CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10437	**Date: November 6, 2020**
	Change Request 12015

SUBJECT: Manual Updates Related to the Hospice Election Statement and the Implementation of the Election Statement Addendum

I. SUMMARY OF CHANGES: This Change Request (CR) manualizes the election statement revisions and implements the election statement addendum. In the fiscal year (FY) 2020 Hospice final rule (84 FR 38484), CMS finalized modifications to the hospice election statement content requirements at § 418.24(b) to increase coverage transparency for patients under a hospice election. Also in the FY 2020 hospice final rule, CMS finalized the requirements as set forth at § 418.24(c) for the hospice election statement addendum titled, ‘‘Patient Notification of Hospice Non Covered Items, Services, and Drugs’’.

EFFECTIVE DATE: October 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 9, 2020

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	9/Table of Contents
R	9/20/20.2.1.1/Hospice Election Statement
R	9/20/20.1.2/Hospice Election Statement Addendum
N	9/20/20.1.3/Hospice Notice of Election
R	9/40/40.1.5/Short-Term Inpatient Care

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-02	Transmittal: 10437	Date: November 6, 2020	Change Request: 12015

SUBJECT: Manual Updates Related to the Hospice Election Statement and the Implementation of the Election Statement Addendum

EFFECTIVE DATE: October 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
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I. GENERAL INFORMATION

A. Background: To address identified vulnerabilities in coverage transparency under the Medicare hospice benefit, in the FY 2020 Hospice Wage Index and Payment Rate Update final rule (84 FR 38520), CMS finalized changes to the regulations at § 418.24(b) regarding the content requirements for the hospice election statement. In addition to the modifications to the hospice election statement, CMS also finalized a policy relating to the provision of an addendum to the election statement to increase coverage transparency. The content requirements for the hospice election statement addendum are set forth in the regulations at § 418.24(c). These changes are effective for hospice elections beginning on or after October 1, 2020 and represent a one-year delay which allowed hospices the time to make the necessary modifications to their existing hospice election statements, develop their own hospice election statement addendum, and establish processes to incorporate these changes into their work flow.

B. Policy: Effective for hospice elections beginning on or after October 1, 2020, in addition to the existing content requirements at § 418.24(b), the hospice election statement must also include the following information:

- Information about the holistic, comprehensive nature of the Medicare hospice benefit;
- A statement that, although it would be rare, there could be some necessary items, drugs, or services that will not be covered by the hospice because the hospice has determined that these items, drugs, or services are to treat a condition that is unrelated to the terminal illness and related conditions;
- Information about beneficiary cost-sharing for hospice services;
- Notification of the beneficiary's (or representative's) right to request an election statement addendum that includes a written list and a rationale for the conditions, items, drugs, or services that the hospice has determined to be unrelated to the terminal illness and related conditions and that immediate advocacy is available through the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) if the beneficiary (or representative) disagrees with the hospice's determination.

Additionally, for hospice elections beginning on or after October 1, 2020, in the event that the hospice determines there are conditions, items, services, or drugs that are unrelated to the individual's terminal illness and related conditions, the individual (or representative), non-hospice providers furnishing such items, services, or drugs, or Medicare contractors may request a written list as an addendum to the hospice election statement. The hospice election statement addendum content requirements are described at § 418.24(c). A signed addendum in the requesting beneficiary's medical record would be a condition for payment. This condition for payment is met if there is a signed addendum in the requesting beneficiary's medical record with the hospice. A signed addendum is only acknowledgement of receipt of the addendum (or its updates) and not necessarily the individual's (or representative's) agreement with the hospice's determinations.

If the hospice election statement addendum is requested on the effective date of the initial hospice election (that is, the start of care date) the hospice must provide this information, in writing, to the individual (or representative) within 5 days from the effective date of the election. If this addendum is requested during

the course of hospice care (that is, after the effective date of the hospice election), the hospice must provide this information, in writing, within 72 hours (that is, 3 days) of the request to the requesting individual (or representative), non-hospice provider, or Medicare contractor. If the addendum is requested on the effective date of the hospice election (that is, the start of care date) and the beneficiary dies within the first 5 days from the start of hospice care, or if the addendum is requested during the course of hospice care and the beneficiary dies within 3 days of the request, and before the hospice is required to furnish the addendum, the addendum would not be required to be furnished after the patient has died, and this condition for payment would be considered met. If there are any changes to the content on the addendum during the course of hospice care, the hospice must update the addendum and provide these updates, in writing, to the individual (or representative).

While the addendum is not submitted with hospice claims, if the claim has been selected for medical review, and it is clear based on received documentation that the beneficiary requested but did not receive the addendum within the time period specified at 42 CFR 418.24(c), the failure to provide such addendum should result in a claims denial. However, the Medicare Administrative Contractor may request the addendum to accompany any additional documentation request to mitigate such denial. A denial resulting from a violation of this specific condition for payment would be limited to only the claim subject to review (that is, it would not invalidate the entire hospice election).

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12015.1	The contractors shall be aware of the revisions to Pub. 100-02, chapter 9 related to the policies discussed in this CR.			X						
12015.2	If the Contractor selects a claim for medical review, and it is clear based on received documentation that the beneficiary requested but did not receive the addendum within the time period specified at 42 CFR 418.24(c), the failure to provide such addendum should result in a claims denial. The Contractor should request the addendum to accompany any additional documentation request to mitigate such denial. A denial resulting from a violation of this specific condition for payment would be limited to only the claim subject to review (that is, it would not invalidate the entire hospice election).			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12015.3	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.			X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Amanda Barnes, 443-651-1207 or amanda.barnes@cms.hhs.gov, Kelly Vontran, 410-786-0332 or kelly.vontran@cms.hhs.gov.

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Benefit Policy Manual

Chapter 9 - Coverage of Hospice Services Under Hospital Insurance

Table of Contents
(Rev.10437, Issued: 11-06-20)

20.2.1.1 Hospice Election *Statement*

(Rev. 10437, Issued: 11-06-20, Effective: 10-01-20, Implementation: 12-09-20)

An individual who meets the eligibility requirements of § 418.20 may file an election statement with a particular hospice. If the individual is physically or mentally incapacitated, his or her representative (as defined in § 418.3) may file the election statement.

Each hospice designs and prints its election statement. The election statement must include the following items of information:

1. Identification of the particular hospice that will provide care to the individual;

2. The individual's or representative's (as applicable) acknowledgment that the individual has been given a full understanding of hospice care, particularly the palliative rather than curative nature of treatment;

3. *The individual's acknowledgement that the individual has been provided information on the hospice's coverage responsibility and that certain Medicare services are waived by the election. For hospice elections beginning on or after October 1, 2020, this would include providing the individual with information indicating that services unrelated to the terminal illness and related conditions are exceptional and unusual and the hospice should be providing virtually all care needed by the individual who has elected hospice;*

4. The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive;

5. The individual's designated attending physician (if any). Information identifying the attending physician recorded on the election statement should provide enough detail so that it is clear which physician, Nurse Practitioner (NP), or Physician Assistant (PA) was designated as the attending physician. This information should include, but is not limited to, the attending physician's full name, office address, NPI number, or any other detailed information to clearly identify the attending physician.

6. The individual's acknowledgment that the designated attending physician was the individual's or representative's choice.

7. *For hospice elections beginning on or after October 1, 2020 the hospice must provide:*
   - *Information on individual cost-sharing for hospice services;*
   - *Notification of the individual's (or representative's) right to receive an election statement addendum if there are conditions, items, services, and drugs the hospice has determined to be unrelated to the individual's terminal illness and related conditions and would not be covered by the hospice;*
   - *Information on the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), including the right to immediate advocacy and BFCC-QIO contact information.*

8. The signature of the individual or representative.

An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual:

(1) Remains in the care of a hospice;
(2) Does not revoke the election; and

(3) Is not discharged from the hospice.

For Medicare payment purposes, an election for Medicare hospice care must be made on or after the date that the hospice provider is Medicare-certified. As with any election, the hospice must fulfill all other admission requirements, such as certification or recertification, any required face-to-face encounters, or Conditions of Participation (CoP) assessments. See also Pub. 100-04, *Medicare Claims Processing Manual*, chapter 11, section 20.1.1.

An individual may change, once in each election period, the designation of the particular hospice from which he or she elects to receive hospice care. The change of the designated hospice is not considered a revocation of the election, but is a transfer. To change the designation of hospice programs, the individual must file, with the hospice from which he or she has received care and with the newly designated hospice, a signed statement that includes the following information:

- the name of the hospice from which the individual has received care;
- the name of the hospice from which they plan to receive care; and
- the date the change is to be effective.

As described in Pub. 100-04, Medicare Claims Processing Manual, chapter 11, section 20.1.1, when a hospice patient transfers to a new hospice, the receiving hospice must file a new Notice of Election; however, the benefit period dates are unaffected. The receiving hospice must complete all assessments required by the hospice conditions of participation as described in *42 CFR 418.54*. Because the benefit period does not change in a transfer situation, if the patient is in the third or later benefit period and transfers hospices, a face-to-face encounter is not required if the receiving hospice can verify that the originating hospice had the encounter.

A change of ownership of a hospice is not considered a change in the patient's designation of a hospice and requires no action on the patient's part.

Medicare beneficiaries enrolled in managed care plans may elect hospice benefits. Federal regulations require that the Medicare contractor assigned the hospice specialty workload maintain payment responsibility for hospice services and may pay for other claims if that Medicare contractor is the geographically assigned Medicare contractor for the managed care enrollees who elect hospice; for specifics, see regulations at 42 CFR 417, subpart P, 417.585, Special Rules: Hospice Care (b), and 42 CFR 417.531 Hospice Care Services (b). Institutional claims for services not related to the terminal illness would otherwise be the responsibility of another geographically assigned Medicare contractor.

Managed care enrollees who have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service Medicare contractors as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice was revoked. As specified above, by regulation, the duration of payment responsibility by fee-for-service Medicare contractors extends through the remainder of the month in which hospice is revoked by hospice beneficiaries.

See Pub. 100-04, Medicare Claims Processing Manual, Chapter 2, "Admission and Registration" and Chapter 11, "Processing Hospice Claims," for requirements for hospice reporting to the Medicare contractor.

20.2.1.2 Hospice Election Statement Addendum

(Rev. 10437, Issued: 11-06-20, Effective: 10-01-20, Implementation: 12-09-20)

For Hospice elections beginning on or after October 1, 2020, in the event that the hospice determines there are conditions, items, services, or drugs that are unrelated to the individual's terminal illness and related conditions, the individual (or representative), non-hospice providers furnishing such items, services, or drugs, or Medicare contractors may request a written list as an addendum to the election statement.

If the election statement addendum is requested on the effective date of the initial hospice election (that is, the start of care date) the hospice must provide this information, in writing, to the individual (or representative) within 5 days from the effective date of the election. If this addendum is requested during the course of hospice care (that is, after the effective date of the hospice election), the hospice must provide this information, in writing, within 72 hours (that is, 3 days) of the request to the requesting individual (or representative), non-hospice provider, or Medicare contractor. If there are any changes to the content on the addendum during the course of hospice care, the hospice must update the addendum and provide these updates, in writing, to the individual (or representative).

If the addendum is requested on the effective date of the hospice election (that is, the start of care date) and the beneficiary dies within the first 5 days from the start of hospice care and before the hospice is required to furnish the addendum, the addendum would not be required to be furnished after the patient has died, and this condition for payment would be considered satisfied. Likewise, if the addendum is requested during the course of hospice care (that is, after the effective date of the hospice election), and the beneficiary dies within 3 days from that request and before the hospice is required to furnish the addendum, the addendum would not be required to be furnished after the patient has died, and this condition for payment would be considered satisfied.

The election statement addendum must include the following:

1. *The addendum must be titled "Patient Notification of Hospice Non-Covered Items, Services, and Drugs."*

2. *Name of the hospice.*

3. *Individual's name and hospice medical record identifier.*

4. *Identification of the individual's terminal illness and related conditions.*

5. *A list of the individual's conditions present on hospice admission (or upon plan of care update) and the associated items, services, and drugs not covered by the hospice because they have been determined by the hospice to be unrelated to the terminal illness and related conditions.*

6. *A written clinical explanation, in language the individual (or representative) can understand, as to why the identified conditions, items, services, and drugs are considered unrelated to the individual's terminal illness and related conditions and not needed for pain or symptom management. This clinical explanation must be accompanied by a general statement that the decision as to whether or not conditions, items, services, and drugs are related is made for each patient and that the individual should share this clinical explanation with other health care providers from which they seek items, services, or drugs unrelated to their terminal illness and related conditions.*

7. *References to any relevant clinical practice, policy, or coverage guidelines*

8. *Information on the following:*

    i. *Purpose of Addendum. The purpose of the addendum is to notify the individual (or representative), in writing, of those conditions, items, services, and drugs the hospice will not be covering because the hospice has determined they are unrelated to the individual's terminal illness and related conditions.*

    ii. *Right to Immediate Advocacy. The addendum must include language that immediate advocacy is available through the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) if the individual (or representative) disagrees with the hospice's determination.*

9. *Name and signature of the individual (or representative) and date signed, along with a statement that signing this addendum (or its updates) is only acknowledgement of receipt of the addendum (or its updates) and not necessarily the individual's (or representative's) agreement with the hospice's determinations.*

Example: *Mr. Brown requests the election statement addendum on October 3rd, the effective date of his initial hospice election (that is, at the time of admission to hospice). The hospice must provide this information, in writing, to Mr. Brown within 5 days from the effective date of the hospice election. Therefore, the addendum would be required to be provided to Mr. Brown on or before October 8th.*

Example: *Mrs. Smith's effective date of her hospice election was November 1st, but she did not request the election statement addendum on that date. On December 4th, Mrs. Smith requests the election statement addendum. Since Mrs. Smith requested the election statement addendum during the course of hospice care (that is, after the effective date of the hospice election), the hospice must provide this information, in writing, within 3 days of her request, Therefore, the addendum would be required to be provided to Mrs. Smith on or before December 7th.*

Example: *Miss Jones requested the election statement addendum on May 1st, the effective date of her initial hospice election. Miss Jones died on May 3rd. Because Miss Jones died within the first 5 days from the start of hospice care and before the hospice was able to furnish the addendum, the addendum would not be required to be furnished after Miss Jones has died, and this condition for payment would be considered met. While the addendum is not submitted with hospice claims, it is a condition for payment if the beneficiary (or representative) has requested it. This condition for payment is satisfied when there is a beneficiary (or representative) request present, which is documented by a valid signed addendum in the requesting beneficiary's medical record with the hospice. If the claim has been selected for medical review, and it is clear based on received documentation that the beneficiary requested but did not receive the addendum within the time period specified at 42 CFR 418.24(c), the failure to provide such addendum should result in a claims denial. However, the Medicare Administrative Contractor may request the addendum to accompany any additional documentation request to mitigate such denial. A denial resulting from a violation of this specific condition for payment would be limited to only the claim subject to review (that is, it would not invalidate the entire hospice election).*

20.2.1.*3*- Hospice Notice of Election

(Rev. 10437, Issued: 11-06-20, Effective: 10-01-20, Implementation: 12-09-20)

Upon electing the Medicare hospice benefit, the beneficiary waives the right to Medicare payment for any Medicare services related to the terminal illness and related conditions (i.e., the patient's prognosis) during a hospice election, except when provided by, or under arrangement by, the designated hospice or individual's attending physician if he or she is not employed by the designated hospice (42 CFR 418.24 (d)).

In order to establish the hospice election in the Medicare claims processing system, the hospice must submit a Notice of Election (NOE) as described in chapter 11, section 20.1.1 of the Medicare Claims Processing Manual (Pub.100-04). Prompt filing of the hospice NOE with the Medicare contractor is required to properly enforce this waiver and prevent inappropriate payments to non-hospice providers. The effective date of hospice election is the same as the hospice admission date.

Timely-filed hospice NOEs shall be filed within 5 calendar days after the hospice admission date. A timely-filed NOE is one that is submitted to and accepted by the Medicare contractor within 5 calendar days after the hospice election. The practical meaning of 'submitted to and accepted by the Medicare contractor' is that the NOE was not returned to the provider for correction.

Example: The date of hospice election is October 1st. A timely-filed NOE would be submitted and accepted by the Medicare contractor on or before October 6th.

In instances where a NOE is not timely-filed, Medicare shall not cover and pay for the days of hospice care from the hospice admission date to the date the NOE is submitted to, and accepted by, the Medicare contractor. These days shall be provider liable, and the provider shall not bill the beneficiary for them.

Example: The date of hospice election is October 1st. The NOE was not submitted and accepted by the Medicare contractor until October 10th. Provider liable days would be October 1st through October 9th.

There may be some circumstances that may be beyond the control of the hospice where it may not be possible to timely-file the NOE within 5 calendar days after the effective date of election or timely-file the Notice of Termination or Revocation (NOTR) (see section 20.2.4 - Hospice Notice of Termination or Revocation) within 5 calendar days after the effective date of a beneficiary's discharge or revocation. Therefore, the regulations do allow for exceptions. There are four circumstances that may qualify the hospice for an exception to the consequences of filing the NOE more than 5 calendar days after the effective date of election. These exceptional circumstances are as follows:

1. Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice's ability to operate;

2. An event that produces a data filing problem due to a CMS or Medicare contractor systems issue that is beyond the control of the hospice;

3. A newly Medicare-certified hospice that is notified of certification after the Medicare certification date, or is awaiting its user ID from its Medicare contractor; or,

4. Other circumstances determined by CMS to be beyond the control of the hospice.

If one of the four circumstances described above prevents a hospice from timely-filing its NOE, the hospice must document the circumstance to support a request for an exception, which would waive the consequences of filing the NOE late. Using that documentation, the hospice's Medicare contractor will determine if a circumstance encountered by a hospice qualifies for an exception to the consequences for filing an NOE more than 5 calendar days after the effective date of election. If the request for an exception is denied, the Medicare contractor will retain the decision of the denial. Hospices retain their usual appeal rights on the claim for payment.

A retroactive Medicare entitlement qualifies as one of the exceptions to a timely-filed NOE as this would be a circumstance that is beyond the hospice's control. An individual must be entitled to Medicare Part A in order to be eligible to receive services under the Medicare hospice benefit and an individual who receives retroactive Medicare entitlement is entitled to Medicare hospice services effective on the first day of that entitlement. In the event of retroactive Medicare entitlement, the hospice would submit a request for an exception, which would waive the consequences of filing the NOE late. To receive an exception, the individual must meet eligibility requirements under the Medicare hospice benefit and must have elected to receive services under the Medicare hospice benefit. Therefore, the hospice must be able to provide the following documentation to Medicare contractors and/or CMS, if requested:

(1) Proof of retroactive Medicare entitlement;
(2) The certification of terminal illness that meets the criteria set forth in section 20.1; and
(3) The hospice election statement that meets the criteria set forth in section *20.2.1.1*.

See Pub. 100-04, Medicare Claims Processing Manual, Chapter 11, "Processing Hospice Claims" for requirements for NOE submission, reporting provider-liable days, and qualifying circumstances for a request for exception.

40.1.5 - Short-Term Inpatient Care

(Rev. 10437, Issued: 11-06-20, Effective: 10-01-20, Implementation: 12-09-20)

Short-term inpatient care may be provided in a participating hospital, hospice inpatient unit, or a participating SNF or NF that additionally meets the special hospice standards regarding patient and staffing areas. Medicare payment cannot be made for inpatient hospice care provided in a VA facility to Medicare beneficiaries eligible to receive Veteran's health services. Services provided in an inpatient setting must conform to the written plan of care. However, dually eligible veterans residing at home in their community may elect the Medicare hospice benefit. See § 60, *Provision of Hospice Services to Medicare/Veteran's Eligible Beneficiaries.*

Medicare covers two levels of inpatient care: respite care for relief of the patient's caregivers, and general inpatient care which is for pain control and symptom management. General inpatient care (GIP) may only be provided in a Medicare participating hospital, SNF, or hospice inpatient facility. Respite care may only be provided in a Medicare participating hospital or hospice inpatient facility, or a Medicare or Medicaid participating nursing facility.

General inpatient care is allowed when the patient's medical condition warrants a short-term inpatient stay for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings.

General inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit. For example, a brief period of general inpatient care may be needed in some cases when a patient elects the hospice benefit at the end of a covered hospital stay. If a patient in this circumstance continues to need pain control or symptom management, which cannot be feasibly provided in other settings while the patient prepares to receive hospice home care, general inpatient care is appropriate.

Other examples of appropriate general inpatient care include a patient in need of medication adjustment, observation, or other stabilizing treatment, such as psycho-social monitoring. It is not appropriate to bill Medicare for general inpatient care days for situations where the individual's caregiver support has broken down unless the coverage requirements for the general inpatient level of care are otherwise met. For a hospice to provide and bill for the general inpatient level of care, the patient must require an intensity of care directed towards pain control and symptom management that cannot be managed in any other setting.

Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons who normally care for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than 5 consecutive days at a time. Payment for the sixth and any subsequent day of respite care is made at the routine home care rate, and the patient would be liable for room and board. Respite care cannot be provided to hospice patients who reside in a facility (such as a long term care nursing facility). Provision of respite care depends upon the needs of the patient and of the patient's caregiver, within the limitations given.

Several examples of appropriate respite care for a patient who does not reside in a facility include providing a few days for the caregiver to rest at home, to visit family, attend a wedding, or attend a graduation for a needed break, or providing a few days immediately following a GIP stay if the usual caregiver has fallen ill. See also, section 40.2.2.

Note that hospice inpatient care in an SNF or NF serves to prolong current benefit periods for general Medicare hospital and SNF benefits. This could potentially affect patients who revoke the hospice benefit.

If a hospice patient receives general inpatient care for 3 days or more in a hospital, and chooses to revoke hospice, then the 3-day stay (although not equivalent to a hospital level of care) would still qualify the beneficiary for covered SNF services.