Hospice Billing Series: Part 2: Details of Medicare Claims Processing

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- Washington State Hospice and Palliative Care Organization
- Hospice Council of West Virginia

Directed by The Hospice & Home Care Webinar Network
Melinda Gaboury is co-founder and CEO of Healthcare Provider Solutions, Inc., of Nashville, Tennessee which specializes in financial, reimbursement, clinical, and cost-reporting services to the home care, hospice, and rehabilitation therapy industries. She has over 23 years’ experience in Medicare hospice and home health. A frequent presenter and an active Advisory Board and Workgroup Member of the Home Care and Hospice Financial Managers Association (HHFMA), Melinda is also the author of the “Home Care Pocket Guide to OASIS-C1: A Reference Guide for Field Staff.”
Clarification of the Effective Date of Election

- The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the effective date of the election statement. An individual may not designate an effective date that is retroactive. (The bold text is the update to this requirement outlined in CR 8727 issued on May 1, 2014 with an effective date of August 4, 2014).

- ($418.24 Election of hospice care; Subpart B) Patient elects hospice care by signing a notice of hospice care election form (NOE). The effective date may be later than the signing date. **This is the first allowable date of billing.**

- ($418.54- Initial and comprehensive assessment of the patient; Subpart C)
  - The hospice RN must complete an initial assessment within 48 hours of the effective date of the election of hospice care.
  - This is an assessment of the patient’s/ family’s immediate care needs.
  - The comprehensive nursing assessment may be completed during this first assessment visit as appropriate.
2018 FINAL Regulation

- CR 10064 updates the Medicare Claims Processing Manual, Chapter 11, Section 20.1 as of July 27, 2017. Changes are effective January 1, 2018. Hospices will use the claim format for submitting the NOE electronically. CMS considers the NOE a notification only even though it is identified via a claim type (81A, 82A). The changes to chapter 11 add explanation for what is required on the NOE and outlines exceptions to the 5-day timely filing requirements for the NOE.

- This CR included important changes to other sections of Chapter 11 including the following:
  - 20.1 - Procedures for Hospice Election and Related Transactions
  - 20.1.1 - Notice of Election (NOE)
  - 20.1.2 - Notice of Termination/Revocation (NOTR)
  - 20.1.3 - Change of Provider/Transfer Notice
  - 20.1.4 – Cancellation of an Election
  - 20.1.5 – Change of Ownership Notice
Hospices should note that in the final rule CMS indicated that it plans to work with the Medicare Administrative Contractors (MACs) to confirm whether they are requesting comprehensive clinical information from hospices during medical review and if not whether such information should be included in the Additional Development Requests (ADRs). CMS reminded providers that a hospice’s admission assessment can accompany the certification of terminal illness; however, CMS expects that the findings of the admission assessment would support the terminal prognosis not establish it. Based on this, hospices should ensure they are gathering the clinical information that medical directors are currently required to consider for the certification of terminal illness. This information includes:

1. Diagnosis of the terminal condition of the patient.
2. Other health conditions, whether related or unrelated to the terminal condition.
3. Current clinically relevant information supporting all diagnoses.
Sequential Claim Billing

• NOE must be in S/LOC P B9997 prior to submitting the first monthly claim

• Claims must be submitted sequentially. This means that the prior claim must be processed and in S/LOC P, D or R. A suspended (in S/LOC “S”) or RTP (Return to Provider) claim does not meet the sequential billing requirement.

• Claims must be consecutive with NO skip in days between the prior claim and the subsequent claim.

• The Medicare Claims Processing Manual (Pub. 100-04), Chapter 11, Section 90 states “Hospices must bill for their Medicare beneficiaries on a monthly basis.”
<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Revenue Code</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Home Care</td>
<td>0651</td>
<td>1 unit = 1 day</td>
</tr>
<tr>
<td>Continuous Home Care</td>
<td>0652</td>
<td>1 unit = 15 minutes</td>
</tr>
<tr>
<td>Inpatient Respite Care</td>
<td>0655</td>
<td>1 unit = 1 day</td>
</tr>
<tr>
<td>General Inpatient Care</td>
<td>0656</td>
<td>1 unit = 1 day</td>
</tr>
</tbody>
</table>
Routine Home Care (RHC)

- Hospice is paid the routine home care rate for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care
  – paid without regard to the volume or intensity
Effective for hospice services with dates of service on or after January 1, 2016, a hospice day billed at the RHC level of care will be paid one of two RHC rates based upon the following:

1. The day is billed as an RHC level of care day.
2. If the day occurs during the first 60 days of an episode, the RHC rate will be equal to the RHC ‘High’ Rate.
3. If the day occurs during days 61 and beyond, the RHC rate will be equal to the RHC ‘Low’ Rate.
4. For a hospice patient who is discharged and readmitted to hospice within 60 days of that discharge, his/her prior hospice days will continue to follow the patient and count toward his/her patient days for the receiving hospice in the determination of whether the receiving hospice may bill at the high or low RHC rate, upon hospice election.

5. For a hospice patient who has been discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the patient’s 60-day window, paid at the RHC ‘High’ Rate upon the new hospice election.
Continuous Home Care (CHC)

- CHC is provided during periods of crisis as needed to maintain the patient in their home.
- To qualify as CHC, a minimum of 8-hours of care must be provided in a 24-hour period, beginning and ending at midnight.
  - The care does not need to be continuous.
- Care can be provided by SN (RN or LPN) and Hospice Aides; however, at least half (50%) of the care must be provided by a SN.
Continuous Home Care (CHC)

- When billing CHC, units are billed to indicate the number of 15-minute increments provided in each 24-hour period of CHC.
  - Example: 8 hours of CHC = 32 units

- If these criteria are not met (e.g. only 7 hours of care was provided), routine home care must be billed.

- Hours for the Aide CANNOT be written off in order to make the hours 50/50
  - Example: 4.5 hours Hospice Aide – 4 hours SN: agency CANNOT write off the extra half hour for the Aide so that the hours are at least 50% SN and it can be billed as CHC
Inpatient Respite Care

- Respite care is provided in a hospital, skilled nursing facility, or other inpatient facility, to provide temporary relief to the patient’s family members or other caregivers.
- Respite care should be used on a short-term, occasional basis, when necessary to relieve the caregiver.
- Respite is payable for up to 5 consecutive days. Days beyond day 5 are billed at the RHC rate.
Inpatient Respite Care

• More than one respite stay in a billing period is allowed.
• The day of admission to respite is billed as a respite day. The day of discharge is billed as a routine home care day.
• If the patient dies while in respite, the day of death is billed as respite.
General Inpatient Care (GIP)

- GIP is provided in an inpatient setting to control the patient’s pain or manage the symptoms of their terminal illness that cannot feasibly be provided in another setting.
- The day of admission to GIP is billed as a GIP day. The day of discharge is billed as a RHC day. If the patient dies while in GIP, the day of death is billed as GIP.
Sequential Claim Billing

✓ **HIC – Required:** Enter the beneficiary's Health Insurance Claim Number (HICN).

✓ **TOB – Required:** Type of bill (system generated). FISS Page 01 defaults the type of bill (TOB) to 81A.
  • You may need to change this depending on the TOB you are entering.
    1st Digit  2nd Digit
    8 — Hospice  1 — Hospice (nonhospital based)
    2 — Hospice (hospital based)

3rd Digit
1—Admit through discharge; 2—Interim—first claim
3—Interim—continuing claim; 4—Interim—last claim

✓ **NPI – Required:** Enter your Hospice National Provider Identifier.

✓ **PAT.CNTL# - Optional:** Up to 20 digits are available for you to enter your internal account number for tracking purposes. This number will display on your Remittance Advice or your Electronic Remittance Advice.
Sequential Claim Billing

✓ **STMT DATES FROM** – **Required:** Enter the begin and end dates of the billing period.

✓ **LAST** – **Required:** Enter the beneficiary’s last name exactly as it appears on the Medicare card or the beneficiary’s eligibility file, including any spaces, apostrophes, hyphens or suffixes.

✓ **FIRST** – **Required:** Enter the beneficiary’s first name exactly as it appears on the Medicare card or the beneficiary’s eligibility file.

✓ **MI** – **Optional:** Enter the beneficiary’s middle initial.

✓ **DOB** – **Required:** Enter the beneficiary’s date of birth.

✓ **ADDR 1-6** – **Required:** Enter the beneficiary's full mailing address, including street name and number, post office box number or RFD, city and state.

✓ **ZIP** – **Required:** Enter the beneficiary’s 5- or 9- digit zip code.

✓ **SEX** – **Required:** Enter the beneficiary’s gender using the appropriate alpha character. M = Male F= Female
Sequential Claim Billing

✓ **MS – Optional:** Beneficiary's marital status.

✓ **ADMIT DATE – Required:** Enter the effective date of the hospice election or date of hospice transfer. (must match the Admit date on the NOE or Change)

✓ **HR – Required (DDE ONLY):** Hour of Admission — Enter the hour of admission (based on a 24-hour clock). If the hour of admission is unknown, enter '01'.

✓ **TYPE – Required:** Enter the Priority (Type) of Admission code. 1 — Emergency; 2 — Urgent; 3 — Elective; 4 — Newborn 5 — Trauma; 9 — Information not available

✓ **SRC – Required:** Enter a Point of Origin (Source of Admission) code

✓ 1 — Non-health care facility; 2 — Clinic or Physician's office; 4 — Transfer from hospital (different facility); 5 — Transfer from skilled nursing facility (SNF) or intermediate care facility (ICF); 6 — Transfer from another health care facility; 8 — Court/Law enforcement; 9 — Information not available

✓ **STAT – Required:** Enter the beneficiary’s Discharge Status Code as of the “TO” date on this claim.
# Discharge STAT Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Discharged to home or self-care. <strong>This code should not be used for patients who die while under hospice care.</strong></td>
</tr>
<tr>
<td>30</td>
<td>Still a hospice patient - hospice services continue to be provided.</td>
</tr>
</tbody>
</table>
| 40   | Expired at home.*  
Note: When patient status code '40' is reported, an occurrence code 55 and the date of death must also be reported. |
| 41   | Expired in a medical facility, such as a hospital, skilled nursing facility (SNF), intermediate care facility (ICF) or freestanding hospice.*  
Note: When patient status code '41' is reported, an occurrence code 55 and the date of death must also be reported. |
| 42   | Expired – place unknown.*  
Note: When patient status code '42' is reported, an occurrence code 55 and the date of death must also be reported. |
| 50   | Discharged/transferred to hospice – home. Use this code when a patient transfers to another hospice under routine or continuous care. |
| 51   | Discharged/transferred to hospice – medical facility. Use this code when a patient transfers to another hospice under respite or general inpatient care. |

*Ensure the "TO" date on the claim is the date of death.
Occurrence code 32 and date are required when the Advance Beneficiary Notice (ABN) was provided to the beneficiary, and the beneficiary requested the services provided be billed to Medicare. The date reflects the date the ABN was provided to the beneficiary.

### Occurrence Codes (FL 31-34)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Date of certification or recertification</td>
</tr>
<tr>
<td>42</td>
<td>Date of revocation (ONLY)</td>
</tr>
<tr>
<td>55</td>
<td>Date of death (when patient status = 40, 41 or 42)</td>
</tr>
</tbody>
</table>

*CMS Pub. 100-04, Chapter 11, Section 30.3*

### Occurrence Span Codes (FL 35-36)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77</td>
<td>Noncovered days due to untimely recertification (Not for FTF)</td>
</tr>
<tr>
<td>M2</td>
<td>Multiple respite stays, From/To dates of each stay</td>
</tr>
</tbody>
</table>

*CMS Pub. 100-04, Chapter 11, Section 30.3*
## Occurrence & Condition Codes

<table>
<thead>
<tr>
<th>Discharge Reason</th>
<th>Occurrence Code</th>
<th>Condition Code</th>
<th>Patient Status Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient revokes</td>
<td>42</td>
<td>None</td>
<td>Appropriate code</td>
</tr>
<tr>
<td>Patient transfers hospices</td>
<td>None</td>
<td>None</td>
<td>50 or 51</td>
</tr>
<tr>
<td>Patient no longer terminal</td>
<td>None</td>
<td>None</td>
<td>Appropriate code</td>
</tr>
<tr>
<td>Patient discharged for cause</td>
<td>None</td>
<td>H2</td>
<td>Appropriate code</td>
</tr>
<tr>
<td>Patient moves out of service area</td>
<td>None</td>
<td>52</td>
<td>Appropriate code</td>
</tr>
<tr>
<td>Death</td>
<td>55</td>
<td>None</td>
<td>40, 41, or 42</td>
</tr>
</tbody>
</table>

### Condition Code (FL 18-28)

<table>
<thead>
<tr>
<th>Condition Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2</td>
<td>Discharge for cause (i.e. patient/staff safety)</td>
</tr>
<tr>
<td>52</td>
<td>Discharge for patient unavailability, inability to receive care, or out of service area</td>
</tr>
<tr>
<td>85</td>
<td>Delayed recertification of hospice terminal illness (effective for claims received on or after 1/1/2017)</td>
</tr>
</tbody>
</table>

*CMS Pub. 100-04, Chapter 11, Section 30.3*
Sequential Claim Billing

✓ FAC.ZIP – *Required:* Facility ZIP code of the provider or the subpart (5- or 9-digit). The ZIP code entered must match the ZIP code in the Master Address field of the provider's address file at Medicare MAC.

✓ **Value Codes – Amounts – *Required:***

  ✓ Value code 61 and the core based statistical area (CBSA) code are required when billing routine (revenue code 0651) and/or continuous home care (revenue code 0652).

  ✓ Value code G8 and the CBSA code are required when billing respite (revenue code 0655) and/or general inpatient care (revenue code 0656).
### Revenue Codes – Visits

<table>
<thead>
<tr>
<th>Discipline Visit Description</th>
<th>REV</th>
<th>HCPCS, Modifiers (PM if post-mortem)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical therapy</td>
<td>0421</td>
<td>G0151, PM</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>0431</td>
<td>G0152, PM</td>
</tr>
<tr>
<td>Speech language pathology</td>
<td>0441</td>
<td>G0153, PM</td>
</tr>
<tr>
<td>Skilled nursing</td>
<td>0551</td>
<td>G0154, PM (not valid for visits on/after 1/1/2016)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G0299, PM (valid for RN visits on/after 1/1/2016)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G0300, PM (valid for LPN visits on/after 1/1/2016)</td>
</tr>
<tr>
<td>Medical social service (visit)</td>
<td>0561</td>
<td>G0155, PM</td>
</tr>
<tr>
<td>Medical social service (phone call)</td>
<td>0569</td>
<td>G0155, PM</td>
</tr>
<tr>
<td>Home health aide</td>
<td>0571</td>
<td>G0156, PM</td>
</tr>
</tbody>
</table>
## Location Codes

<table>
<thead>
<tr>
<th>Levels of Care Description</th>
<th>REV</th>
<th>HCPCS (Place of Service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine home care (Q5001-Q5010)</td>
<td>0651</td>
<td>Q5001 – Home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q5002 – Assisted living facility</td>
</tr>
<tr>
<td>Continuous home care (Q5001-Q5003, Q5009-Q5010)</td>
<td>0652</td>
<td>Q5003 – LTC or non-skilled NF (receiving unskilled care)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q5004 – Skilled nursing facility (receiving skilled care)</td>
</tr>
<tr>
<td>Respite care (Q5003-Q5009)</td>
<td>0655</td>
<td>Q5005 – Inpatient hospital</td>
</tr>
<tr>
<td>General inpatient care (Q5004-Q5009)</td>
<td>0656</td>
<td>Q5006 – Inpatient hospice facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q5007 – Long term care hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q5008 – Inpatient psychiatric facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q5009 – Place not otherwise specified</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q5010 – Hospice residential facility</td>
</tr>
</tbody>
</table>
## Location Codes

<table>
<thead>
<tr>
<th>Allowed Place of Service (HCPCS) Codes for Levels of Care (Revenue) Codes</th>
<th>Routine 651</th>
<th>CHC 652</th>
<th>Respite 655</th>
<th>GIP 656</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5001 – Home</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Q5002 – Assisted living facility</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>Q5003 – LTC or non-skilled NF (unskilled care)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Q5004 – Skilled nursing facility (skilled care)</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Q5005 – Inpatient hospital</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Q5006 – Inpatient hospice facility</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Q5007 – Long term care hospital</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Q5008 – Inpatient psychiatric facility</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Q5009 – Place not otherwise specified</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Q5010 – Hospice residential facility</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
</tbody>
</table>
Multiple Location Codes

If care is rendered at multiple locations, each location is to be identified on the claim with a corresponding HCPCS code.

- For example, routine home care may be provided for a portion of the billing period in the patient’s residence and another portion in an assisted living facility.

  • Report one revenue code 651 line with HCPCS code Q5001 and another revenue code 651 line with HCPCS code Q5002.
# Time Reporting Units

<table>
<thead>
<tr>
<th>Units</th>
<th>Minutes</th>
<th>(&lt;) means less than</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&lt; 23 minutes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>= 23 minutes to &lt; 38 minutes</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>= 38 minutes to &lt; 53 minutes</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>= 53 minutes to &lt; 68 minutes</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>= 68 minutes to &lt; 83 minutes</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>= 83 minutes to &lt; 98 minutes</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>= 98 minutes to &lt; 113 minutes</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>= 113 minutes to &lt; 128 minutes</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>= 128 minutes to &lt; 143 minutes</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>= 143 minutes to &lt; 158 minutes</td>
<td></td>
</tr>
</tbody>
</table>
## Claim Form Locators

<table>
<thead>
<tr>
<th>R = required</th>
<th>C = conditional</th>
<th>N = not required</th>
<th>O = optional</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FISS Pg</strong></td>
<td><strong>FISS Field Name</strong></td>
<td><strong>UB FL</strong></td>
<td><strong>Data Entered</strong></td>
</tr>
<tr>
<td>2</td>
<td>Tot Unit</td>
<td>46</td>
<td>Total units</td>
</tr>
<tr>
<td>2</td>
<td>Cov Unit</td>
<td>46</td>
<td>Covered units</td>
</tr>
<tr>
<td>2</td>
<td>Tot Charge</td>
<td>47</td>
<td>Total charges</td>
</tr>
<tr>
<td>2</td>
<td>Ncov Charge</td>
<td>48</td>
<td>Noncovered charges</td>
</tr>
<tr>
<td>2</td>
<td>Serv Date</td>
<td>45</td>
<td>Service date</td>
</tr>
<tr>
<td>3</td>
<td>CD</td>
<td>50</td>
<td>Payer code</td>
</tr>
<tr>
<td>3</td>
<td>Payer</td>
<td>50</td>
<td>Payer name</td>
</tr>
<tr>
<td>3</td>
<td>RI</td>
<td>52</td>
<td>Release of information</td>
</tr>
<tr>
<td>3</td>
<td>SERV FAC NPI</td>
<td>N/A</td>
<td>NPI of Facility</td>
</tr>
<tr>
<td>3</td>
<td>Medical Record Nbr</td>
<td>3b</td>
<td>Medical Record Number</td>
</tr>
<tr>
<td>3</td>
<td>Diag Codes</td>
<td>67</td>
<td>Diagnosis codes</td>
</tr>
<tr>
<td>3</td>
<td>Att Phys NPI</td>
<td>76</td>
<td>Attending physician's NPI</td>
</tr>
<tr>
<td>3</td>
<td>L</td>
<td>76</td>
<td>Attending physician's last name</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>76</td>
<td>Attending physician's first name</td>
</tr>
</tbody>
</table>

7 Required when patient in nursing facility, hospital, hospice inpatient facility.
CMS will amend the regulations at §418.24(b)(1) and require the election statement to include the patient’s choice of attending physician.

Information identifying the attending physician should be recorded on the election statement in enough detail so that it is clear which physician or NP was designated as the attending physician. Hospices have the flexibility to include this information on their election statement in whatever format works best for them, provided the content requirements in §418.24(b) are met.

Language on the election form should include an acknowledgement by the patient (or representative) that the designated attending physician was the patient’s (or representative’s) choice.
If a patient (or representative) wants to change his or her designated attending physician, he or she must follow a procedure similar to that which currently exists for changing the designated hospice. Specifically, the patient (or representative) must file a signed statement, with the hospice, that identifies the new attending physician in enough detail so that it is clear which physician or NP was designated as the new attending physician.

The statement needs to include the date the change is to be effective, the date that the statement is signed, and the patient’s (or representative’s) signature, along with an acknowledgement that this change in the attending physician is the patient’s (or representative’s) choice. The effective date of the change in attending physician cannot be earlier than the date the statement is signed.
CMS provides clarification that attending physician status need not change when a patient enters GIP. If attending physician is not available, hospice physician fills in.

Hospice should document in medical record situations where attending is no longer willing or available to follow patient. Hospice should inform patient or representative that new attending may be chosen.

CMS will issue educational materials to alert hospices and treating physicians about inappropriate use of attending physician modifier on claim and update beneficiary materials.
Physician Services

Professional services (hands-on, direct patient care) are separately reimbursed by Medicare. However, who bills the services is dependent upon the physician’s “status” with the hospice.

• Attending Physician not employed, contracted or compensated by hospice – the physician bills their services to the Part B Carrier or B MAC. Correct coding must be used for proper payment.

• Physician is employed, contracted or compensated by hospice – the hospice bills the services to their RHHI. The services can be submitted on the patient’s claim with their daily levels of care.

When billing physician services to the MAC, hospices should include the following in addition to the usual claim information:

- Revenue code ‘657’ to indicate the physician’s professional service
- Appropriate HCPCS code for the service
- Modifier ‘GV’ if the services were provided by a nurse practitioner
- Modifier ‘26’ to indicate the professional component of a technical service
- Units, charges and the date of the physician’s service
Nurse Practitioner Services

Services provided by nurse practitioners (NPs) generally follow the same guidelines that govern the separate reimbursement of physician’s services.

NP services are covered under the hospice benefit when:

- Serving as attending physician, and
- Providing professional hand-on care to patient
When billing nurse practitioner services to the intermediary or carrier, a GV modifier must be included to indicate they are NP services, rather than physician services. Services provided by physicians assistants are not covered under hospice benefit.
Hospice Claim Requirements

- General Inpatient Care (GIP) Visits
- Inpatient Facility Identification
- Post-Mortem Visits
- Injectable Drugs
- Non-Injectable Drugs
- Infusion Pumps
Claims must report line item visits provided to patients receiving GIP

- Only by hospice employed personnel
- Includes visits by all billable disciplines of service:
  - Nurses, aides, social workers, social worker phone calls, & physical, occupational & speech-language pathologists
  - Visit reporting the same as for routine & continuous home care

Includes visits provided to patients in billable GIP locations

- Q5004 skilled nursing facility (SNF)
- Q5005 inpatient hospital
- Q5007 long term care hospital
- Q5008 inpatient psychiatric facility

Visits must be reported in 15-minute increments
Inpatient hospice facility patients receiving GIP excluded from line-item reporting requirement

Q5006 = HCPCS location code

No changes to current visit reporting requirements

Visits remain reported by week
Inpatient Facility Identification

Claims must report inpatient facility NAME, ADDRESS & National Provider Identifier (NPI) number
  - Only when facility is different than provider submitting claim

Includes claims billed with inpatient locations:
  - Q5003 Nursing facility (NF), patient receiving unskilled care
  - Q5004 SNF, patient receiving skilled care
  - Q5005 inpatient hospital
  - Q5006 inpatient hospice facility, only if facility is not same as hospice submitting claim
  - Q5007 long term care hospital
  - Q5008 inpatient psychiatric facility
Post-Mortem Visits

- Claims must report post-mortem visits when occurring **on date** of death - after **time** of death
  - *Date of death is defined as the date of death that is reported on the death certificate*
  - Includes visits performed by hospice employed nurses, aides, social workers & therapists
  - *Regardless of level of care or site of service*
Post-Mortem Visits

- Requires visits to be reported in 15-minute increments
- Requires modifier code “PM”
- Requires split visit billing if death occurs during visit
  - *Hospices shall report hospice visits that occur before death on a separate line from those which occur after death.*
- Excludes visits occurring on dates after the date of death
Injectable Drugs

- Claims must report injectable prescription drugs
  - Requires line-item reporting on claim per fill
  - Requires revenue code 0636
  - Requires applicable HCPCS code
  - Requires applicable units
    - Should represent amount filled based on drug & HCPCS definition
  - Requires charge amount
- Excludes over-the-counter (OTC) drugs
Non-Injectable Drugs

- Claims must report non-injectable prescription drugs (excludes OTC drugs)
  - Requires line-item reporting on claim per fill
  - Requires revenue code 0250
  - Requires National Drug Code (NDC) qualifier
  - HCPCS code not required
  - Requires applicable units
    - Should represent amount filled based on drug definition
  - Requires charge amount
Infusion Pumps

- Claims must report infusion pumps
  - Requires line-item reporting on claim per each pump order
  - Requires revenue codes 029X
    - 0290 for general equipment classification
    - 0291 for rental
    - 0292 for purchase of new equipment
    - 0293 for purchase of used equipment
    - 0299 for other equipment
  - Requires applicable HCPCS code
  - Requires applicable units
  - Requires charge amount
Infusion Pump Meds

- Claims must also report related medication necessary for effective use of pump
  - Requires line-item reporting per medication fill
  - Requires revenue code 0294
  - Requires applicable HCPCS code
  - Requires applicable units
    - Should represent amount filled based on drug definition
  - Requires charge amount
- Excludes OTC drugs & nutrition
We reminded providers to report all diagnoses on the hospice claim for the terminal illness and related conditions, including those that affect the care and clinical management for the beneficiary. Additionally, in the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47201), we provided further clarification regarding diagnosis reporting on hospice claims. We clarified that hospices will report all diagnoses identified in the initial and comprehensive assessments on hospice claims, whether related or unrelated to the terminal prognosis of the individual, effective October 1, 2015. Analysis of FY 2015 hospice claims show that only 37 percent of hospice claims include a single, principal diagnosis, with 63 percent submitting at least two diagnoses and 46 percent including at least three.
Effective for hospice services with dates of service on or after January 1, 2016, a hospice day billed at the RHC level of care will be paid one of two RHC rates based upon the following:

1. The day is billed as an RHC level of care day.
2. If the day occurs during the first 60 days of an episode, the RHC rate will be equal to the RHC ‘High’ Rate.
3. If the day occurs during days 61 and beyond, the RHC rate will be equal to the RHC ‘Low’ Rate.
4. For a hospice patient who is discharged and readmitted to hospice within 60 days of that discharge, his/her prior hospice days will continue to follow the patient and count toward his/her patient days for the receiving hospice in the determination of whether the receiving hospice may bill at the high or low RHC rate, upon hospice election.
5. For a hospice patient who has been discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the patient’s 60-day window, paid at the RHC ‘High’ Rate upon the new hospice election.
2016 Hospice Payment Reform

Routine Home Care (RHC) Per Diem Rates

Example:

- Patient elected hospice for the first time on 01/10/16.
- The patient revoked hospice on 01/30/16.
- The patient re-elected hospice on 02/16/16.
- The patient discharged deceased from hospice care on 03/28/16.

✓ Since the break in hospice care from 01/30 to 02/16 was less than 60 days the patient day count continues on the second admission.

✓ RHC provided during first election from 01/10/16 to 01/30/16 accounts for 21 days that the high RHC rate would apply. The 60 day count continues with second admission on 2/16/16 and the high RHC rate would apply for an additional 39 days. Day 61 begins the low RHC rate on 3/27/16.

✓ Multiple RHC days are reported on a single line item on the claim. The line item date of service represents the first date at the level of care and the units represent the number of days. As a result, both high and low RHC rates may apply to a single line item.
05/30/17 – Medicare has corrected most of the system errors associated with 2016 hospice service intensity add-on and RHC payments; however, two issues still remain, which require Hospices to submit adjustments. Refer to the MLN Matters Special Edition article SE17014 for additional information.

Routine Home Care FIX

**Required Action:** Hospices should now submit adjustments to claims with outstanding SIA and RHC payment errors, except for those where the prior benefit days are greater than 99.

Hospices can identify adjustments to be made by reviewing the CWF hospice benefit file to see if the benefit days used on prior election periods total more than 99 with no 60-day gap in between periods. Hospices may adjust claims with greater than 99 prior days after August 21, 2017.
2016 Hospice Payment Reform

Service Intensity Add-On Payment (SIA)

Effective for hospice services with " dates of service on and after January 1, 2016, a hospice claim will be eligible for an end of life (EOL) Service Intensity Add-On (SIA) payment if the following criteria are met:

1. The day is an RHC level of care day.

2. The day occurs during the last seven days of life (and the beneficiary is discharged dead).

3. Service is provided by a Registered Nurse (RN) or social worker that day for at least 15 minutes and up to 4 hours total.

4. The service is not provided by a social worker via telephone.
The SIA Payment amount shall equal:

- The number of hours (in 15 minute increments) of service provided by an RN or social worker during the last 7 days of life for a minimum of 15 minutes and up to 4 hours total per day;
- Multiplied by the current hospice Continuous Home Care (CHC) hourly rate per 15 minutes x visit units (not greater than 16).
- Adjusted for wage index.
## 2016 Hospice Payment Reform

### Service Intensity Add-On Payment (SIA)

*Example:*

Billing Period: 12/01/XX – 12/09/XX  
Patient Status: 40 RHC in home, discharged deceased.

<table>
<thead>
<tr>
<th>Line Item</th>
<th>Revenue Code</th>
<th>HCPCS</th>
<th>Date of Service</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>0651</td>
<td>Q5001</td>
<td>12/01/XX</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>0551</td>
<td>G0299</td>
<td>12/01/XX</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>0571</td>
<td>G0156</td>
<td>12/02/XX</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>0561</td>
<td>G0155</td>
<td>12/05/XX</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>0571</td>
<td>G0156</td>
<td>12/05/XX</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>0551</td>
<td>G0299</td>
<td>12/06/XX</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>0571</td>
<td>G0156</td>
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<td>4</td>
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<td>G0299</td>
<td>12/09/XX</td>
<td>4</td>
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<td>0561</td>
<td>G0155</td>
<td>12/09/XX</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>0571</td>
<td>G0156</td>
<td>12/09/XX</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
Day 1 of 7, 12/03/XX, no qualifying units reported for the EOL SIA.

Day 2 of 7, 12/04/XX, no qualifying units reported for the EOL SIA.

Day 3 of 7, 12/05/XX, qualifying units are 4. Day 3 of the EOL SIA payment is stored on the first applicable visit line for that date: 0561 G0155 12/05/XX UNITS 4

Day 4 of 7, 12/06/XX, qualifying units are 3. Day 4 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551 G0299 12/06/XX UNITS 3

Day 5 of 7, 12/07/XX, no qualifying units reported for the EOL SIA.

Day 6 of 7, 12/08/XX, no qualifying units reported for the EOL SIA.

Day 7 of 7, 12/09/XX, qualifying units are 10. Day 7 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551 G0299 12/09/XX UNITS 4.
## 2017 Hospice Payment Rates

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY2016 Payment Rates</th>
<th>SBNF</th>
<th>Proposed Wage Index Standardization Factor (SBNF)</th>
<th>FY2017 Proposed Hospice Pymt Update Percentage</th>
<th>FY2017 Payment Rates – Final and (proposed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care (days 1-60)</td>
<td>$186.84</td>
<td>X 1.0000</td>
<td>X 0.9989</td>
<td>X 1.021</td>
<td>$190.55</td>
</tr>
<tr>
<td>651</td>
<td>Routine Home Care (days 61+)</td>
<td>$146.83</td>
<td>X 0.9999</td>
<td>X 0.9995</td>
<td>X 1.021</td>
<td>$149.82</td>
</tr>
<tr>
<td>652</td>
<td>Continuous Home Care Full rate = 24 hours of care</td>
<td>$944.79</td>
<td>N/A</td>
<td>X 1.0000</td>
<td>X 1.021</td>
<td>$964.63</td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$167.45</td>
<td>N/A</td>
<td>X 1.0000</td>
<td>X 1.021</td>
<td>$170.97</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$720.11</td>
<td>N/A</td>
<td>X 0.9996</td>
<td>X 1.021</td>
<td>$734.94</td>
</tr>
</tbody>
</table>
# 2018 Hospice Payment Rates

## Table 12: FY 2018 Hospice RHC Payment Rates

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2017 Payment Rates</th>
<th>SIA Budget Neutrality Factor</th>
<th>Wage Index Standardization Factor</th>
<th>FY 2018 Hospice Payment Update</th>
<th>FY 2018 Payment Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care (days 1-60)</td>
<td>$190.55</td>
<td>X 1.0017</td>
<td>X 1.0000</td>
<td>X 1.01</td>
<td>$192.78</td>
</tr>
<tr>
<td>651</td>
<td>Routine Home Care (days 61+)</td>
<td>$149.82</td>
<td>X 1.0005</td>
<td>X 1.0001</td>
<td>X 1.01</td>
<td>$151.41</td>
</tr>
</tbody>
</table>

## Table 13: FY 2018 Hospice CHC, IRC, and GIP Payment Rates

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY 2017 Payment Rates</th>
<th>Wage Index Standardization Factor</th>
<th>FY 2018 Hospice Payment Update</th>
<th>FY 2018 Payment Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>652</td>
<td>Continuous Home Care</td>
<td>$964.63</td>
<td>X 1.0022</td>
<td>X 1.01</td>
<td>$976.42</td>
</tr>
<tr>
<td></td>
<td>Full Rate = 24 hours of care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$40.68 = FY 2018 hourly rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$170.97</td>
<td>X 1.0006</td>
<td>X 1.01</td>
<td>$172.78</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$734.94</td>
<td>X 1.0017</td>
<td>X 1.01</td>
<td>$743.55</td>
</tr>
</tbody>
</table>
Thank You For Listening!

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