

Hospice Beneficiary Election Statement Addendum Frequently Asked Questions (FAQ's)

Updated: FY 2022 Hospice Final Rule Effective 10.1.2021

Question	Answer
<p>1. Should an addendum request be made in writing?</p>	<p><i>The addendum request does not need to be in writing.</i></p> <p><i>CMS provides language regarding the addendum within the Beneficiary Election Statement example (p.2). In this document, a signature is captured attesting to the fact that patient or their representative understand that they have the right to request an addendum at any time.</i></p> <p>https://www.cms.gov/files/document/model-hospice-election-statement-modified-july-2020.pdf</p> <p><i>However, a signed addendum within the patient's medical record indicates that the patient requested the information. CMS has provided an example of the addendum on their website.</i></p> <p>https://www.cms.gov/files/document/model-hospice-election-statement-addendum-july-2021.pdf</p>
<p>2. What is the penalty for providing the addendum late? For example: election start date is 02.02.2021 and the beneficiary requested the addendum that day. The addendum was provided and signed on day six or 02.08.2021. The claim billed for all days of routine care. What days are denied payment?</p>	<p><i>The addendum is a condition for payment. If the requirements are not met, including the timeframe for furnishing the addendum, this is a violation of the condition for payment and would result in a claim denial. As per the Medicare Benefit Policy Manual, this denial is limited to only the claim subject to review and would not invalidate the entire election.</i></p> <p><i>If the addendum is requested within the first 5 days of a hospice election (that is, in the first 5 days of the hospice election date), the hospice must provide this information, in writing, to the individual (or representative), nonhospice provider, or Medicare contractor within 5 days from the date of the request. If the addendum is requested during the course of hospice care (that is, after the first 5 days of the hospice election date), the hospice must provide this information, in writing, within 3 days of the request to the requesting individual (or representative), nonhospice provider, or Medicare contractor. In the example, the addendum was requested on the day of the hospice election, 02.02.2021. The hospice would have to furnish the requested addendum on or before 02.07.2021 in order to satisfy this condition for payment. The addendum is not routinely submitted with the hospice claim.</i></p>

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If the claim has been selected for medical review, and it is clear based on received documentation that the beneficiary requested but did not receive the addendum within the time period specified at 42 CFR 418.24(c), the failure to provide such addendum should result in a claims denial. However, the Medicare Administrative Contractor may request the addendum to accompany any additional documentation request to mitigate such denial. A denial resulting from a violation of this specific condition for payment would be limited to only the claim subject to review (that is, it would not invalidate the entire hospice election).

3. Can a hospice agency provide an addendum to every beneficiary?

Hospice agencies may choose to provide an addendum to every electing patient. However, it is only mandatory when the patient or their representative requests it.

4. There is a carve out for providing a requested addendum if the patient dies within 3 or 5 days of the request for an addendum. What if the patient is a live discharge or revocation during that time frame?

While live discharge or revocation is not addressed in regulation or sub-regulatory guidance, Hospice agencies are expected to document that the addendum was discussed with the patient (or representative) similar to how other patient and family discussions are documented.

Hospice agencies should ensure clear documentation supporting the rationale that the beneficiary requested but did not receive the addendum within the time period specified related to the live discharge or revocation.

*Update: FY 2022 Hospice Final Rule Effective 10.1.2021
If the individual dies, revokes, or is discharged within the required timeframe (3 or 5 days after a request, depending on when such request was made) for furnishing the addendum, and before the hospice has furnished the addendum, the addendum would not be required to be furnished to the individual (or representative). The hospice must note the reason the addendum was not furnished to the patient and the addendum would become part of the patient's medical record if the hospice has completed it at the time of discharge, revocation, or death.*

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If the beneficiary requests the addendum and the hospice furnishes the addendum within 3 or 5 days (depending upon when the request for the addendum was made), but the beneficiary dies, revokes, or is discharged prior to signing the addendum, a signature from the individual (or representative) is no longer required.

The hospice must note (on the addendum itself) the reason the addendum was not signed and the addendum would become part of the patient's medical record.

5. If the patient requests the addendum at admission, do addendums need to be provided throughout the entire episode with every change in coverage?

If there are changes to the content on the addendum during the course of hospice care, the agency must update the addendum and provide the information, in writing, to the patient or their representative in order to communicate these changes to the patient (or representative).

6. Is it required to receive a signed addendum back from the patient representative? What if they reside in another state and it requires mailing via USPS?

A signed addendum is a federal requirement. If the representative resides in another state, thorough documentation regarding the situation in the patient's medical record noting a good faith effort including when and how the addendum was mailed, and copies of the addendum should be provided, as well as follow up conversations with the representative with regard to when the document was signed and how it was delivered to the agency may be acceptable.

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Obtaining the required signatures on the election statement has been a longstanding regulatory requirement. Therefore, hospices should already have processes and procedures in place to ensure that required signatures are obtained, either from the beneficiary, or from the representative. Likewise, since the addendum is part of the election statement, then it is required to be part

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of the patient's record (if requested by the beneficiary or representative).

The signed addendum is only acknowledgement of the beneficiary's (or representative's) receipt of the addendum (or its updates) and the payment requirement is considered met if there is a signed addendum (and any signed updates) in the requesting beneficiary's medical record with the hospice.

Some beneficiaries or representatives may have time constraints that prevent them from signing and returning the addendum by a certain deadline, in which case, the date that the hospice furnishes the addendum to the beneficiary may differ from the date that the beneficiary (or representative) signs the addendum. Hospices would need to make sure the "date furnished" on the addendum is within the required timeframe (3 or 5 days, depending upon when the request was made), rather than the signature date.

7. If the addendum is issued timely and the patient or their representative does not return it for many days, will the hospice agency be penalized?

Thorough documentation regarding the situation in the patient's medical record noting a good faith effort including when and how the addendum was delivered to the patient or their representative, and copies of the addendum should be provided, follow up conversations with the patient or their representative with regard to why the document was not signed timely, as well as when and how it was delivered to the agency may be acceptable. However, it is the responsibility of the hospice agency to obtain the signed addendum in a timely fashion as per federal regulations.

Update: FY 2022 Hospice Final Rule Effective 10.1.2021

Some beneficiaries or representatives may request an emailed addendum or request more time to review the addendum before signing, in which case the date that the hospice furnished the addendum to the beneficiary (or representative) may differ from the date that the beneficiary or representative signs the addendum. This means the hospice may furnish the addendum within the

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required timeframe; however, the signature date may be beyond the required timeframe.

The “date furnished” must be within the required timeframe (that is, 3 or 5 days of the beneficiary or representative request, depending on when such request was made), rather than the signature date. The hospice would include the “date furnished” in the patient’s medical record and on the addendum itself.

8. What is meant by the term “cost sharing”?

The amount of the total cost that the patient will pay for care, medication and/or services; including co-payments, coinsurance and/or deductibles.

The 5 percent coinsurance for IRC and the \$5 per drug copayment is what CMS meant by this. While we know there are some hospices who may not charge for this, the beneficiary should be made aware of what the regulations state in regards to their possible financial liability.

9. If the non-hospice provider requests an addendum, should we ask for a release of information from the patient?

CMS said the following in the FY 2020 Hospice final Rule (84 FR 38508):

Likewise, the hospice beneficiary (or representative) would not have to separately consent to the release of this information to non-hospice providers furnishing services for unrelated conditions as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other health care providers that are covered entities to use or disclose protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient’s express authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient (45 CFR 164.506).

Therefore, the patient does not have to authorize release of this information to provide the addendum to non-hospice providers.

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<p>10. How should the hospice agency document when the patient rescinds request for the addendum?</p>	<p><i>If the patient requests the addendum and then rescinds their request for the addendum or its updates, the agency must include that documentation within the patient's medical record. How the agency chooses to record such rescindment of the addendum or updates would be individual and specific to each hospice agency policies and procedures.</i></p>
<p>11. Should the hospice agency document that the addendum was NOT requested, or only when it is requested?</p>	<p><i>Regulations require that the election statement include the following: The Hospice must provide notification of the individual's (or representative's) right to receive an election statement addendum, as set forth in paragraph (c) of this section, if there are conditions, items, services, and drugs the hospice has determined to be unrelated to the individual's terminal illness and related conditions and would not be covered by the hospice.</i></p> <p><i>CMS stated in the FY 2020 final rule that they would expect hospices to document, in some fashion, that the addendum was discussed with the patient (or representative) at the time of admission, similar to how other patient and family discussions are documented. Likewise, hospices can develop a way to document whether or not the addendum was requested at the time of hospice election (or at any time throughout the course of hospice care).</i></p> <p><i>It is necessary for the hospice to document that the addendum was discussed and whether or not it was requested, in order to prevent potential claims denials related to any absence of an addendum (or addendum updates) in the medical record.</i></p> <p><i>However, CMS did not propose a specific format in which to document such conversations and hospices can develop their own processes to incorporate into their workflow.</i></p>
<p>12. If the addendum was requested, but the signed copy is</p>	<p><i>While the addendum is not submitted with hospice claims, it is a condition for payment if the beneficiary (or representative) has requested it. This condition for</i></p>

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<p>not attached to the patient's chart at the time of billing, can the hospice agency still bill for that benefit period?</p>	<p><i>payment is satisfied when there is a beneficiary (or representative) request present, which is documented by a valid signed addendum in the requesting beneficiary's medical record with the hospice. If a hospice claim has been selected for medical review, and it is clear based on received documentation that the beneficiary requested, but did not receive, the addendum within the time period specified at 42 CFR 418.24(c), the failure to provide such addendum should result in a claims denial. However, the Medicare contractor may request the addendum to accompany any additional documentation request to mitigate such denial. A denial resulting from a violation of this specific condition for payment would be limited to only the claim subject to review (that is, it would not invalidate the entire hospice election).</i></p>
<p>13. If a medication is related to the hospice primary diagnosis, but is not covered, does it go on the addendum?</p>	<p><i>No. The addendum is only to include those items, services, and drugs the hospice has determined to be <u>unrelated</u> to the terminal illness and related conditions. Related drugs that a hospice has determined not to be reasonable and necessary for the palliation and management of the terminal illness and related conditions DO NOT go on the addendum. The addendum only includes <u>unrelated</u> items, services, and drugs that the beneficiary may be able to obtain through other Medicare benefits.</i></p>
<p>14. When a patient refuses an addendum during the initial visit, and a few weeks later a new medication is prescribed by their attending physician that the agency believes is not covered, because the hospice agency has determined it to be unrelated to the terminal illness and related conditions,</p>	<p><i>Yes, this would be considered "Best Practice".</i></p>

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<p>should the agency document the conversation about the new medication and again offer the addendum?</p>	
<p>15. Is it required that the hospice addendum be documented within the IDG discussion?</p>	<p><i>If the patient or their representative requested an addendum and changes are made to the plan of care affecting costs during an IDG meeting, it would be considered “Best Practice” to discuss these changes to the plan of care and addendum simultaneously.</i></p>
<p>16. When an addendum is updated, does the patient or their representative have to request the document again or is it the responsibility of the agency to deliver it within a certain period?</p>	<p><i>The beneficiary (or representative) does not have to continually request an update given they requested the addendum in the first place. CMS does not specify an explicit timeframe to furnish the update. An updated addendum affords the beneficiary the opportunity to make treatment decisions to best align with their preferences and goals.</i></p>
<p>17. Does CMS have a list of examples of what should be listed as “non-covered”?</p>	<p><i>The hospice determines what items, services, and drugs they consider unrelated to the terminal illness and related conditions. As the hospice plan of care is individualized, so is the determination of those items, services and drugs the hospice has determined to be “unrelated” to the terminal illness and related conditions. There is no “standardized” list as the expectation is that virtually all of the care needed by the terminally ill individual should be provided by the hospice.</i></p>
<p>18. When a non-hospice provider or a MAC requests an addendum, but the patient or their representative did not request and sign</p>	<p><i>This is only a condition for payment if the beneficiary (or representative) request the information. If the request is made, then the requirements at 418.24(c) must be met. But while not a condition for payment if a non-hospice provider or MAC requests the addendum, CMS expects that the hospice will furnish such information.</i></p>

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an addendum, is this a violation of the condition for payment?

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If a non-hospice provider requests the addendum, rather than the beneficiary or representative, the non-hospice provider is not required to sign the addendum.

Hospices can develop processes (including how to document such requests from non-hospice providers and Medicare contractors) to address circumstances in which the non-hospice provider or Medicare contractor requests the addendum, and the beneficiary or representative does not.

19. What should the hospice agency do if a patient or their representative refuses to sign the addendum?

The hospice agency must make a good faith effort at documenting the attempts to obtain the signature, including the name of the individual requested to sign the document, as well as the dates and times of the attempts to obtain the information and the reasons for refusal.

It is important to note that the signature is only acknowledgement of receipt of the addendum and not the beneficiary's (or representative's) agreement with the hospice's determinations.

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If the beneficiary (or representative) refuses to sign the addendum, the hospice must document on the addendum the reason the addendum was not signed and the addendum would become part of the patient's medical record.

In such a case, although the beneficiary has refused to sign the addendum, the "date furnished" must still be within the required timeframe (that is, within 3 or 5 days of the beneficiary or representative request, depending on when such request was made), and noted in the chart and on the addendum itself.

20. When changes are made to the plan of care that do not

The addendum must be updated if there is any change to the items, services or drugs that are determined to be unrelated to the terminal illness and related conditions.

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<p>include any non-covered items, does an updated addendum need to be provided?</p>	<p><i>That is, if there are new items, services, or drugs that are determined to be unrelated, then these would be added to the addendum or if there were previous items, services or drugs that were unrelated but now determined to be related, than those would be removed. If the hospice care plan is updated but there is no change to the unrelated items, services, or drugs, the addendum does not need to be updated. The addendum is only updated if there are any changes to those items, services, or drugs determined by the hospice to be unrelated.</i></p>
<p>21. Will MACs be reviewing for signed addendum in the patient's medical record?</p>	<p><i>MACs will review for signed addendums within the requesting beneficiary's medical record.</i></p> <p><i>The signed addendum is only acknowledgement of the beneficiary's (or representative's) receipt of the addendum (or its updates) and the payment requirement is considered met if there is a signed addendum (and any signed updates) in the requesting beneficiary's medical record with the hospice. A signed addendum indicates the hospice discussed the addendum and its contents with the beneficiary (or representative).</i></p>
<p>22. If a patient requests an addendum but has no non-covered items, services, or drugs, is the agency still required to complete the addendum?</p>	<p><i>The purpose of the addendum is to provide a list of those items, services, and drugs the hospice has determined to be unrelated to the terminal illness and related conditions. If a beneficiary still requests an addendum, the addendum would not include any information but a hospice could document that, while it was requested, the hospice has determined that there is no item, service or drug that is unrelated at the time the request was made. However, if that changes over the course of hospice care, the hospice would have to update the addendum to reflect any items, services or drugs it determines to be unrelated.</i></p>
<p>23. If the hospice agency inadvertently fails to provide an updated addendum when there has been a change at some</p>	<p><i>It is the responsibility of the hospice agency to keep the patient updated regarding non-covered items if they have requested an addendum. Therefore, if updates were made to the addendum, it is mandatory that they be shared with the patient.</i></p>

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<p>point, is that also a breach of condition of payment?</p>	
<p>24. If an agency is unable to provide respite or inpatient services because of the pandemic, does that require an addendum?</p>	<p><i>The Hospice Election Statement Addendum is <u>only</u> required in the event that the hospice determines there are conditions, items, services, or drugs that are unrelated to the individual's terminal illness and related conditions <u>and if the beneficiary (or representative) requests the addendum</u></i></p> <p><i>The hospice must meet the Conditions of Participation at 418.108, "Short inpatient care".</i></p>
<p>25. Please explain why a MAC would request an addendum.</p>	<p><i>If the claim has been selected for medical review, and it is clear based on received documentation that the beneficiary requested but did not receive the addendum within the time period specified at 42 CFR 418.24(c), the failure to provide such addendum should result in a claims denial. However, the Medicare Administrative Contractor may request the addendum to accompany any additional documentation request to mitigate such denial.</i></p>
<p>26. What is the timeframe for providing addendum updates to the patient?</p>	<p><i>While CMS does not explicitly require a timeframe for furnishing these updates, we would expect it to be timely in order to allow the beneficiary to make necessary treatment decisions.</i></p>
<p>27. We are confusing the Advance Beneficiary Notice (ABN) with the Addendum. Can you clarify when ABNs should be delivered for hospice patients?</p>	<p><i>An ABN serves to transfer liability of costs to the beneficiary and is given regardless if a beneficiary requests it and is not "tied to" the election statement.</i></p> <p><i>For example, if there is an item or service that is usually paid for by Medicare Part A, but may not be paid for in your patient's case because it is not considered medically reasonable and necessary such as your patient insists on a brand name drug and there is not a medical reason why the generic cannot be used, or if your patient is not deemed terminally ill but opts to remain on service, or if the level of hospice care is determined to be not reasonable or medically necessary.</i></p>

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References:

- **Medicare Benefit Policy Manual (Pub. 100-02), chapter 9, “Coverage of Hospice Services Under Hospital Insurance”:** [Medicare Benefit Policy Manual \(CMS Pub. 100-02\), Ch. 9, §10, §20.2.1 and 40.1.3.1](#)
- **CMS Hospice Center:** <https://www.cms.gov/Center/Provider-Type/Hospice-Center>
- **MLN Matters: MM12015: Manual Updates Related to the Hospice Election Statement and the Implementation of the Election Statement Addendum**
- **Medicare Claims Processing Manual, chapter 30, “Financial Liability Protections”;** **Section 50:** <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c30.pdf>
- **Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements:** <https://www.govinfo.gov/content/pkg/FR-2021-08-04/pdf/2021-16311.pdf>