

(2) If the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice; or

(3) Is a volunteer under the jurisdiction of the hospice.

*Hospice* means a public agency or private organization or subdivision of either of these that is primarily engaged in providing hospice care as defined in this section.

*Hospice care* means a comprehensive set of services described in 1861(dd)(1) of the Act, identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.

*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.

*Licensed professional* means a person licensed to provide patient care services by the State in which services are delivered.

*Multiple location* means a Medicare-approved location from which the hospice provides the same full range of hospice care and services that is required of the hospice issued the certification number. A multiple location must meet all of the conditions of participation applicable to hospices.

*Palliative care* means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

*Physician* means an individual who meets the qualifications and conditions as defined in section 1861(r) of the Act and implemented at §410.20 of this chapter.

*Physician designee* means a doctor of medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available.

*Pseudo-patient* means a person trained to participate in a role-play situation, or a computer-based mannequin device. A pseudo-patient must be capable of responding to and interacting with the hospice aide trainee, and must demonstrate the general characteristics of the primary patient population served by the hospice in key areas such as age, frailty, functional status, cognitive status and care goals.

*Representative* means an individual who has the authority under State law (whether by statute or pursuant to an appointment by the courts of the State) to authorize or terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill patient who is mentally or physically incapacitated. This may include a legal guardian.

*Restraint* means—(1) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort); or

(2) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

*Seclusion* means the involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving.

*Simulation* means a training and assessment technique that mimics the reality of the homecare environment, including environmental distractions and constraints that evoke or replicate substantial aspects of the real world in a fully interactive fashion, in order to teach and assess proficiency in performing skills, and to promote decision making and critical thinking.

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*Terminally ill* means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

[48 FR 56026, Dec. 16, 1983, as amended at 52 FR 4499, Feb. 12, 1987; 55 FR 50834, Dec. 11, 1990; 70 FR 45144, Aug. 4, 2005; 72 FR 50227, Aug. 31, 2007; 73 FR 32204, June 5, 2008; 79 FR 50509, Aug. 22, 2014; 83 FR 38654, Aug. 6, 2018; 84 FR 38543, Aug. 6, 2019; 86 FR 42605, Aug. 4, 2021]

### Subpart B—Eligibility, Election and Duration of Benefits

#### § 418.20 Eligibility requirements.

In order to be eligible to elect hospice care under Medicare, an individual must be—

- (a) Entitled to Part A of Medicare; and
- (b) Certified as being terminally ill in accordance with § 418.22.

#### § 418.21 Duration of hospice care coverage—Election periods.

(a) Subject to the conditions set forth in this part, an individual may elect to receive hospice care during one or more of the following election periods:

- (1) An initial 90-day period;
  - (2) A subsequent 90-day period; or
  - (3) An unlimited number of subsequent 60-day periods.
- (b) The periods of care are available in the order listed and may be elected separately at different times.

[55 FR 50834, Dec. 11, 1990, as amended at 57 FR 36017, Aug. 12, 1992; 70 FR 70546, Nov. 22, 2005]

#### § 418.22 Certification of terminal illness.

(a) *Timing of certification*—(1) *General rule.* The hospice must obtain written certification of terminal illness for each of the periods listed in § 418.21, even if a single election continues in effect for an unlimited number of periods, as provided in § 418.24(c).

(2) *Basic requirement.* Except as provided in paragraph (a)(3) of this section, the hospice must obtain the written certification before it submits a claim for payment.

(3) *Exceptions.* (i) If the hospice cannot obtain the written certification

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within 2 calendar days, after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment.

(ii) Certifications may be completed no more than 15 calendar days prior to the effective date of election.

(iii) Recertifications may be completed no more than 15 calendar days prior to the start of the subsequent benefit period.

(4) *Face-to-face encounter.* (i) As of January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient whose total stay across all hospices is anticipated to reach the 3rd benefit period. The face-to-face encounter must occur prior to, but no more than 30 calendar days prior to, the 3rd benefit period recertification, and every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care.

(ii) During a Public Health Emergency, as defined in § 400.200 of this chapter, or through December 31, 2024, whichever is later, if the face-to-face encounter conducted by a hospice physician or hospice nurse practitioner is for the sole purpose of hospice recertification, such encounter may occur via a telecommunications technology and is considered an administrative expense. *Telecommunications technology* means the use of interactive multimedia communications equipment that includes, at a minimum, the use of audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site hospice physician or hospice nurse practitioner.

(b) *Content of certification.* Certification will be 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 with the written certification as set forth in paragraph (d)(2) of this section. 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.

(i) If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician's signature.

(ii) If the narrative exists as an addendum to the certification or recertification form, in addition to the physician's signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.

(iii) The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record or, if applicable, his/her examination of the patient.

(iv) The narrative must reflect the patient's individual clinical circumstances and cannot contain check boxes or standard language used for all patients.

(v) The narrative associated with the 3rd benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.

(4) The physician or nurse practitioner who performs the face-to-face encounter with the patient described in paragraph (a)(4) of this section must attest in writing that he or she had a face-to-face encounter with the patient, including the date of that visit. The attestation of the nurse practitioner or a non-certifying hospice phy-

sician shall state that the clinical findings of that visit were provided to the certifying physician for use in determining continued eligibility for hospice care.

(5) All certifications and recertifications must be signed and dated by the physician(s), and must include the benefit period dates to which the certification or recertification applies.

(c) *Sources of certification.* (1) For the initial 90-day period, the hospice must obtain written certification statements (and oral certification statements if required under paragraph (a)(3) of this section) from—

(i) The medical director of the hospice, the physician designee (as defined in § 418.3), or the physician member of the hospice interdisciplinary group; and

(ii) The individual's attending physician, if the individual has an attending physician. The attending physician must meet the definition of physician specified in § 410.20 of this subchapter.

(2) For subsequent periods, the only requirement is certification by one of the physicians listed in paragraph (c)(1)(i) of this section.

(d) *Maintenance of records.* Hospice staff must—

(1) Make an appropriate entry in the patient's medical record as soon as they receive an oral certification; and

(2) File written certifications in the medical record.

[55 FR 50834, Dec. 11, 1990, as amended at 57 FR 36017, Aug. 12, 1992; 70 FR 45144, Aug. 4, 2005; 70 FR 70547, Nov. 22, 2005; 74 FR 39413, Aug. 6, 2009; 75 FR 70463, Nov. 17, 2010; 76 FR 47331, Aug. 4, 2011; 85 FR 19289, Apr. 6, 2020; 88 FR 51199, Aug. 2, 2023; 89 FR 64272, Aug. 6, 2024]

#### § 418.24 Election of hospice care.

(a) *Election statement.* An individual who meets the eligibility requirement 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.

(b) *Content of election statement.* The election statement must include the following:

(1) Identification of the particular hospice and of the attending physician

that will provide care to the individual. The individual or representative must acknowledge that the identified attending physician was his or her choice.

(2) The individual's or representative's acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual's terminal illness and related conditions.

(3) Acknowledgement that the individual has been provided information on the hospice's coverage responsibility and that certain Medicare services, as set forth in paragraph (g) of this section, 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 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.

(5) For Hospice elections beginning on or after October 1, 2020, the Hospice must provide information on individual cost-sharing for hospice services.

(6) For Hospice elections beginning on or after October 1, 2020, the Hospice must provide notification of the individual's (or representative's) right to receive an election statement addendum, as set forth in paragraph (c) of this section, 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.

(7) For Hospice elections beginning on or after October 1, 2020, the Hospice must provide 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.

(c) *Content of hospice election statement addendum.* 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. 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 the individual's (or representative's) agreement with the hospice's determinations. If the beneficiary (or representative) refuses to sign the addendum, the hospice must document on the addendum the reason the addendum was not signed and the addendum would become part of the patient's medical record. If a non-hospice provider or Medicare contractor requests the addendum, the non-hospice provider or Medicare contractor are not required to sign the addendum.

(10) Date the hospice furnished the addendum.

(d) *Timeframes for the hospice election statement addendum.* (1) If the addendum is requested within the first 5 days of a hospice election (that is, in the first 5 days of the hospice election date), the hospice must provide this information, in writing, to the individual (or representative), non-hospice provider, or Medicare contractor within 5 days from the date of the request.

(2) If the addendum is requested during the course of hospice care (that is, after the first 5 days of the hospice election date), the hospice must provide this information, in writing, within 3 days of the request to the requesting individual (or representative), non-hospice provider, or Medicare contractor.

(3) If there are any changes to the plan of care during the course of hospice care, the hospice must update the addendum and provide these updates, in writing, to the individual (or rep-

resentative) in order to communicate these changes to the individual (or representative).

(4) If the individual dies, revokes, or is discharged within the required timeframe for furnishing the addendum (as outlined in paragraphs (d)(1) and (2) of this section, and before the hospice has furnished the addendum, the addendum would not be required to be furnished to the individual (or representative). The hospice must note the reason the addendum was not furnished to the patient and the addendum would become part of the patient's medical record if the hospice has completed it at the time of discharge, revocation, or death.

(5) If the beneficiary dies, revokes, or is discharged prior to signing the addendum (as outlined in paragraphs (d)(1) and (2) of this section), the addendum would not be required to be signed in order for the hospice to receive payment. The hospice must note (on the addendum itself) the reason the addendum was not signed and the addendum would become part of the patient's medical record.

(e) *Notice of election.* The hospice chosen by the eligible individual (or his or her representative) must file the Notice of Election (NOE) with its Medicare contractor within 5 calendar days after the effective date of the election statement.

(1) *Consequences of failure to submit a timely notice of election.* When a hospice does not file the required Notice of Election for its Medicare patients within 5 calendar days after the effective date of election, Medicare will not cover and pay for days of hospice care from the effective date of election to the date of filing of the notice of election. These days are a provider liability, and the provider may not bill the beneficiary for them.

(2) *Exception to the consequences for filing the NOE late.* CMS may waive the consequences of failure to submit a timely-filed NOE specified in paragraph (e)(1) of this section. CMS will determine if a circumstance encountered by a hospice is exceptional and qualifies for waiver of the consequence specified in paragraph (e)(1) of this section. A hospice must fully document

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and furnish any requested documentation to CMS for a determination of exception. An exceptional circumstance may be due to, but is not limited to, the following:

(i) Fires, floods, earthquakes, or similar unusual events that inflict extensive damage to the hospice's ability to operate.

(ii) A CMS or Medicare contractor systems issue that is beyond the control of the hospice.

(iii) A newly Medicare-certified hospice that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its Medicare contractor.

(iv) Other situations determined by CMS to be beyond the control of the hospice.

(f) *Duration of election.* 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 under the provisions of § 418.26.

(g) *Waiver of other benefits.* For the duration of an election of hospice care, an individual waives all rights to Medicare payments for the following services:

(1) Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice).

(2) Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services—

(i) Provided by the designated hospice;

(ii) Provided by another hospice under arrangements made by the designated hospice; and

(iii) Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

(h) *Re-election of hospice benefits.* If an election has been revoked in accordance with § 418.28, the individual (or his

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or her representative if the individual is mentally or physically incapacitated) may at any time file an election, in accordance with this section, for any other election period that is still available to the individual.

(i) *Changing the attending physician.* To change the designated attending physician, the individual (or representative) must file a signed statement with the hospice that states that he or she is changing his or her attending physician.

(1) The statement must identify the new attending physician, and include the date the change is to be effective and the date signed by the individual (or representative).

(2) The individual (or representative) must acknowledge that the change in the attending physician is due to his or her choice.

(3) The effective date of the change in attending physician cannot be before the date the statement is signed.

[55 FR 50834, Dec. 11, 1990, as amended at 70 FR 70547, Nov. 22, 2005; 79 FR 50509, Aug. 22, 2014; 84 FR 38544, Aug. 6, 2019; 86 FR 42605, Aug. 4, 2021; 89 FR 64272, Aug. 6, 2024]

### § 418.25 Admission to hospice care.

(a) The hospice admits a patient only on the recommendation of the medical director (or the physician designee, as defined in § 418.3) in consultation with, or with input from, the patient's attending physician (if any).

(b) In reaching a decision to certify that the patient is terminally ill, the hospice medical director (or the physician designee, as defined in § 418.3) must consider at least the following information:

(1) Diagnosis of the terminal condition of the patient.

(2) Other health conditions, whether related or unrelated to the terminal condition.

(3) Current clinically relevant information supporting all diagnoses.

[70 FR 70547, Nov. 22, 2005, as amended at 89 FR 64272, Aug. 6, 2024]

### § 418.26 Discharge from hospice care.

(a) *Reasons for discharge.* A hospice may discharge a patient if—

(1) The patient moves out of the hospice's service area or transfers to another hospice;

(2) The hospice determines that the patient is no longer terminally ill; or

(3) The hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause that meets the requirements of paragraphs (a)(3)(i) through (a)(3)(iv) of this section, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. The hospice must do the following before it seeks to discharge a patient for cause:

(i) Advise the patient that a discharge for cause is being considered;

(ii) Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation;

(iii) Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and

(iv) Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.

(b) *Discharge order.* Prior to discharging a patient for any reason listed in paragraph (a) of this section, the hospice must obtain a written physician's discharge order from the hospice medical director. 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.

(c) *Effect of discharge.* An individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice—

(1) Is no longer covered under Medicare for hospice care;

(2) Resumes Medicare coverage of the benefits waived under § 418.24(e); and

(3) May at any time elect to receive hospice care if he or she is again eligible to receive the benefit.

(d) *Discharge planning.* (1) The hospice 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.

(2) 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.

(e) *Filing a notice of termination of election.* When the hospice election is ended due to discharge, the hospice must file a notice of termination/revocation of election with its Medicare contractor within 5 calendar days after the effective date of the discharge, unless it has already filed a final claim for that beneficiary.

[70 FR 70547, Nov. 22, 2005, as amended at 79 FR 50509, Aug. 22, 2014; 84 FR 38544, Aug. 6, 2019]

#### § 418.28 Revoking the election of hospice care.

(a) An individual or representative may revoke the individual's election of hospice care at any time during an election period.

(b) To revoke the election of hospice care, the individual or representative must file a statement with the hospice that includes the following information:

(1) A signed statement that the individual or representative revokes the individual's election for Medicare coverage of hospice care for the remainder of that election period.

(2) The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made).

(c) An individual, upon revocation of the election of Medicare coverage of hospice care for a particular election period—

(1) Is no longer covered under Medicare for hospice care;

(2) Resumes Medicare coverage of the benefits waived under § 418.24(f)(2); and

(3) May at any time elect to receive hospice coverage for any other hospice election periods that he or she is eligible to receive.

(d) When the hospice election is ended due to revocation, the hospice must file a notice of termination/revocation of election with its Medicare contractor within 5 calendar days after the effective date of the revocation,