

**Continuous Care in Hospice:**

**The misunderstood service with great benefits for patients and providers**

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Perhaps the most misunderstood and least implemented service of the Medicare Hospice Benefit is Continuous Care. It's been called everything from "double dipping" by providers who don't understand how it works and believe competitors who use it are defrauding the government to a "godsend" by families who have been able to honor the wishes of a patient who didn't want any more trips to a hospital.

If your hospice has steered away from implementing Continuous Care, perhaps now is the time to reconsider. While staffing and scheduling can be challenging from both a quality of care and a financial management perspective, the potential increases in patient satisfaction, census development and bottom line improvement can be well worth the additional leadership and oversight required by the agency management team to get the service up and running.

In this edition of the newsletter and the next, we'll take a closer look at Continuous Care for those our readers who don't have much experience with it. As a starting point, this month we'll review the definitions and requirements of the Medicare benefit and introduce a couple of scenarios to highlight the payment rate and its implications.

**The Definition of Continuous Care**

Continuous Care is defined in the Federal Register, Section 418.204, Special Coverage Requirements. It is specifically for a period of crisis in which nursing care may be needed as much as 24 hours in a day to maintain a patient at home rather than sending him or her to a facility where the General Inpatient Level of Care can be provided. Care can be provided (and billed) as Continuous Care for as few as 8 hours a day. Nursing care provided by LPNs and/or RNs can be augmented by Hospice Aides and/or Homemakers as long as the total number of hours provided by these disciplines is equal to a greater than 8 hours AND at least 50% of the hours are provided by RNs or LPNs.

Keep in mind that the needs addressed by Continuous Care have to justify the amount of hours of skilled care provided. The focus of continuous care is the patient rather than the family, and the goal of the care is to achieve palliation or management of acute medical symptoms.

Chapter 11, Revision 1494, issued 4-29-08, of the Medicare Claims Processing Manual provides further direction on the billing requirements for Continuous Care:

- It is to be recorded and billed in 15 minute increments, or up to 32 units a day
- A Continuous Care “Day” begins and ends at midnight
- Continuous Care need not be “continuous” within the calendar day
- Only direct care can be counted—breaks, reporting off, staff supervision and staff education do not qualify as counted time
- Aide/homemaker care cannot be discounted or provided at no charge to meet the 50% minimum for number of nursing units of care
- Overlapping hours between nurses and aides/homemakers are counted separately
- Visits by social workers, counselors and other team members should occur as called for by the plan or care, but the hours cannot be counted as Continuous Care hours
- Physicians or ARNPs who are visiting for assessment and management purposes would be billed separately as on any other day and as allowed in other circumstances

What happens if you provide continuous care services but fail to provide at least 8 hours and at least 50% skilled nursing? The day is considered a Routine Home Care day and is paid at that level.

### **Payments for Continuous Care**

The current non-adjusted payment for Continuous Care (CHC) is \$816.94 for 24 hours of care. Of this, the wage component, which is subject to Indexing, is \$561.32; the non-weighted amount is \$255.32. The 24 hour rate breaks down to approximately \$34 for an hour of care; therefore, the minimum payment for a Continuous Care day would be \$272 (for 8 hours of care). In addition to staffing, all other needed therapies, medications, supplies, equipment and other covered services are to be provided as required by the plan of care.

Consider these two scenarios:

### **PATIENT A**

Patient A starts Continuous Care based on the primary RN’s assessment at 11am that the patient’s symptoms are wildly out of control and need continuous oversight to assess problems and then administer an appropriate care plan. By the time orders are obtained and staffing is scheduled and in place, Continuous Care is provided for a total 9 hours on day 1, 23 hours on day 2 and 12 hours on day 3, when the patient comes off Continuous Care and resumes Routine Home Care. Because all three days meet both the 8 minimum and 50% skilled rules, Medicare is billed for 44 hours of Continuous Care at \$34/hour or \$1496. Day 4 will be a Routine Home Care Day.

### **PATIENT B**

Patient B is transported to the Inpatient Unit at 3 pm based on the primary RN’s assessment at 11am that the patient’s symptoms are wildly of control. The symptoms subside substantially by noon on the third day and the patient is discharged based on a

physician's assessment that discharge home is appropriate. Medicare is billed for two inpatient days at \$622.66 per day and three physician's visits at \$125/visit or \$1620. Day 3 at the unit will be a Routine Home Care Day, because the patient was discharged home that day. If this patient had died while still in Inpatient Care on day 3, the payment would have increased to \$2220 because a patient's day of discharge is paid at the General Inpatient Level if the patient discharge reason is "Died."

From the payor's perspective, the reimbursement for these two scenarios is pretty similar; in fact, the scenario that Medicare seems to favor, Inpatient Level, actually turns out to be slightly less (excluding physician visits) for the patient who discharges alive on day 3 and quite a bit more for the patient who dies on day 3. But when you add in physician visits, which are, in our experience, more frequent per inpatient day than per continuous care day, the reimbursement for inpatient days is almost always higher than that for continuous care patients for patients whose length of stay on these levels of care is 3-4 days.

However, Medicare is concerned about the use—and frankly, the abuse—of both Continuous Care and General Inpatient Care for patients whose care needs do not meet the requirements for initiating or continuing either level of care. The point? Management of the patient, daily assessment and careful documentation of care provision and appropriateness are extremely important to avoid ADRs and the resulting recoupment of reimbursement.

ABOUT THE AUTHOR: Barbara Gray is a Senior Consultant of Beth Carpenter and Associates, a consulting firm which provides real-world expertise to improve the performance and results of home care, hospice and private duty client . Barbara has more than 20 years of experience in health care management and operations as a leader and innovative problem solver creating organizations capable of delivering on their promises of revenue growth, margin performance and outstanding service. Ms. Gray has succeeded in moving start-ups from vision to reality, jump starting organizations to move to the next level and stabilizing organizations to achieve optimal financial results. Barbara can be reached at [bgray@bethcarpenterandassociates.com](mailto:bgray@bethcarpenterandassociates.com).