Hospice Discharges: Linking Compliance and Ethics

Our hospice has a long-standing patient who is no longer eligible for the hospice benefit because he no longer meets the 6- month prognosis. However, under state law, we could take care of this patient because he has a 12-month prognosis. Also, we have a palliative care program in place that could provide services for him. We believe it would be difficult for this patient to be discharged without follow-up support. What is permissible under the regulations?

Just as there is no absolute bar to providing "prehospice" care, there is also no absolute prohibition to providing care after the person is discharged from the Medicare benefit. What is important to determine is:

1. Is the person truly ineligible for the Medicare Hospice Benefit?
2. What are the motivations for providing either palliative care or hospice licensed care after the person loses eligibility for the Medicare or Medicaid benefit?
3. How can the hospice protect itself from the inference that the care provided is an impermissible inducement, prohibited by the Anti-Kickback Statute?

Discharging a Medicare Hospice Patient

Before discharge, the hospice team should make a careful assessment regarding eligibility. Because of the recent increase in ADRs (additional documentation requests) and resulting claim denials, many hospices are fearful that a claim that is challenged by the fiscal intermediary will lead to significant exposure for the hospice. Nevertheless, hospice regulations as well as sound ethical practice, require, if the patient continues to be eligible despite the fact that the patient has been on the program for more than 6 months, that the hospice continue to care for the patient under the Medicare Hospice Benefit. Some hospices fearful of scrutiny or financial stress may discharge the patient who has been deemed ineligible after ADR without appealing that determination and even though they believe the patient is still hospice eligible. In those cases, some hospices are continuing to cover the core services but not the full range of hospice services. This stance poses several regulatory risks. First, if the hospice believes that the person is eligible for Medicare hospice, that person should not be discharged, even in the face of a fiscal intermediary denial. The importance of vigorously defending a patient's eligibility cannot be overstated. However, this will require

POSTED:

May 31, 2004

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resources of the hospice and documentation that clearly supports the ongoing eligibility of the patient. A hospice that is meeting the regulations and the hospice's own ethical imperatives, will be prepared to challenge improper fiscal intermediary determinations through the process of a Request for Reconsideration and, if the client is still denied after Reconsideration, a Part A Medicare appeal and hearing before an Administrative Law Judge.

Care After the Appropriate Discharge of Medicare Hospice Patient

First, is the care to be provided "hospice" as defined by state licensure? If it is not "hospice," then is it palliative care? In order to provide ongoing care to an individual discharged from the Medicare Hospice Benefit, not only must the individual be ineligible for the Medicare Hospice Benefit, but state law must allow for the provision of that care, whether it is hospice care as more broadly defined under state law or non-hospice "palliative" care. Either way, it is important to ascertain that state law permits this type of care, that the Conditions of Participation are adhered to vis-à-vis the provision of hospice care to those who do not qualify for the Medicare Hospice Benefit and that the hospice's liability carrier is informed that the hospice organization is providing this type of care, to ensure that there is protection in the case of a claim.

Billing Issues

Some hospices still make it a practice never to bill a patient or family. If the hospice intends to provide free care to an individual who has been discharged from the hospice, there is significant risk of violation of the Anti-Kickback Statute. While the Office of the Inspector General has made it clear that discounts for patients who cannot afford to pay their bills are permissible, OIG guidance is clear that the federal Anti-Kickback Statute prohibits providers from giving or receiving anything of value in exchange for referrals of business payable by Medicare or Medicaid. If the hospice routinely waives fees for services provided to those ineligible for the Medicare Hospice Benefit, there may be an inference that the waiver is designed to induce those patients to return to the Medicare Hospice Benefit when they again become eligible. In order to overcome such an inference, the hospice is advised to bill all patients, regardless of payor source. Most hospices do not wish to turn away patients for lack of ability to pay. In that event, a good faith determination of financial need and the establishment of a sliding scale fee schedule are advised. The determination of need and the sliding scale

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fees may be determined based on factors such as a patient's income, assets and expenses, the size of a patient's family, the scope and extent of the patient's medical bills and the local cost of living. The law does not address what factors should go into a sliding scale fee schedule, and hospices are encouraged to develop one that is fair and easy to administer.

What this means for hospices is that providing some free care or reduced fees for care should be encouraged as part of the hospice's mission to serve the entire community regardless of ability to pay. However, it is important to implement reasonable guidelines for determining financial need.

Conclusion

As with all complex issues, hospices are advised to consult with their legal counsel regarding structuring of programs designed to assist those who no longer qualify for the Medicare or Medicaid hospice benefits. This brief article does not constitute or serve as a substitute for legal advice. While it may be permissible in certain instances to provide hospice care or palliative care to an individual who no longer qualifies for the Medicare or Medicaid Hospice Benefit, the hospice should engage in a careful process for reviewing such circumstances. Is the individual truly ineligible for Medicare or Medicaid hospice? If so, is the care being provided consistent with state and federal law and have risk management and liability insurance issues been addressed? If free care is being provided, is it based on a good faith determination of financial need?

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