MEDICARE HOSPICE COVERAGE AND APPEALS

Medicare covers hospice care for those who have been diagnosed as terminally ill. Terminally ill means that the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course. Hospice care is a comprehensive set of services identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or the patient's family members.

The hospice benefit is different from all other Medicare benefits in that it does not provide for the curative treatment of illness or injury; rather it is designed for the palliation and management of terminal illness. Palliative care is defined as patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Throughout the continuum of illness, it involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitates patient autonomy, access to information, and choice.

Medicare covered hospice care must be provided by a Medicare-certified hospice program. The hospice must comply with Medicare's conditions of participation. Hospice care should "allow the patient to remain at home as long as possible by providing support to the patient and family, and by keeping the patient as comfortable as possible while maintaining his or her dignity and quality of life."

One can receive hospice benefits under Medicare only after specifically opting into the hospice benefit and thereby opting out of Medicare coverage for services related to the terminal illness. Electing hospice care, however, does not mean that all curative treatment is waived.

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1 Copyright © Center for Medicare Advocacy, Inc. All rights reserved. Portions of these materials were originally written by the Center for Medicare Advocacy as the Hospice Chapter of the Medicare Practice Manual and are now included in the Medicare Handbook, Aspen Publishing Co., (2010, Updated annually.)
2 42 U.S.C. §1395x(dd).
3 42 C.F.R. §418.3.
4 42 C.F.R. §418.3.
7 42 C.F.R. §418.3.
8 42 C.F.R. §§418.52—418.116.
Beneficiaries who elect the Medicare hospice benefit may still receive Medicare coverage for medically reasonable and necessary treatment for diagnoses unrelated to their terminal illness.\(^\text{10}\)

**ELIGIBILITY**

The Medicare hospice benefit is provided under Part A of the Medicare program. Therefore, in order to be eligible for this benefit, one must be enrolled in Medicare Part A. In addition, prior to receiving Medicare hospice care, the beneficiary must be certified by the hospice physician and the individual's attending physician as terminally ill.\(^\text{11}\) The certification is based on the physician's clinical judgment regarding the normal course of the individual's illness. The certification must specify that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.\(^\text{12}\) Clinical information and other documentation that support the medical prognosis must be filed in the medical record with the written certification.\(^\text{13}\) The clinical information will be part of the hospice's eligibility assessment for the patient.\(^\text{14}\) The certification is filed with the hospice.\(^\text{15}\)

**ELECTION**

An election to receive hospice care is made by filing an election statement with a hospice of choice.\(^\text{16}\) An election statement may be filed by either the beneficiary or his or her legal representative.\(^\text{17}\) Once a beneficiary has elected to receive the hospice benefit, he or she waives all rights to Medicare payment for services that are related to the treatment of the terminal condition or a related condition except for services provided by the designated hospice or by another provider under arrangements made by the designated hospice, or by the individual's attending physician.\(^\text{18}\)

The election statement itself must:

- Identify the hospice that will provide the beneficiary's care;

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\(^\text{10}\) 42 C.F.R. §418.24.
\(^\text{11}\) 42 C.F.R. §418.22(c). *Sources of certification.* (1) For the initial 90-day period, the hospice must obtain written certification statements ... from (i) The medical director of the hospice or the physician member of the hospice interdisciplinary group; and (ii) The individual's attending physician if the individual has an attending physician. (2) For subsequent periods, the only requirement is certification by one of the physicians listed in paragraph(c)(1)(i) of this section.
\(^\text{12}\) 42 C.F.R. §418.22(b)(1).
\(^\text{13}\) 42 C.F.R. §418.22(b)(2).
\(^\text{14}\) 42 C.F.R. §418.22(b)(2).
\(^\text{15}\) 42 C.F.R. §418.22.
\(^\text{16}\) 42 C.F.R. §418.24.
\(^\text{17}\) 42 C.F.R. §418.24.
\(^\text{18}\) This is only the case if the attending physician is not an employee of the designated hospice or receiving compensation from the hospice for the provided services. 42 C.F.R. §418.24(d)(2)(iii). Furthermore, the Medicare Hospice Manual limits such services to the personal professional services of the attending physician. In other words, the costs for services such as labs or X-rays must be provided under arrangements with the hospice and will not be reimbursed by Medicare if independently ordered by the attending physician. Medicare Claims Processing (MCP) Manual, Centers for Medicare & Medicaid Services (CMS) Pub. 100-04, Ch. 11, §40.1.3.
• Contain an acknowledgment by the individual that he or she has been given a full understanding of the palliative rather than the curative nature of hospice care as it relates to the individual’s terminal illness;
• Contain an acknowledgment that the beneficiary, in electing hospice care, understands that he or she is waiving certain other Medicare services;
• State the effective date of the election, which in no event can be prior to the date of the election statement, and
• Be signed by the beneficiary or his or her legal representative.

CERTIFICATION REQUIREMENTS

An individual may elect to receive hospice care during one or more of the following election periods: an initial 90-day period; a subsequent 90-day period; or an unlimited number of subsequent 60-day periods. At the start of the first benefit period, a hospice physician and the beneficiary’s attending physician must make a written certification that the beneficiary is terminally ill. For subsequent periods, only a hospice physician must certify the beneficiary as terminally ill.

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 remains in the care of the hospice, does not revoke the election, and is not discharged from the hospice. Prior to each new election period, a hospice physician must review the patient’s clinical information and if hospice care remains appropriate, recertify in writing that the beneficiary continues to be terminally ill.

The certification is based on the physician’s or medical director’s clinical judgment regarding the normal course of the individual’s illness. The certification must conform to the following requirements:

1. The certification must specify that the individual’s prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.
2. Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record. Initially, the clinical information may be provided verbally, and must
be documented in the medical record and included as part of the hospice’s eligibility assessment.

3. The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms.

   a. If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician’s signature.
   b. If the narrative exists as an addendum to the certification or recertification forms, the physician must also sign immediately following the narrative in the addendum.
   c. The narrative shall include a statement under the physician signature attesting that by signing, the physician confirms that he/she confirms that he/she composed the narrative based on his/her review of the patient’s medical record or, if applicable, his or her examination of the patient.
   d. The narratives must reflect the patient’s individual clinical circumstances and cannot contain check boxes or standard language used for all patients.28

ADMISSION

The hospice admits a patient only on the recommendation of the hospice medical director in consultation with, or input from, the patient’s attending physician.29 In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information: diagnosis of the terminal condition of the patient; other health conditions, whether related or unrelated to the terminal condition; and current clinically relevant information supporting all diagnoses.30

COVERED SERVICES

A. Interdisciplinary Group

Any services that are to be provided to a Medicare hospice patient must be included in a written plan of care established by the hospice interdisciplinary group.31 The hospice must designate a registered nurse that is a member of the interdisciplinary group to coordinate care and to ensure continuous assessment of each patient’s and family’s needs and implementation of the

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28 42 C.F.R. § 418.22 (Effective October 1, 2009)
29 42 C.F.R. §418.25(a).
30 42 C.F.R. §418.25(b).
31 42 C.F.R. §§418.36, 418.58, and 418.68. The hospice must designate an interdisciplinary group which, in consultation with the patient’s attending physician, must prepare a written plan of care. The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.
interdisciplinary plan of care. The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:

- Doctor of medicine or osteopathy (who is an employee or under contract with the hospice);
- Registered nurse;
- Social worker; and
- Pastoral or other counselor.  

B. Hospice Plan of Care

The plan of care must be created in collaboration with the beneficiary's attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:

- Interventions to manage pain and symptoms;
- A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs;
- Measurable outcomes anticipated from implementing and coordinating the plan of care;
- Drugs and treatment necessary to meet the needs of the patient;
- Medical supplies and appliances necessary to meet the needs of the patient; and
- The interdisciplinary group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies. 

The plan of care must be reviewed and/or revised as the patient's condition requires, but no less frequently than every 15 calendar days.

C. Physician Services

The hospice medical director, physician employees, and contracted physician(s) of the hospice in conjunction with the patient's attending physician are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness.

D. Nursing Care

The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in

32 42 C.F.R. §418.56(a)(1).
33 42 C.F.R. §418.56(b).
34 42 C.F.R. §418.56(c).
35 42 C.F.R. §418.56(d).
36 42 C.F.R. §418.64(a).
the patient's initial assessment,\textsuperscript{37} comprehensive assessment,\textsuperscript{38} and updated assessments.\textsuperscript{39} Nursing care may be provided on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an individual at home. A period of crisis is one in which the patient requires continuous care to achieve palliation or management of acute medical symptoms.\textsuperscript{40}

E. Medical Social Services

Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the patient's family's needs and acceptance of these services.\textsuperscript{41}

F. Counseling Services

Counseling services must be available to the patient and family to assist the patient and family in minimizing stress and problems that arise from the terminal illness, related conditions, and the dying process.\textsuperscript{32} Counseling services must include, but are not limited to bereavement counseling, dietary counseling, and spiritual counseling.\textsuperscript{43}

G. Bereavement Counseling

Bereavement counseling is emotional, psychosocial, and spiritual support and services provided before and after the death of a patient to assist with issues related to grief, loss, and adjustment.\textsuperscript{44} Though not reimbursed by Medicare, bereavement counseling is a required hospice service.\textsuperscript{45} Each Medicare-certified hospice provider must have an organized program for the provision of bereavement services under the supervision of a qualified professional with experience or education in grief or loss counseling.\textsuperscript{46} Bereavement services should be made available to family and other affected individuals\textsuperscript{47} for up to one year after the death of the patient.\textsuperscript{48}

\textsuperscript{37} Initial assessment means an evaluation of the patient's physical, psychosocial, and emotional status related to the terminal illness and related conditions to determine the patient's immediate care and support needs. 42 C.F.R. §418.3. The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care. 42 C.F.R. §418.54(a).
\textsuperscript{38} Comprehensive assessment means a thorough evaluation of the patient's physical, psychosocial, emotional, and spiritual status related to the terminal illness and related conditions. This includes a thorough evaluation of the caregiver's and family's willingness and capability to take care of the patient. 42 C.F.R. §418.3. The comprehensive assessment must be completed no later than 5 days after the election of hospice care. 42 C.F.R. §418.54(b).
\textsuperscript{39} 42 C.F.R. §§418.64(b)(1).
\textsuperscript{40} 42 C.F.R. §§418.204(a).
\textsuperscript{41} 42 C.F.R. §§418.64(c).
\textsuperscript{42} 42 C.F.R. §§418.64(d).
\textsuperscript{43} 42 C.F.R. §§418.64(d).
\textsuperscript{44} 42 C.F.R. §§418.3.
\textsuperscript{45} 42 C.F.R. §§418.204(e).
\textsuperscript{46} 42 C.F.R. §§418.64(d)(1)(i).
\textsuperscript{47} Bereavement counseling extends to residents of a SNF/NF or ICF/MR when appropriate and identified in the bereavement plan of care. 42 C.F.R. §§418.64(d)(1)(i).
\textsuperscript{48} 42 C.F.R. §§418.64(d)(1)(ii).
H. Dietary Counseling

Dietary counseling should be provided when identified in the plan of care as a needed service. When provided, it must be performed by a qualified individual, which might be a diettian or a nurse. The qualified individual must address and assure that the dietary needs of the patient are met.\(^{49}\)

I. Spiritual Counseling

Regarding spiritual counseling the hospice must:

- Provide an assessment of the patient's and family's spiritual needs;
- Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires;
- Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs; and
- Advise the patient and family of this service.\(^{50}\)

J. Physical Therapy, Occupational Therapy, and Speech-Language Pathology

Physical therapy, occupational therapy, and speech-language pathology services must be available to hospice patients and, when provided, offered in a manner consistent with accepted standards of practice.\(^{51}\)

K. Hospice Aide and Homemaker Services

1. Hospice Aides

Hospice aide training and supervision requirements are extensive and are described in the conditions of participation.\(^{52}\) Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group.\(^{53}\) The hospice aide provides services that are:

- Ordered by the interdisciplinary group;
- Included in the plan of care;
- Permitted to be performed under state law by such hospice aide; and
- Consistent with the hospice aide training.\(^{54}\)

The duties of the hospice aide include, but are not limited to:

\(^{49}\) 42 C.F.R. §418.64(d)(2).
\(^{50}\) 42 C.F.R. §418.64(d)(3).
\(^{51}\) 42 C.F.R. §418.72.
\(^{52}\) 42 C.F.R. §418.76.
\(^{53}\) 42 C.F.R. §418.76(g).
\(^{54}\) 42 C.F.R. §418.76(g)(2).
• Provision of hands-on personal care;
• Performance of simple procedures as an extension of therapy or nursing services;
• Assistance in ambulation or exercises; and
• Assistance in administering medications that are ordinarily self-administered.\textsuperscript{55}

Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and improvement activities. Hospice aides must also complete the appropriate records in compliance with the hospice's policies and procedures.\textsuperscript{56}

2. Hospice Homemakers

Homemaker services must be provided by individuals who have successfully completed a hospice orientation addressing the needs and concerns of patients and families coping with a terminal illness.\textsuperscript{57} Homemaker services must be coordinated and supervised by a member of the interdisciplinary group.\textsuperscript{58} Instructions for homemaker duties must be prepared by a member of the interdisciplinary group.\textsuperscript{59} Homemakers must report all concerns about the patient or family to the member of the interdisciplinary group who is coordinating homemaker services.\textsuperscript{60}

L. Volunteer Services

For each Medicare-certified hospice program, volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of all paid hospice employees and contract staff.\textsuperscript{61}

M. Medical Supplies and Durable Medical Equipment

Medical supplies and appliances and durable medical equipment (DME) related to the palliation and management of the terminal illness and related conditions must be provided by the hospice while the patient is under hospice care.\textsuperscript{62} Medical supplies and appliances include things such as colostomy bags and supplies directly related to colostomy care.\textsuperscript{63} DME includes items such as hospital beds and wheelchairs.\textsuperscript{64}

N. Drugs and Biologicals

Drugs and biologicals related to the palliation and management of the terminal condition and related conditions, as identified in the hospice plan of care, must be provided by the hospice

\textsuperscript{55} 42 C.F.R. \S 418.76(g)(3).
\textsuperscript{56} 42 C.F.R. \S 418.76(g)(4).
\textsuperscript{57} 42 C.F.R. \S 418.76(j)(1).
\textsuperscript{58} 42 C.F.R. \S 418.76(k)(1).
\textsuperscript{59} 42 C.F.R. \S 418.76(k)(2).
\textsuperscript{60} 42 C.F.R. \S 418.76(k)(3).
\textsuperscript{61} 42 C.F.R. \S 418.78.
\textsuperscript{62} 42 C.F.R. \S 418.106.
\textsuperscript{63} 42 C.F.R. \S 410.36.
\textsuperscript{64} 42 C.F.R. \S 410.38.
while the patient is under hospice care.\textsuperscript{65} For each medication provided while the beneficiary is not an inpatient (general inpatient or respite care), the hospice program may charge the beneficiary a coinsurance payment.\textsuperscript{66} This coinsurance cannot exceed $5.00.\textsuperscript{67}

The hospice must ensure that the interdisciplinary group confers with an individual with education and training in drug management as defined in hospice policies and procedures and state law, who is an employee of or under contract with the hospice to ensure that drugs and biologicals meet each patient's needs.\textsuperscript{68}

\textbf{O. Short-Term General Inpatient Care}

Short-term general inpatient care must be made available by the hospice for pain control and symptom management.\textsuperscript{69} The care must be provided in a Medicare-certified hospice or a Medicare-certified hospital or nursing facility (NF).\textsuperscript{70} While an individual is receiving general inpatient care for pain control or symptom management, each shift at the facility must include a registered nurse who provides direct patient care.\textsuperscript{71} Rooms for hospice patients receiving general inpatient care must have a home-like atmosphere and be designed to preserve the dignity, comfort, and privacy of hospice patients.\textsuperscript{72}

On August 31, 2007, the Centers for Medicare & Medicaid Services (CMS) issued the following policy “clarification”:

\begin{quote}
Hospice providers should submit claims for inpatient respite care in situations where there is an inability to maintain the individual in his or her home, but the individual does not require an inpatient level of care.... To receive payment for general inpatient care under the Medicare hospice benefit, beneficiaries must require an intensity of care directed towards pain control and symptom management that cannot be managed in any other settings. It is the level of care provided to meet the individual's needs and not the location of where the individual resides, or caregiver breakdown, that determines payment rates for Medicare services (Emphasis in original).\textsuperscript{73}
\end{quote}

Nonetheless, the Medicare Benefit Policy Manual states, as it did prior to the policy clarification, that general inpatient care is appropriate for caregiver breakdown. Specifically it states that general inpatient care is covered under the Medicare hospice benefit in the event that skilled nursing care is needed by the patient because his or her home support has "broken down."

\textsuperscript{65} 42 C.F.R. §418.106.  
\textsuperscript{66} 42 C.F.R. §418.400.  
\textsuperscript{67} 42 C.F.R. §418.400(a).  
\textsuperscript{68} 42 C.F.R. §418.106.  
\textsuperscript{69} 42 C.F.R. §418.108.  
\textsuperscript{70} 42 C.F.R. §418.108.  
\textsuperscript{71} 42 C.F.R. §§418.108 and 418.110(b).  
\textsuperscript{72} 42 C.F.R. §§418.108, 418.110(e) and (f).  
\textsuperscript{73} 72 Fed. Reg. 50,214 at 50,220 (Aug. 31, 2007).
Furthermore, the manual continues to list the following as examples of circumstances in which general inpatient care is appropriate: medication adjustment; observation; other stabilizing treatment, such as psychosocial monitoring; or a patient whose family is unwilling to permit needed care to be furnished in the home.  

When an individual’s hospice care is billed to Medicare at a general inpatient level of care, the per diem rate pays for both the beneficiary's hospice care and the beneficiary's room and board. It should be noted that hospice inpatient care in a skilled nursing facility (SNF) serves to prolong current benefit periods for general Medicare hospital and SNF benefits. On the other hand, if a hospice patient receives general inpatient care for three or more days and then revokes the hospice benefit, then the three-day stay in the inpatient facility (although not necessarily the same as a hospital level of care in terms of kind of care provided) would qualify the beneficiary for covered SNF services. In other words, the three-day general inpatient hospice stay is considered, for purposes of obtaining Medicare coverage of SNF care, to be the equivalent of a three-day qualifying hospital stay.

P. Inpatient Care for Respite Purposes

Inpatient care for respite purposes is provided to the hospice patient when necessary to relieve the beneficiary's caregiver(s). Respite care may be provided only on an occasional basis and is limited to no more than five consecutive days at a time. The respite care must be provided in a Medicare-certified hospice, a Medicare-certified hospital, a Medicare-certified SNF, or a Medicare- or Medicaid-certified NF. Rooms must be designed to ensure the dignity, comfort, and privacy of patients. The facility providing respite care must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

While the beneficiary is at a respite level of care, the hospice benefit pays for both the beneficiary's medical care and the beneficiary's room and board. There is a coinsurance amount that the hospice agency may require the patient to pay if respite services are received. The daily coinsurance amount for respite care can be no more than 5 percent of the payment made by CMS.

74 “General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings. Skilled nursing care may be needed by a patient whose home support has broken down if this breakdown makes it no longer feasible to furnish care in the home setting.” MBP Manual, Ch. 9, §40.1.5.
75 MBP Manual, Ch. 9, §40.1.5.
76 42 C.F.R. §418.302.
77 MBP Manual, Ch. 9, §40.1.5. This is significant in the event the beneficiary should decide to revoke the hospice benefit. It means that each day spent at a general inpatient level of care would be categorized at a skilled level of care for purposes of calculating benefit periods. Medicare coverage is only available for 100 days of SNF care within a benefit period. A benefit period does not end until there is a 60-day break from inpatient skilled care.
78 MBP Manual, Ch. 9, §40.1.5.
79 42 C.F.R. §418.204(b)(1).
80 42 C.F.R. §418.204(b)(2).
81 42 C.F.R. §§418.108(b), 418.110(e) and (f).
82 42 C.F.R. §§418.108(b)(2), 418.110(f).
83 42 C.F.R. §418.108(b)(2).
for a respite day. The actual amount will vary from hospice to hospice.\textsuperscript{84} However, in no event may the total amount of the coinsurance exceed the inpatient hospital deductible in effect in the year in which the hospice benefit was elected. In 2010, this amount is $1,100. The coinsurance is payable for each coinsurance period. A coinsurance period begins on the first day an election is effective and ends with the close of the first period of 14 consecutive days on each of which an election is not in effect for the beneficiary.\textsuperscript{85} So, for example, if the patient elected 210 consecutive days of hospice coverage, the patient would be required to pay the respite coinsurance up to the maximum only once.

**DISCHARGE REQUIREMENTS**

A hospice may discharge a patient if the patient moves out of the hospice's service area or transfers to another hospice, the hospice determines that the patient is no longer terminally ill, or the hospice determines that the patient's or other person's 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.\textsuperscript{86}

There are no appeal rights available to beneficiaries who are discharged from hospice for cause. However, per the regulations, prior to such a discharge, the hospice must:

- Advise the patient that a discharge for cause is being considered;
- Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation;
- Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and
- Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical record.\textsuperscript{87}

Prior to discharging a patient due to non-terminal status, the hospice must obtain a written physician's discharge order from the hospice medical director.\textsuperscript{88} 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.\textsuperscript{89}

\textsuperscript{84} For October 1, 2009 through September 30, 2010, the Medicare per diem rate for hospice respite care is about $147.83. See http://www.cms.hhs.gov/transmittals/downloads/R1796CP.pdf
\textsuperscript{85} 42 C.F.R. §418.400(b).
\textsuperscript{86} 42 C.F.R. §418.26(a).
\textsuperscript{87} 42 C.F.R. §418.26(a). See also Medicare Benefit Policy (MBP) Manual, CMS Pub. 100-02, Ch. 9, §20.2.1, "There may be extraordinary circumstances in which a hospice would be unable to continue to provide hospice care to a patient. These situations include issues where patient safety or hospice staff safety is compromised. The hospice must make every effort to resolve these problems satisfactorily before it considers discharge an option. All efforts by the hospice to resolve the problem(s) must be documented in detail in the patient's clinical record and the hospice must notify the fiscal intermediary and State Survey Agency of the circumstances surrounding the impending discharge. The hospice may also need to make referrals to other relevant state/community agencies (i.e., Adult Protective Services) as appropriate."
\textsuperscript{88} 42 C.F.R. §418.26(b).
\textsuperscript{89} 42 C.F.R. §418.26(b).
An individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice, is no longer covered under Medicare for hospice care; resumes previously waived Medicare coverage; and may at any time elect to receive hospice care if he or she is again eligible to receive the benefit.

Hospice programs must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill. The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

Prior to a patient's discharge due to non-terminal status, no later than "no later than the next to last time services are furnished," the hospice must issue a standardized termination notice. This notice must indicate that Medicare coverage for hospice care is ending, the date coverage ends, the beneficiary's financial liability for continued service, and how to appeal the discharge. This generic notice is the first step in the expedited appeals process, which guarantees Medicare beneficiaries review of their cases within 72 hours of request.

**EXPEDITED APPEALS**

In the event that the hospice program intends to discharge a beneficiary because it believes that he or she is no longer terminally ill, it must first give the beneficiary a standardized termination notice. The standardized termination notices are designed to inform beneficiaries that they are being discharged from hospice care and that they have a right to an expedited appeal. A beneficiary who wishes to exercise the right to an expedited appeal must submit a request for a determination to the Quality Improvement Organization (QIO) in the state in which the beneficiary is receiving services, in writing or by telephone, by no later than noon of the calendar day following receipt of the provider's notice of termination.

Coverage of provider services continues until the date and time designated on the termination notice, unless the QIO reverses the providers service termination decision. If the QIO's decision is delayed because the provider did not timely supply necessary information or records, the provider may be liable for the costs of an additional coverage, as determined by the QIO. If the QIO finds that the beneficiary did not receive valid notice, coverage of provider services continues until at least 2 days after valid notice has been received.

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90 See §5.01.
91 42 C.F.R. §418.26(c).
92 42 C.F.R. §418.26(d)(1).
93 42 C.F.R. §418.26(d)(2).
94 42 C.F.R. §405.1200.
95 42 C.F.R. §405.1200.
97 42 C.F.R. §411.404.
98 42 C.F.R. §411.404.
99 42 C.F.R. §405.1202(b).
100 42 C.F.R. §405.1202(c).
When a beneficiary requests an expedited determination by a QIO, the burden of proof rests with the provider to demonstrate that termination of coverage is the correct decision, either on the basis of medical necessity, or based on other Medicare coverage requirements. ¹⁰¹

No later than 72 hours after receipt of the request for an expedited review, the QIO must notify the beneficiary, beneficiary's physician, and the hospice program of its determination whether termination of Medicare coverage is the correct decision, either on the basis of medical necessity or based on other Medicare coverage policies. ¹⁰² If the beneficiary is unsatisfied with the QIO's decision, she may request an expedited reconsideration which should be issued by the Qualified Independent Contractor within 72 hours of the request. ¹⁰³

The expedited appeal regulations do not entertain the possibility that the hospice medical director, despite the QIO's decision may not certify the beneficiary as terminally ill. In other words, no regulation or policy specifically states an expedited appeal decision overturning a hospice decision to terminate care negates the physician certification requirement for Medicare coverage.

**MANAGED CARE MODEL ELUDES APPEAL RIGHTS**

As was discussed above, the Medicare hospice benefit covers a generous array of service. However, hospices have essentially unfettered control in determining how much care and what kind of care each patient receives. For example, the hospice generally determines whether a patient receives four nursing visits a week or one, seven hospice-aide visits a week or two, morphine to control pain or aspirin. This is because Medicare coverage is available for services specified on the plan of care, and the hospice writes the plan of care.

Since Medicare coverage became available for hospice care, no entity has monitored or evaluated the specific services provided to hospice patients. ¹⁰⁴ It will not be until January 01, 2010 that hospices, when they bill for coverage, will be required by the Centers for Medicare & Medicaid Services (CMS) to report kind, frequency and length of visit for various covered services. ¹⁰⁵

At this time, there is no way to appeal whether appropriate medical equipment, medications, or therapy have been provided or whether enough skilled nursing visits or hospice aide visits have been rendered to a hospice patient. More to the point, Medicare beneficiaries receiving hospice care have no way of appealing the hospice program’s decision not to provide a particular service. For instance, when an attending physician orders a particular pain medication, and the hospice decides not to include it on the hospice plan of care, the Medicare beneficiary has no right to appeal this decision.

¹⁰¹ 42 C.F.R. §405.1202(d).
¹⁰² 42 C.F.R. §405.1202(e)(6).
¹⁰³ 42 C.F.R. §405.1204.
¹⁰⁵ Medicare Claims Processing Manual, CMS Pub. 100-04, Ch. 11, § 20.1.2.
LITIGATION REGARDING HOSPICE DUE PROCESS RIGHTS

The Center for Medicare Advocacy recently filed a lawsuit challenging the failure of CMS to provide notice and appeal rights for Medicare beneficiaries in hospice who have been denied a requested item or service. Back v. Sebelius, ED CV 09-01706 VAP(DTBx), (C.D.Cal. filed Sept. 9, 2009). The complaint alleges that the denial of such an appeal process violates the Medicare statute and the due process clause of the U.S. Constitution. A copy of the Back complaint is attached to this Issue Brief.
I. INTRODUCTION

1. This case seeks to correct the lack of a remedy for Medicare beneficiaries who have been denied needed medical services by their hospice organizations. Emily Back, the deceased wife of plaintiff Howard Back, was a Medicare beneficiary who had elected to receive comprehensive end of life treatment from a Medicare hospice provider. During her final illness she experienced excruciating pain, which was not successfully managed by the pain medications supplied by the
hospice. Her attending physician prescribed another medication, Fentanyl Citrate Buccal (Actiq). The Medicare hospice refused to supply Mrs. Back with Actiq, so to alleviate his wife’s suffering her husband purchased it himself. After Mrs. Back’s death, plaintiff attempted to obtain reimbursement for the cost of the Actiq from the hospice. When that was refused, he attempted without success to appeal the hospice denial decision through the Medicare appeals process. However, the Medicare program provides no remedy for hospice patients who are improperly denied medications by their hospices, in violation of the Medicare statute and the due process clause of the United States Constitution. Plaintiff asks this Court for declaratory and injunctive relief to require the Medicare administration to establish a fair appeals process for hospice beneficiaries.

II. JURISDICTION

2. This Court has jurisdiction pursuant to 28 U.S.C. § 1331 and 42 U.S.C. § 405(g), which is incorporated into the Medicare statute by 42 U.S.C. § 1395ff(b)(1)(A).

3. The declaratory judgment sought by plaintiff is authorized by 28 U.S.C. § 2201.

III. PARTIES

4. Plaintiff Howard Back is the husband of deceased Medicare beneficiary Emily Back. They resided, and he still resides, in Palm Desert, California. Mrs. Back was diagnosed as terminally ill in October, 2007, and elected to receive palliative hospice services from Visiting Nurse Association (VNA) in lieu of regular Medicare benefits. Her physician prescribed Actiq to control her extreme
pain, but the hospice wrongly refused to provide it to her. Mr. Back purchased the
Actiq for his wife at his own expense, and now seeks an appeals process for the
refusal of VNA to reimburse him for the medication

5. Defendant Kathleen Sebelius is the Secretary of the United States
Department of Health and Human Services. As such she is responsible for the
administration of the Medicare program. VNA contracts with defendant to provide
hospice services to Medicare beneficiaries, and acts in accordance with defendant’s
instructions in providing such services. Secretary Sebelius is sued in her official
capacity.

IV. LEGAL FRAMEWORK

6. Medicare is the federal program that provides health insurance to the
aged and the disabled. It was established by Congress in 1965 as Title XVIII of
the Social Security Act, codified at 42 U.S.C. § 1395 et seq. Part A of traditional
Medicare covers institutional services including hospital, skilled nursing facility,
home health and hospice services. Part B of traditional Medicare covers
supplemental medical services such as physician, therapy, ambulance services,
medical equipment, etc. Part C gives Medicare beneficiaries the option of
receiving these same services under various alternative delivery systems, including
managed care and private fee-for-service plans. Prescription drug coverage is
available for purchase under Part D.
7. Hospice services are covered under Part A of Medicare for beneficiaries who have been diagnosed as terminally ill. 42 U.S.C. § 1395x(dd). Hospice services do not attempt to cure the terminal illness, but are designed to alleviate pain and manage that illness by optimizing the quality of life and treating suffering. When a beneficiary elects hospice services, a written plan of care is adopted with the attending physician. 42 C.F.R. § 418.56(b). The package of hospice services includes physician services, nursing care, medical social services, counseling services for the patient and family, therapy services, hospice aid and homemaker services, medical supplies and equipment, short term inpatient care, and drugs and biologicals (products used to induce immunity to various infectious diseases or noxious substances of biological origin.) 42 U.S.C. §1395x(dd)(1)(E).

When a beneficiary elects hospice services, the hospice is paid a flat fee for the package of services similar to the capitation Medicare pays to managed care plans to provide medical services at a set monthly rate. 42 C.F.R. §§ 418.301-302.


9. The defendant’s Medicare regulations provide an appeals process for hospice patients, but this process is more limited than the usual Medicare appeals process. Beneficiaries can appeal a decision that they are not eligible for hospice care, or that a specific service is billed separately from the hospice payment, but no provision is made for appealing the refusal by a hospice to provide a particular
service such as drugs that is included in the hospice payment. MLN Matters

V. STATEMENT OF FACTS

10. Emily Back had a long history of back pain and other painful
conditions. Her diagnoses included severe back and sciatic nerve pain, angina,
asthma, diabetes, coronary artery disease (S/P myocardial infarction 1986)
rheumatoid arthritis, carpal tunnel, macular degeneration, and hearing loss. In
August, 2007 she suffered a fall that caused massive damage to her spine.

11. In October, 2007 Mrs. Back was determined to be terminally ill. She
elected to receive palliative rather than curative care under the Medicare hospice
program with VNA.

12. Mrs. Back continued to suffer constant, extreme pain, which could not
be controlled by any of the medications supplied to her by VNA. These
ineffective medications included huge amounts of oxycontin and oxydose drops,
morphine, and Fentanyl patches.

13. On February 2, 2008 Mrs. Back was experiencing desperate pain that
seemed to be increasing. Her physician prescribed Actiq 1600 mg "lollypops," but
VNA refused to provide this medication.

14. Because of VNA’s refusal to provide the prescribed pain medication for
his wife, plaintiff purchased it himself. He filled the prescription for 30 Actiq
lollypops on February 2nd at a cost to him of $1,699.99. On February 14th plaintiff
filled a second prescription for 30 Actiq, at a cost of $1,699.99. On February 23
Mrs. Back needed more, and plaintiff filled a prescription for 45 at a cost of
$2,539.99.


16. On September 4, 2008 Mr. Back submitted the bills for the Actiq
medication that he had purchased to VNA and asked for reimbursement.

17. On September 22, 2008 VNA responded to Mr. Back’s request by a
letter from Paula Peoples, Vice President of Clinical Operations. Ms. Peoples
acknowledged that VNA knew the Actiq had been prescribed by Mrs. Back’s
attending physician, but it nevertheless denied him reimbursement. Her letter said
that other pain medications available from VNA were “almost always effective”
and the VNA had not agreed to include this medication in Mrs. Back’s plan of
care.

18. On November 4, 2008 plaintiff wrote again to Ms. Peoples at VNA. He
pointed out that the pain medications provided to Mrs. Back by VNA had not, in
fact, been effective, and that her physician said he could suggest nothing else
except Actiq. He also stated that Actiq had, in fact, been included in Mrs. Back’s
care plan on February 2, 2008 with signoff by the hospice interdisciplinary team.
He asked for a formal appeal to the Medicare contractor.

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19. The CEO of VNA responded to Mr. Back's second letter on November
11, 2008. It advised him that the Medicare intermediary was National
Government Services (NGS) in Kansas.

20. On December 3, 2008 plaintiff Back wrote to NGS, requesting an
appeal of the VNA's denial of his request for reimbursement of the cost of the
Actiq for his deceased wife.

21. On December 31, 2008 plaintiff received a form letter from "1-800-
MEDICARE Customer Service Representative" in apparent response to his appeal
letter to NDG. The letter was not addressed to him but to "Ms. Back." This letter
stated that no appeal could be completed unless Ms. Back provided "legal
documents naming you as the person responsible for the estate," with further
requirements that the documents show the beneficiary's "Medicare number."
There was no return address or contact information provided on this letter except
for the national Medicare 800 phone number, which provides only scripted general
information.

22. The requirement that plaintiff provide a court order appointing him as
executor of the estate before he can appeal, set out in the unsigned Medicare letter
of December 31, 2008, is not correct. A claimant is entitled to file an appeal based
on 42 C.F.R. § 424.62(c)(1), as the person who paid for the services, or 42 C.F.R. §
424.62(c)(3)(i), as the surviving spouse of the person who paid for the services.
23. On February 9, 2009 plaintiff again wrote to defendant’s Center for Medicare & Medicaid Services (CMS) at the P.O. Box address on the envelope of the letter to him of December 31, 2008, enclosing a copy of Mrs. Back’s will.

24. On February 23, 2009 plaintiff received another form letter like the letter of December 31, 2008 from 1-800-MEDICARE Customer Service, making no reference to the will that plaintiff had provided in his letter of February 9, 2009. The form letter was again addressed to “Ms. Back.” The letter incorrectly stated that only the legal representative of a deceased’s estate or a person taking responsibility for settling the estate could file an appeal, and required a legal document (list of three included) to establish this legal status. It also listed a number of kinds of other information that Mr. Back would also be required to submit with every request for access to Mrs. Back’s records, “because we cannot permanently alter the record after a beneficiary has passed away.”

25. On March 26, 2009 plaintiff’s attorney wrote to NGS requesting an appeal of the hospice denial of reimbursement for prescribed pain medications. The letter set out the regulations concerning the correct requirements for maintaining an appeal by a surviving spouse, copies of authorization of representation documents, the appeal regulations, a description of the facts concerning Mrs. Back’s care during her terminal illness, and receipts for the medication purchased by plaintiff.
26. On April 27, 2009 the 1-800-MEDICARE Customer Service Representative wrote in response to the Estate of Emily Back at the address of plaintiff's attorney. The letter stated that the plaintiff's request for an appeal could not be filed because the Medicare provider must file the claim. It then restated the demand for all the contact information and formal estate documents that had been made in the two earlier form letters, with no acknowledgement that this information had already been provided.

27. Plaintiff cannot comply with the conditions for appeal set out in the 3 form letters from 1-800-MEDICARE. First, there is no contact person or address provided in any of these letters to whom plaintiff can respond, although Plaintiff's counsel did recently call the 800 number inquiring about an appeal process without success. Second, VNA has already refused his claim, and there is no provision in Medicare law for the hospice to claim additional payment for the medication because its cost is included in the capitation payment from Medicare. Third, the representative paperwork and information requirements in these Medicare letters are not correct, but plaintiff has nevertheless complied with them several times to no avail.

VI. FIRST CAUSE OF ACTION: VIOLATION OF MEDICARE STATUTE

28. Defendant’s failure to provide Medicare beneficiaries with a process for appealing the refusal of a Medicare hospice to provide drugs prescribed by the

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attending physician violates the provisions of the Medicare statute concerning
establishment of an appeals process for Medicare beneficiaries who are denied
services. 42 U.S.C. § 1395ff(a)(1).

VII. SECOND CAUSE OF ACTION:
VIOLATION OF THE DUE PROCESS CLAUSE

29. The Fifth Amendment to the United States Constitution provides that a
person shall not be deprived of life, liberty, or property without due process of law.
Due process requires at a minimum that a person receive notice and an opportunity
to be heard before being deprived of a statutory entitlement protected as property.
Plaintiff received no opportunity to be heard before defendant denied him the
reimbursement provided for in the Medicare statute. Defendant’s failure to
provide a process for appealing the refusal of a Medicare hospice to provide drugs
prescribed by the attending physician violates the provisions of the Due Process
Clause.

VIII. PRAYER FOR RELIEF

WHEREFORE, plaintiff respectfully asks this Court to:

1. Issue a declaratory judgment that:

   a. Defendant’s failure to provide Medicare beneficiaries with a
      process for appealing the refusal of a Medicare hospice to provide drugs prescribed
      by the attending physician violates the provisions of the Medicare statute
concerning establishment of an appeals process for Medicare beneficiaries who are
denied services. 42 U.S.C. § 1395ff(a)(1); and,

b. Defendant's failure to provide Medicare beneficiaries with a
process for appealing the refusal of a Medicare hospice to provide drugs prescribed
by the attending physician violates the Due Process Clause of the United States
Constitution.

2. Issue a permanent injunction prohibiting Defendant from failing to
provide Medicare beneficiaries with an administrative process for appealing the
refusal of a Medicare hospice to provide drugs prescribed by the attending
physician.

3. Provide plaintiff Back with an administrative process for appealing the
refusal of VNA to reimburse him for the cost of the Actiq that he purchased for his
dying wife after it was prescribed by her physician.

4. For costs of suit herein.

5. For reasonable attorneys' fees and expenses pursuant to the Equal Access

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COMPLAINT FOR DECLARATORY JUDGMENT AND INJUNCTION
6. Grant such other and further relief as to the Court shall seem just and proper.

DATED: September 8, 2009

By: ____________________________
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