

The Least You Need to Know:

The Medicare Administrative Contractors (MACs) are denying hospice medical review audits due to the lack of specifics on the election statement form. CMS has continued to provide guidance and regulatory changes over the last decade on what MUST be in the Election Statement when the patient or representative elect hospice. Every year for the last several years, hospices and EMRs have been trying to keep up with CMS and the changes- while trying to discern what was a mandated change, and what was a CMS "best practice" to provide additional information to patients.

In More Detail...

In 2021, CMS updated Chapter 9 and released new guidance regarding an expansion of the election statement. It was not clear at the time the level of detail that was needed re: cost savings and the notification to the patient that it should be a rarity that a medication or service would not be covered by their hospice.

The MACs have begun denying medical record reviews due to the lack of these things being clear in the actual Hospice Election Statement. CMS, nor the MACs are prescriptive about what the form must look like, but they have made it clear through denials, that all components must be on the election itself (not in a patient handbook) in order to count as meeting the requirements for the election.

Actions of a Prudent Hospice™

ONE. Review your current election form to ensure all components are included on the form itself. Pay close attention to the information re: cost sharing and the fact that items/services that are NOT paid for by the hospice are rare.

TWO. Update the election form if necessary. If it was noted that the prior election statement form did not have all of the items within it- then all current patients should receive the additional (missing) information on their original election (or added on), by adding it, and having the patient sign/date when their received this additional information.

THREE. Educate the team regarding the changes and how this may impact workflow, costs, patient experience, etc.

Links to More Info

Model Example Election Statement

<https://www.cms.gov/files/document/model-example-hospice-election-statement.pdf>

NOTE! Please be sure you have the updated example form from this link, and below. The prior CMS Example Model forms are outdated.



Model Example of Hospice Election Statement

Patient Name: _____

Hospice Agency Name: _____

Hospice Election

I, _____ (Patient Name) choose to elect the Medicare hospice benefit and receive Hospice services from _____ (Name of Hospice Agency) to begin on _____ (Start of Care Date).

(Note: The start of care date, also known as the effective date of the election, may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.)

Right to choose an attending physician

- I understand that I have a right to choose my attending physician to oversee my care.
- My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

I do not wish to choose an attending physician

I acknowledge that my choice for an attending physician is:

(Please provide any information that will uniquely identify your attending physician choice.)

Physician Full name: _____

Hospice Philosophy and Coverage of Hospice Care

By electing hospice care under the Medicare hospice benefit, I acknowledge that:

- I was given an explanation and have a full understanding of the purpose of hospice care including that the nature of hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.
- I was provided information on which items, services, and drugs the hospice will cover and furnish upon my election to receive hospice care.
- I was provided with information about potential cost-sharing for certain hospice services, if applicable.
- I understand that by electing hospice care under the Medicare hospice benefit, I waive (give up) the right to Medicare payments for items, services, and drugs related to my terminal illness and related conditions. This means that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected.
- I understand that items, services, and drugs unrelated to my terminal illness and related conditions are exceptional and unusual and, in general, the hospice will be providing virtually all of my care while I am under a hospice election. The items, services, and drugs determined to be unrelated to my terminal illness and related conditions continue to be eligible for coverage by Medicare under separate benefits.

Model Example of Hospice Election Statement

Right to Request “Patient Notification of Hospice Non-Covered Items, Services, and Drugs”

- As a Medicare beneficiary who elects to receive hospice care, you have the right to request at any time, in writing, the “**Patient Notification of Hospice Non-Covered Items, Services, and Drugs**” addendum that lists conditions, items, services, and drugs that the hospice has determined to be unrelated to your terminal illness and related conditions, and that will not be covered by the hospice.
- The hospice must furnish this notification within 5 days, if you request this form on the start of care date, and within 72 hours (or 3 days) if you request this form during the course of hospice care.

Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO)

As a Medicare hospice beneficiary, you have the right to contact the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) to request Immediate Advocacy if you disagree with any of the hospice’s determinations. The BFCC-QIO that services your area is:

BFCC-QIO Name: _____

BFCC-QIO Phone Number: _____

Signature of Beneficiary: _____

Date Signed: _____

Beneficiary is unable to sign

Signature of Representative: _____

Date Signed: _____