

The Medicare Hospice Benefit

What Does It Mean to You—and Your Patients?



VITAS[®]
Healthcare

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By the time Congress established the Medicare Hospice Benefit in 1982, hundreds of organizations in the United States called themselves hospices. Since 1982, to receive Medicare reimbursement, hospices must comply with the Medicare conditions of participation.

This booklet defines and explains these conditions and looks at how they affect patients, families and hospice providers.

All hospices that are reimbursed by Medicare must meet Medicare's definition of:

- Initial and ongoing requirements for a beneficiary to be eligible to receive hospice services under the Medicare Hospice Benefit.
- Different “levels of care”: routine home care, continuous home care*, general inpatient care and respite inpatient care.
- The professional and ancillary services a Medicare-certified hospice must provide.
- Reimbursement for the hospice, the patient's attending physician and other physician services.

The Medicare Hospice Benefit serves as the model for all Medicaid Hospice Benefit programs, most state licensure laws and most private insurance plans.

* At VITAS we call this Intensive Comfort Care®

Initial and ongoing requirements for a beneficiary to be eligible to receive hospice services under the Medicare Hospice Benefit include:

- **Eligibility:** A patient must be eligible for Medicare Part A.
- **Informed consent:** The beneficiary must agree that he or she wishes to receive “palliative, not curative, care” and to surrender all other Medicare benefits relating to the terminal diagnosis, with the exception of the professional services of his or her attending physician.
- **Initial prognosis:** The attending physician and the hospice medical director or team physician must certify that the patient has a “medical prognosis that his or her life expectancy is six months or less, if the illness runs its normal course.”
- **Ongoing prognosis:** At successive intervals of 90-, 90- and unlimited 60-day periods, a hospice physician must certify that the patient's prognosis continues to be six months or less from the date of the most recent certification. Patients are visited by a physician starting with the 3rd benefit period (usually 180 days) to determine their continued appropriateness for the benefit. Patients continue to receive the benefit for as long as they qualify for hospice care. Patients fortunate enough to recover or not to continue to decline are returned to routine Medicare coverage. They may become hospice eligible if their health again declines.

While individual patients may receive hospice services for periods beyond six months, Medicare has a “global cap” on the total annual monies that a hospice can receive. This global cap forces hospices to work closely with community physicians to ensure patients’ appropriateness but does not “punish” a beneficiary or his or her physician if a patient is fortunate enough to live beyond six months.

Medicare-required professional and ancillary hospice services

Medicare covers 100 percent of VITAS’ hospice services under an all-inclusive rate. There are no out-of-pocket expenses to the patient or family. VITAS is responsible for:

- Physician services to assist in the palliation of the terminal illness and related conditions
- All prescription drugs, over-the-counter medications, medical equipment and supplies related to the patient’s terminal illness needed for enhanced comfort, as designated in the plan of care
- An organized program of services to meet the bereavement needs of the family for at least one year after the beneficiary’s death
- A nurse to supervise the entire plan of care and provide hands-on care and patient/family teaching
- Certified hospice aides to provide personal care and assist with activities of daily living
- If indicated for palliative purposes, physical therapy, occupational therapy, speech therapy and dietary counseling
- Lab and other diagnostic tests necessary to achieve optimum palliative care
- Community volunteers who must, by law, provide 5 percent of all patient care hours
- Chaplains to provide pastoral care according to each patient’s unique spiritual needs and desires
- Social workers to focus on the emotional, financial and social stresses associated with terminal illness
- Inpatient care for pain and other symptoms that cannot be managed at home



Levels of care

- **Routine home care**

This is the “basic” and most frequently delivered level of hospice care. Care provided by hospices to Medicare beneficiaries who reside in nursing homes and long term care facilities is classified by Medicare as routine home care.

- **Continuous home care***

This level is usually related to the development of acute medical symptoms in a patient who wishes to stay at home but requires more extensive care than that provided in routine home care. Continuous home care must be provided a minimum of eight hours/day and is primarily, although not exclusively, nursing care.

- **Inpatient care**

For the care of pain and other symptoms that cannot be managed at home, all hospices must have the availability of inpatient care. Such inpatient care can be: a stand-alone hospice facility, a dedicated hospice wing/unit in a hospital, skilled nursing or long term care facility, or “contract beds” within a hospital or facility.

- **Respite care**

Limited to five consecutive days, respite care provides a break for the home care patient’s primary caregiver by admitting the home care patient to an inpatient hospice setting without meeting the criteria for inpatient pain and symptom management.

* VITAS Intensive Comfort Care®



Reimbursement under the Medicare Hospice Benefit

The hospice

Hospices are paid a per-diem rate. This rate covers all professional services, ancillary supplies and equipment defined by the Medicare Hospice Benefit that relate to the patient’s terminal illness and are documented in the plan of care. There is no need to defer hospice care due to financial concerns.

The per-diem rate varies by level of care and by the location where the service is delivered. All hospices in a local market receive the same per-diem rate from Medicare for the same level of service.

The per-diem rate includes the program medical director’s general supervisory services and the team physician’s participation in developing the patient’s plan of care.

Home or inpatient physician visits made by a hospice physician are reimbursed outside the per-diem rate.



A patient's existing or attending physician can continue to direct the clinical care after the patient is on hospice service. Or, if the patient or his/her doctor wishes, a VITAS physician can direct the care related to the primary illness.

The attending physician

The Medicare Hospice Benefit defines the attending physician as an M.D. or D.O. who "is identified by the individual, at the time he or she elects hospice care, as having the most significant role in the determination of the individual's medical care."

The attending physician can continue to bill Medicare Part B for professional services including office, home and inpatient visits.

Laboratory studies, X-rays or other diagnostic tests necessary for proper treatment of the terminal illness are covered under the hospice per-diem rate. The hospice must have a

contract with all providers of these or other tests or procedures. VITAS requires that a physician and/or provider receive prior authorization before performing any procedures or tests.

The consulting physician

To be reimbursed by a hospice, a consulting physician must have a contract with the hospice. VITAS requires prior authorization for consulting physician services.

The patient and family

The Medicare Hospice Benefit is an inclusive benefit. VITAS charges no co-payments. All products and services in the plan of care are paid for by VITAS.

Care clearly unrelated to the terminal illness continues to be covered by Medicare Parts A and B, with all normal rules applicable, e.g., co-payments, coverage guidelines and deductibles.

Ask your VITAS representative for more information about:

- Medicare billing procedures
- Pain and symptom management
- Determining eligibility for hospice care
- Communicating with healthcare professionals or patients and families
- The VITAS story
- How VITAS works with long term care facilities and assisted living communities

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