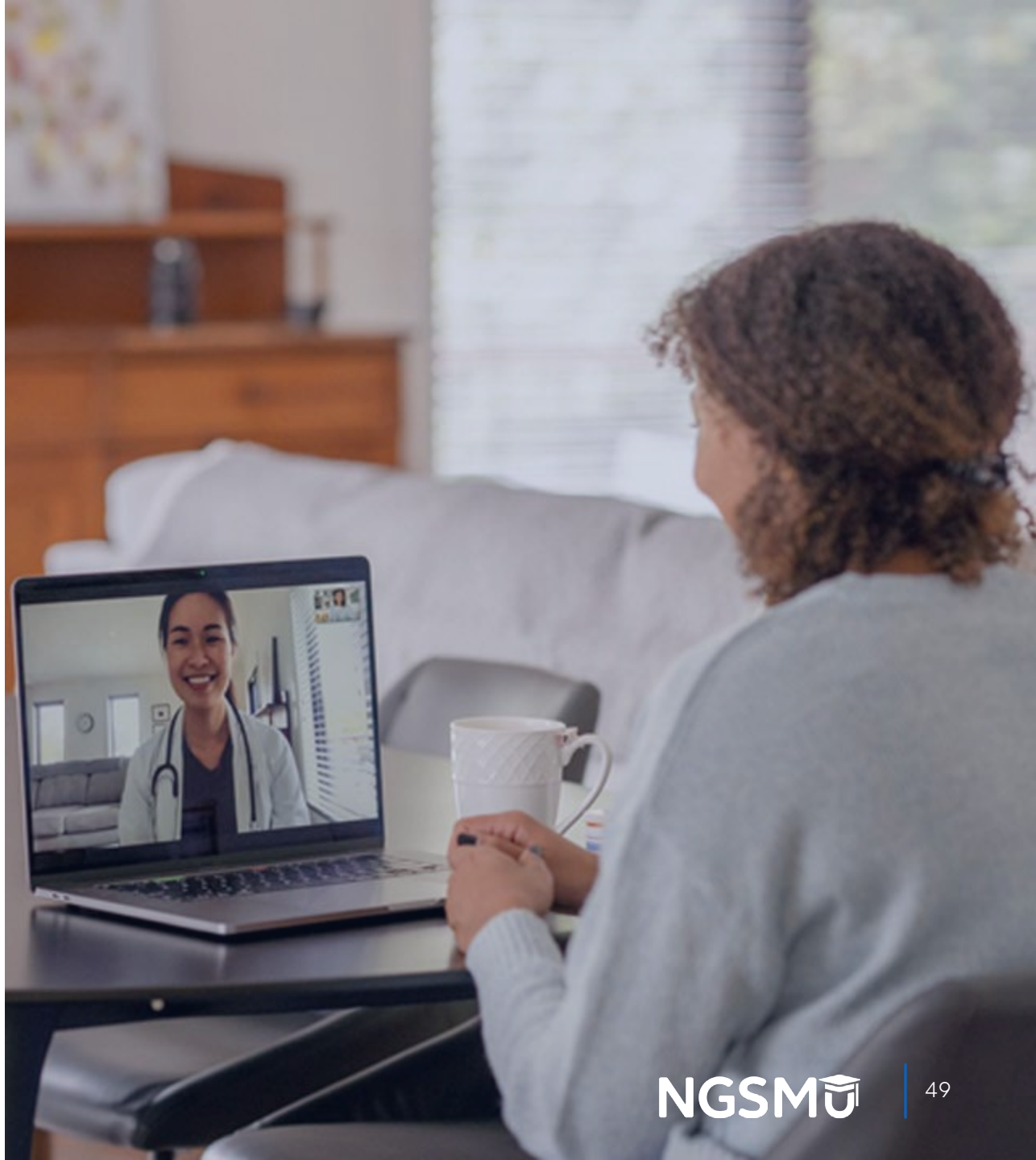
References and Resources

CMS Resources

- CMS website
  - Internet-Only Manuals (IOMs)
    - ✓ CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 9
    - ✓ CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 11
  - Hospice Center
  - Medicare and Medicaid Programs: Hospice Conditions of Participation
  - Hospice Payment Rate Updates
  - The Medicare Learning Network®
    - ✓ Resource Materials
    - ✓ Training
    - ✓ MLN Matters Articles

National Government Services Web Resources

- NGS website
- Events
  - Upcoming education sessions
  - Material from prior webinars
- Education
  - Medicare Topics
- Medicare University
  - ✓ CBT courses



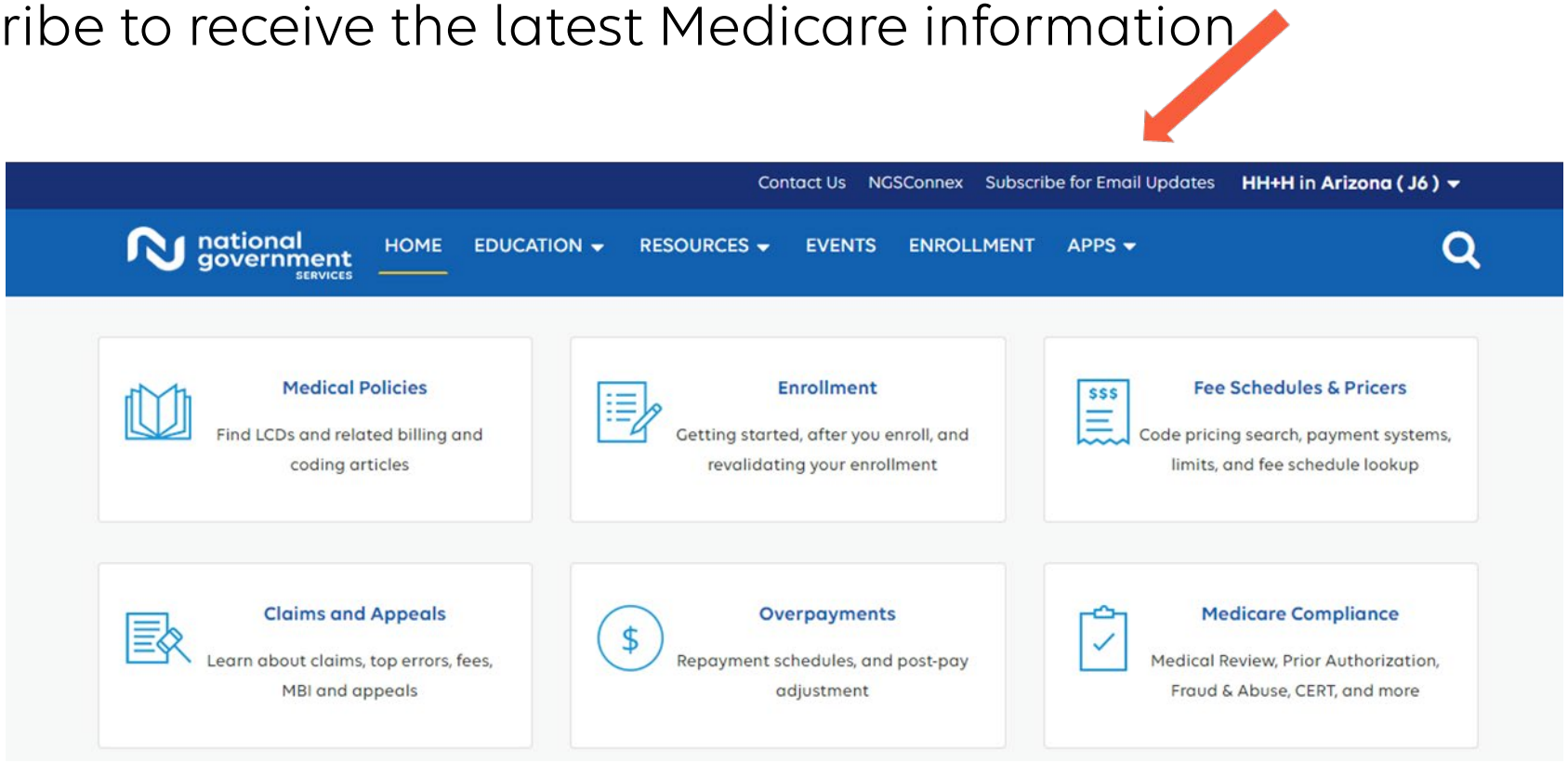
Free Educational Offerings from National Government Services

- NGS YouTube Channel (NGSMedicare.com – YouTube)
- "Bite-sized" tutorials
- Variety of topics
- On-Demand videos

- Medicare University (medicareuniversity.com)
  - Learning platform offering wide variety of training tools
    - ✓ Self-report attendance at webinars and in-person events
    - ✓ CBT courses (self-paced, available 24/7)
    - ✓ Create user id and password to access available courses
    - ✓ List of available courses under Education > Medicare University Courses

Email Updates

- Subscribe to receive the latest Medicare information



Questions?

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