CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12385	**Date: November 30, 2023**
	Change Request 13437

SUBJECT: Hospice Benefit Policy Manual Updates Related to the Addition of Marriage and Family Therapists (MFTs) or Mental Health Counselors (MHCs) to the Hospice Interdisciplinary Team

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to manualize changes to the hospice interdisciplinary group (IDG) to include Marriage and Family Therapists (MFTs) or Mental Health Counselors (MHCs). In the CY 2024 Physician Fee Schedule Final Rule (X FR X), we finalized modifications to the hospice conditions of participation to permit MFTs or MHCs to serve as members of the hospice IDG (§§ 418.56 and 418.114).

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 2, 2024

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	9/40.1.1 – Nursing Care
R	9/40.2.1 - Continuous Home Care (CHC)

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: 12385	Date: November 30, 2023	Change Request: 13437

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I. GENERAL INFORMATION

A. Background: The Consolidated Appropriations Act of 2023 (Pub. L. 117–328) (CAA, 2023), was signed into law on December 29, 2022. Division FF, section 4121 of the CAA, 2023 establishes a new Medicare benefit category for marriage and family therapist (MFT) services and mental health counselor (MHC) services furnished by and directly billed by MFTs and MHCs, respectively. Section 4121(b)(2) of the CAA, 2023 specifically adds these services to covered hospice care services under section 1861(dd)(2)(B)(i)(III) of the Act. The CAA, 2023 revised section 1861(dd) of the Act to state that the hospice interdisciplinary group is required to include one social worker, MFT, or MHC. To implement Division FF, section 4121 of the CAA, 2023, in the CY 2024 Physician Fee Schedule final rule (https://www.cms.gov/medicare/medicare-fee-service-payment/physicianfeesched/pfs-federal-regulation-notices/cms-1784-f), CMS finalized changes to the regulations at §§ 418.56 and 418.114 to permit MFTs or MHCs to serve as members of the hospice IDG.

B. Policy: Effective for hospice elections beginning on or after January 1, 2024, MFTs or MHCs are permitted to serve as members of the hospice IDG.

The Medicare Benefit Policy Manual, Pub. 100-02, chapter 9 has been updated to include changes to the hospice IDG.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13437.1	The contractors shall be aware of the revisions to Pub. 100-02, chapter 9 related to the policies discussed in this CR.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13437.2	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.			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

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. 12385; Isuued:11-30-23)

40.1.1 - Nursing Care

(Rev.12385; Isuued:11-30-23 Effective:01-01-24; Implementation: 01-02-24)

To be covered as nursing services, the services must require the skills of a registered nurse (RN), or a licensed practical nurse (LPN) or a licensed vocational nurse (LVN) under the supervision of a registered nurse, and must be reasonable and necessary for the palliation and management of the patient's terminal illness and related conditions.

Services provided by a nurse practitioner (NP) who is not the patient's attending physician, are included under nursing care. This means that, in the absence of an NP, an RN, LPN, or LVN would provide the service. Since the services are nursing, payment is encompassed in the hospice per diem rate and may not be billed separately regardless of whether the services are provided by an NP or an RN. The following are examples of some services that traditionally are provided by an RN, which could also be provided by an NP, for which separate payment is not made:

a. A patient with a terminal illness of lung cancer complains of leg pain. In the absence of an NP, an RN would assess the patient.
b. Assessment of pain and or symptoms to determine the need for medications, other treatments, continuous home care, general inpatient care etc. In the absence of an NP, an RN would assess the patient.
c. Administration of medications through intravenous (e.g., PICC, central, etc.), intrathecal or any other means. In the absence of an NP, an RN would administer the medication.
d. Family counseling. In the absence of an NP, an RN, social worker, counselor, *marriage and family therapists (MFT) or mental health counselors (MHCs)* would provide this service.
e. Providing a home visit for assessment or provision of care to a patient who is not his/her patient. In the absence of the NP, the service would be provided by an RN, LPN or LVN. Therefore, the NP cannot bill separately for the service.

40.2.1 - Continuous Home Care (CHC)

(Rev.12385; Isuued:11-30-23 Effective:01-01-24; Implementation: 01-02-24

Continuous home care may be provided only during a period of crisis as necessary to maintain an individual at home. A period of crisis is a period in which a patient requires continuous care which is predominantly nursing care to achieve palliation or management of acute medical symptoms. If a patient's caregiver has been providing a skilled level of care for the patient and the caregiver is unwilling or unable to continue providing care, this may precipitate a period of crisis because the skills of a nurse may be needed to replace the services that had been provided by the caregiver. This type of care can also be given when a patient resides in a long term care facility. However, Medicare regulations do not permit CHC to be provided in an inpatient facility (a hospice inpatient unit, a hospital, or SNF).

The hospice must provide a minimum of 8 hours of nursing, hospice aide, and/or homemaker care during a 24-hour day, which begins and ends at midnight. This care need not be continuous, e.g., 4 hours could be provided in the morning and another 4 hours in the evening. In addition to the 8 hour minimum, the services provided must be predominantly nursing care, provided by either an RN, an LPN, or an LVN. Services provided by a nurse practitioner that, in the absence of a nurse practitioner, would be performed by an RN, LPN, or LVN, are nursing services and are paid at the same continuous home care rate. This means that more than half of the hours of care are provided by an RN, LPN, or LVN. Homemaker or hospice aide services may be provided to supplement the nursing care.

NOTE: When fewer than 8 hours of care are required, the services are covered as routine home care rather than continuous home care.

Nursing care in the hospice setting can include skilled observation and monitoring when necessary, and skilled care needed to control pain and other symptoms.

The development of the CHC rate included the daily costs of nursing, hospice aide, social worker, and therapy visits; drugs; supplies and equipment; and the average daily cost of the hospice IDG. However, the statute limits the billable CHC hours of direct patient care to care provided by a nurse, a homemaker, or a hospice aide. Medicare regulations require that an hourly payment be made. While in the majority of

situations, one individual would provide continuous care during any given hour, there may be circumstances where the patient's needs require direct interventions by more than one covered discipline resulting in an overlapping of hours between the nurse and hospice aide. In these circumstances, the overlapping hours would be counted separately. The total hours paid cannot exceed 24 hours per day.

The hospice would need to ensure that these direct patient care services are clearly documented and are reasonable and necessary. Computation of hours of care should also reflect the total hours of direct care provided to an individual that support the care that is needed and required. This means that all nursing and aide hours should be included in the computation for CHC and when the aide hours exceed the nursing hours, CHC would be denied and routine payment will be made. The statutory definition of continuous home care is meant to include the full range of services needed to achieve palliation and management of acute medical situations. Deconstructing what is provided in order to meet payment rules is not allowed. In other words, hospices cannot discount any portion of the hours provided in order to qualify for a continuous home care day.

Documentation of care, modification of the plan of care, and supervision of aides or homemakers would not qualify as direct care nor would these activities qualify as necessitating the services of more than one care provider. In addition, while the services provided by other disciplines such as medical social workers, pastoral counselors, *MFT or MHCs are* an integral part of the care provided to a hospice patient, these services are not included in the statutory definition of continuous care and are not counted towards total hours of continuous care. However, the services of social workers, pastoral counselors, *MFT or MHCs* would be expected during these periods of crisis, if warranted as part of hospice care, and are included in the provisions of routine hospice care.

The following are used to illustrate circumstances that may qualify as CHC. This list is not all-inclusive nor does it indicate that if a patient presents with similar situations, that it would constitute CHC.

1. **Frequent medication adjustment to control symptoms/collapse of family support system**

   Situation A: The patient has had a central venous catheter inserted to provide access for continuous Fentanyl drip for pain control and for the administration of antiemetic medication to control continuous nausea and vomiting. The nurse spends 2 hours teaching the family members how to administer IV medications. She returns in the evening for 1 hour. The hospice aide provides 3 hours of care. The nurse spends 2 hours phoning physicians, ordering medications, documenting and revising the plan of care.

   Determination: Despite 8 hours of service, this does not constitute CHC since 2 of the 8 hours were not activities related to direct patient care.

   Situation B: The patient experiences new onset seizures. He continues to have episodes of vomiting. The nurse remains with the patient for 4 hours (10 AM – 2 PM) until the seizures cease. During that time she provides skilled care and family teaching. The patient's wife states she is unable to provide any more care for her husband. A hospice aide is assigned to the patient for monitoring for 24 hours, beginning at 2:00 PM, with a total of 8 hours of direct care in the first day. The nurse returns intermittently for a total of an additional 5 hours to administer medications, assess the patient and to relieve the aide for breaks. The social worker provides 3 hours of services to work with the patient's wife in identifying alternative methods to care for the patient.

   Determination: This qualifies as a continuous home care day. This constitutes a medical crisis, including collapse of family structure. The caregiver has been providing skilled care and the change in the patient's condition requires the nurse's interventions. Since there is no overlap in nursing care, 17 hours of care (i.e., 9 hours of nursing care and 8 hours of aide care) would be computed as CHC. The social worker hours would not be incorporated. If the caregiver had been providing custodial care and his medical crisis resolved within a short time frame, this situation would not have qualified as CHC.

2. **Symptom management/rapid deterioration/imminent death**

Situation A: 77-year-old patient with lung cancer whose caregiver is 80 years old. The caregiver has been caring for this patient for 4 months and is now exhausted and scared. The care provided consists of assisting with bathing, assisting the patient to ambulate, preparing meals, housekeeping and administering oral medications. Since the patient is dyspneic at rest, she requires assistance in all ADLs, which equates to 9 hours of assistance within a 24-hour period.

Determination: This would not qualify as CHC since there is little nursing care that requires a nurse. The patient would however be a candidate for an inpatient respite level of care.

Situation B: The patient's condition deteriorates. The patient now has circumoral cyanosis, respiratory rate of 44 and labored with intermittent episodes of apnea. The nurse performs a complete assessment and teaches the caregiver on methods to make the patient comfortable. The nurse returns twice within the 24 - hour period to assess the patient. She revises the plan of care after conferring with the patient's attending physician and with the hospice physician. The homemaker and hospice aide are sent to assist the caregiver. Within the 24-hour period, the direct care provided by the nurse equates to 3 hours, homemaker with 2 hours, and hospice aide of 6 hours.

Determination: Since only 3 of the 11 hours were skilled care requiring the services of a nurse, this would not constitute CHC. In this situation, the care required is not predominantly nursing but are comprised of services provided by a hospice aide. In addition, it would not be correct to discount any portion of the hospice aide's hours or to provide these services gratis in order to qualify for the CHC benefit.

Situation C: The next day, the patient's condition deteriorates further. She has increased periods of apnea and air hunger. In addition she is experiencing continuous vomiting and increasing pain. Her blood pressure is beginning to decrease and her respirations are increasing. The nurse remains at the patient's bedside for 4 hours while attempting to control her pain and symptoms. The hospice aide provides care during 1 hour of this period. The nurse leaves and the hospice aide remains at the bedside for 3 hours. The social worker comes and talks with the caregiver and remains for 1 hour. The nurse returns while the aide leaves. The nurse remains with the patient for 2 hours until she dies. The social worker returns and stays with the caregiver for 1 hour until the mortuary arrives.

Determination: The nurse provided 6 hours of direct skilled nursing care; the aide provided 4 hours of direct care resulting in a total of 10 hours of registered nurse and hospice aide care. Since at least 6 of the 10 hours were direct nursing care, and since nursing care was the predominant service provided during the 10 hours, the care meets the criteria for CHC. In addition, since the nurse and the aide provided direct care for the patient simultaneously, it would be appropriate to bill for each resulting in total of 10 billable hours. The patient received 12 hours of care. The 2 hours for the social worker are not counted towards the CHC hours.

Medicare's requirements for coverage of CHC are that at least 8 hours of predominantly nursing care are needed in order to manage an acute medical crisis as necessary to maintain the individual at home. When a hospice determines that a beneficiary meets the requirements for CHC, appropriate documentation must be available to support the requirement that the services provided were reasonable and necessary and were in compliance with an established plan of care in order to meet a particular crisis situation. This would include the appropriate documentation of the situation and the need for continuous care services consistent with the plan of care.

Continuous home care is only furnished during brief periods of crisis and covered only as necessary to maintain the terminally ill individual at home.