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# Anti-Kickback; Fraud and Abuse – Utilization of Continuous Home Care Within Hospice

The requirements to provide continuous home care under the Medicare Hospice Benefit, the difficulty in staffing for continuous home care and the important role it plays in ensuring quality care are all important issues within hospice. Situations frequently arise in which a hospice patient experiences a medical crisis and requires an increased levels of care. Continuous care and general inpatient care are the levels of hospice care specifically designed to provide reimbursement in these situations. Often provision of continuous care can prevent moving the patient to a general inpatient facility.

The important requirement to provide continuous care has been complicated by its use in skilled nursing facilities, the calculation of the nursing care coverage requirement and the process of determining eligibility for this higher reimbursement level in general. The following are frequently asked questions regarding the provision of continuous care.

**1. Understanding that continuous care is available for medical crises, if the family caregiver is either unable or unwilling to continue providing care, is this not a reason to provide continuous home care?**

Section 40.2.1 of the Medicare Benefit Policy Manual (CMS Pub. 100-2) (the "Manual") addresses continuous home care at section 40.2.1. Specifically it states: "Continuous home care may be provided only during a period of crisis. A period of crisis is the period in which a patient requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. If the 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 have been provided by the caregiver." (emphasis supplied.)

Here we see that the type of care that the caregiver has been providing becomes a key issue. If the caregiver has not been providing skilled nursing care, then the caregiver's inability to provide care does not constitute a reason to change the patient's level of care to continuous home care. In its Program Memorandum entitled Continuous Home Care Under Medicare Hospice, Transmittal A-03- 016, February 28, 2003, CMS gave this example of a situation involving caregiver

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breakdown:

> **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.

In this situation, CMS opined that the care would not qualify since there is little nursing care that requires a nurse. CMS took the position that the patient would be a candidate for respite care.

**2. Is it permissible to offer continuous home care when the patient is residing in a skilled nursing facility (SNF) and receiving hospice care and room and board in the SNF?**

Hospices are required to provide continuous home care whenever the interdisciplinary team determines that it is necessary. In a nursing home setting, it may in fact be an important means to keep the patient in the SNF as opposed to moving that patient to a hospital for general inpatient care. However, if the hospice is contracting with the SNF for general inpatient care in addition to routine home care and possibly respite care, the issues become much more complex. How does the hospice determine in any given situation whether to provide general inpatient care or continuous home care? Also, if the skilled nursing facility is hiring the same nurses that the hospice hires for continuous home care, the lines can become blurred in terms of the roles of each entity. It is critical, given the OIG Compliance Guidance for both hospices and nursing facilities that contracting issues as well as clinical decision-making be carefully reviewed so as to blunt any inference of impermissible inducements to refer. It has been reported, for example, that some hospices routinely offer to provide continuous home care to patients and prospective patients, without assessing the need for such care or its appropriateness, in light of the individual patient's care plan.

**3. Since continuous home care requires the hospice to provide a minimum of 8 hours of nursing care during a 24-hour day, and since direct patient care must be "predominantly nursing care provided by either a registered nurse**

**or a licensed practical nurse," may the remaining hours be satisfied by hospice volunteers?**

While it is permissible for the hospice to provide remaining care through home health aides or volunteers, there are numerous quality of care and liability issues that should be addressed. In addition, it is clear that over half of the total care provided by the hospice must be provided by an RN or an LPN. In its Program Memorandum, cited above, CMS makes clear that "hospices cannot discount any portion of the hours provided in order to qualify for a continuous home care day." If hospices fail to report home health aide or volunteer hours in their claim submission, this could constitute a fraudulent claim.

## Summary

The above discussion is not meant to be an exhaustive review of the issues surrounding continuous care. It does not constitute legal advice or serve as a substitute for legal advice. Continuous care has always posed challenges to hospices in terms of appropriate staffing. As hospices strive to provide adequate continuous home care, they must also be vigilant in ensuring that their documentation supports this level of care. Continuous home care is not an automatic right and CMS makes clear in its Manual and Program Memorandum that the benefit is limited to circumstances that constitute periods of crisis. Hospices are encouraged to review the Manual and CMS Program Memoranda in their entirety, as well as to review the OIG Compliance Guidance for Hospices. Also, contracts with skilled nursing facilities, particularly those which include payment for various levels of care, should be carefully reviewed by the hospice's legal counsel.