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Hospice Billing Scenarios

Medicare Billing Basics

CMS

Today's Presenter

- Emily Fox-Squairs
  - Provider Outreach and Education
  - Syracuse, NY

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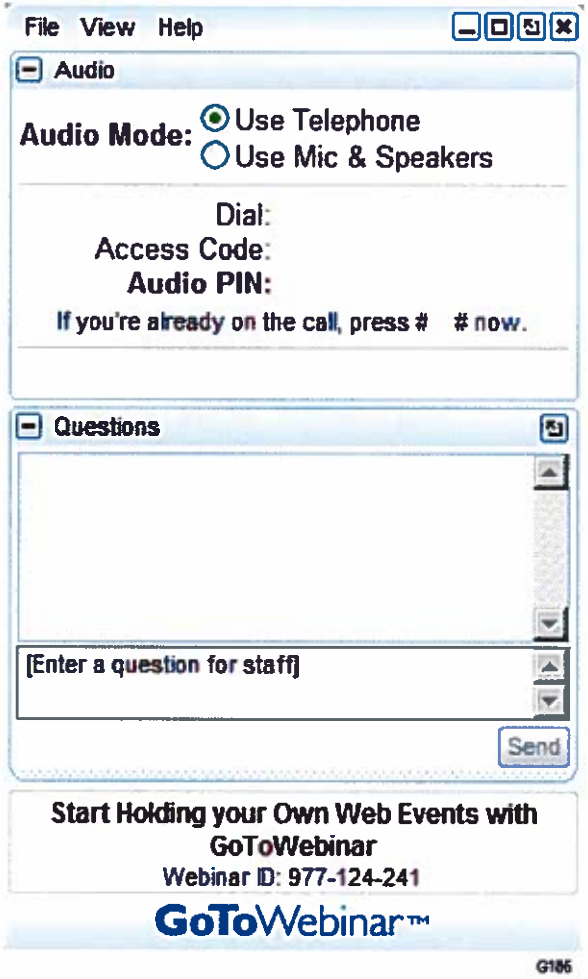

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Acronyms

- Please access the Acronyms page on the NGSMedicare.com website to view any acronym used within this presentation.

Objectives

- To have an understanding of the hospice billing process for hospice providers in the Medicare Program

Agenda

- Hospice billing process
  - NOE
  - Claim submission
- Reporting requirements
- Resources
- Questions?

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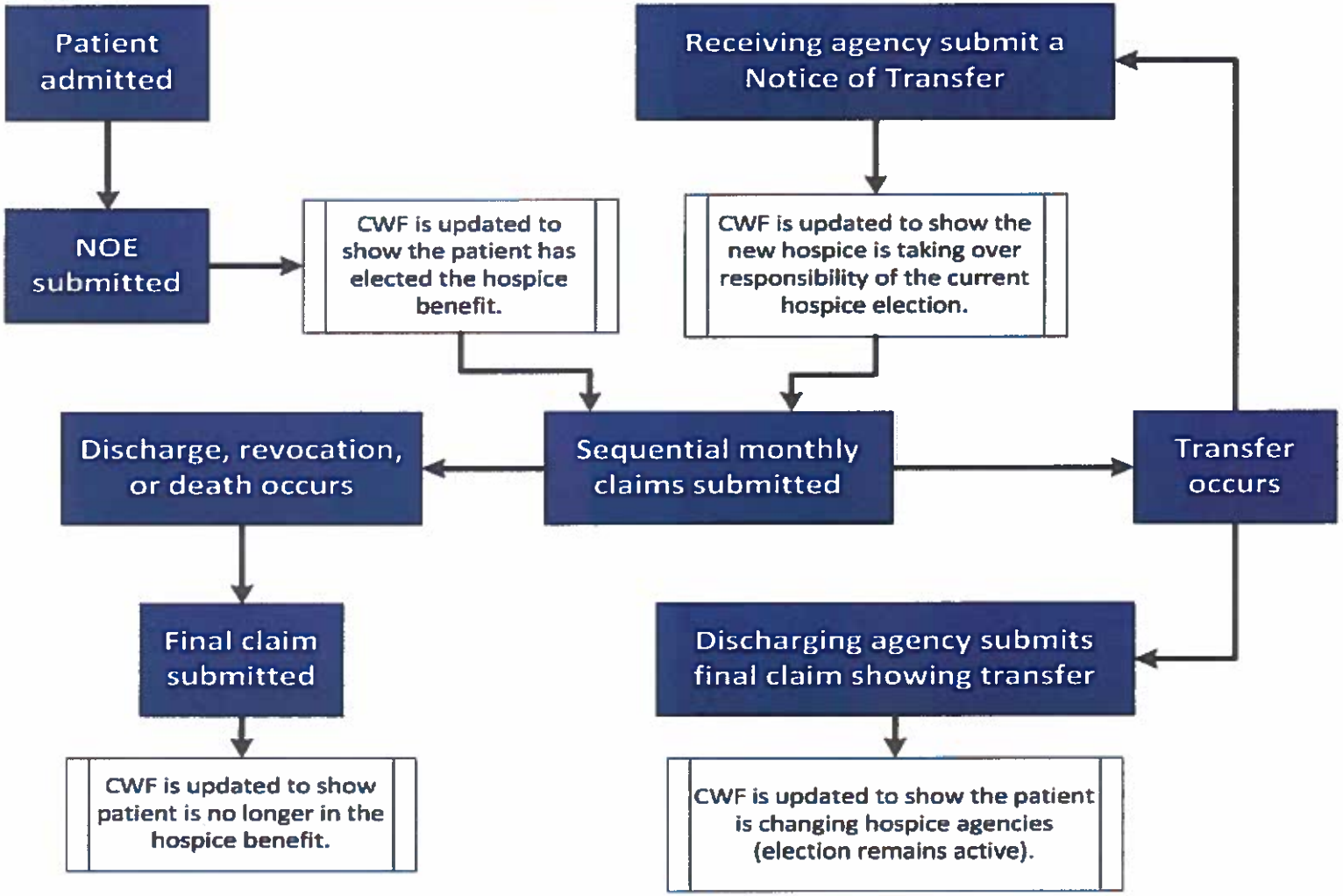
Notices and Claims

CMS

Hospice Billing Flow



Notices and Claims

- The Medicare hospice benefit requires that providers submit two types of billing transactions
  - NOE, and
  - Claim(s)
- Additional billing transactions also used to report revocations/discharges, transfers, corrections to the CWF, and change of ownership

The Notice of Election

- Notifies contractor and CWF of the start date of the beneficiary's election to the hospice benefit
- Must be submitted and processed prior to submitting first hospice claim
  - Status/location P B9997
- Uses only a few of the many form locators on the UB-04
- Payment is not applied

Notice of Election Billing

- TOB: 81A/82A
  - 81X: Free-standing hospice
  - 82X: Hospital-owned hospice

Step-by-step guidance is provided in the Hospice Notice of Election Job Aid

Notice of Election Billing

- Date of the hospice election should be entered in the 'Admit' and 'From' date fields
  - OC 27 date should also match
- Do not report a 'through' date
- The principal diagnosis code is required
  - Defined as the condition established after study to be chiefly responsible for the patient's admission
- Always submit showing Medicare as the primary payer
  - MSP information will be submitted on the claim(s)

Hospice Claims

- Claims must be submitted and processed in date order
  - After the first claim processes, the subsequent claim can then be submitted
    - Claims will RTP if submitted out of order
- Claims must also be submitted monthly and should not span a two-month period
- The first claim can be submitted, only after the NOE has processed

Sequential Claim Billing

- TOB: 81X/82X
  - Third digit (X):
    - 1-Admit through discharge
    - 2-Interim–first claim
    - 3-Interim–continuing claim
    - 4-Interim–last claim

Step-by-step guidance is provided in the Hospice Claim Submission Job Aid

Sequential Claim Billing

- 'Admit' date should match the 'Admit' date on the NOE
- OC 27 is reported on claims that cross a new benefit period
- If appropriate, MSP information should be included on claim
  - MSP claims cannot be submitted in FISS/DDE

Sequential Claim Billing Example

- Patient admitted to hospice for the first time on 05/18/2014 and revokes the benefit on 08/03/2014
  - In their home at time of revocation

TOB	From Date	Through Date	OC/Date	DSC
8X2	051814	053114	27/051814	30
8X3	060114	063014	--	30
8X3	070114	073114	--	30
8X4	080114	080314	42/080314	01

Hospice Discharge Reporting

Situation	Do I report OC 42?	Do I report a Condition Code?	If so, what condition code do I report?
Beneficiary moves out of service area without a transfer	No	Yes	52
Beneficiary moves out of service area with a transfer	No	No	--
Beneficiary is no longer terminally ill	No	No	--
Beneficiary revocation	Yes	No	--
Discharge for cause	No	Yes	H2
Late face-to-face encounter	No	No	--

Did You Know?

- Remarks are used on final claims to verify that the hospice is following the discharge guidelines set forth by CMS. When these remarks are absent or unclear, the final claim will be RTP with reason code 7C625.

Step-by-step guidance is provided in the Avoiding Reason Code 7C625 Job Aid

Transfers

- Patient may change hospices once in each benefit period
- Patient must file a transfer statement with original hospice and newly designated hospice
  - Must include the name of the hospice from which the patient received care, the name of the hospice from which they plan to receive care, and the date the change is to be effective
- Transfer effective date can occur on same date as the discharge from previous agency or the next day

Hospice Transfers

- TOB: 81C/82C
  - Submitted by the hospice agency the beneficiary is transferring to prior to submitting their first claim
    - Notifies contractor and CWF that the admission is a continuation of the current hospice election period
  - The notice of change can only be submitted after the agency the beneficiary is transferring from has submitted their final claim

Step-by-step guidance is provided in the Hospice Transfers job aid

Transfer/Claim Overlap Disputes

- Always try to work it out with the other provider first
  - Document contact attempts
- If all attempts to work it out with the other provider fail
  - You may call the Provider Contact Center

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Reporting Requirements

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Hospice Reporting Requirements

- Reporting requirements for hospice include:
  - Levels of care
  - Locations
  - Disciplines (visits)
  - Prescription injectable and non-injectable drugs
  - Infusion pumps
  - LIDOS
  - Units
  - Charges
  - Other coding: patient status codes, CC, OC, OSC, VC

Did You Know?

- Detailed information on coding as it relates to the Medicare hospice benefit can be found in the hospice job aids available on our website!

Levels of Care

Description	Revenue Code	Unit = Time
Routine Home Care	0651	1 unit = 1 day
Continuous Home Care	0652	1 unit = 15 minutes
Inpatient Respite Care	0655	1 unit = 1 day
General Inpatient Care	0656	1 unit = 1 day

Level of Care Service Dates

- Revenue codes 0651, 0655, and 0656
  - Report a separately dated line item for the level of care, each time the level of care/location changes
- Revenue code 0652
  - Report a separately dated line item for each day that continuous home care is provided, reporting the number of hours, or parts of hours rounded to 15-minute increments, of continuous home care that was provided on that date

Inpatient LOC Discharge Date

- Day of discharge from inpatient LOC is billed/paid at the RHC LOC unless:
  - Patient expires
  - Patient goes to another LOC

Location HCPCS Codes

HCPCS	Definition
Q5001	Hospice care provided in patient's home/residence
Q5002	Hospice care provided in assisted living facility
Q5003	Hospice care provided in nursing LTC facility or non-skilled NF
Q5004	Hospice care provided in SNF
Q5005	Hospice care provided in inpatient hospital
Q5006	Hospice care provided in inpatient hospice facility
Q5007	Hospice care provided in LTCH
Q5008	Hospice care provided in inpatient psychiatric facility
Q5009	Hospice care provided in place NOS
Q5010	Hospice home care provided in a hospice facility

Location HCPCS 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

Discipline Revenue and HCPCS Codes

Discipline Revenue and HCPCS Coding		
Discipline	**Revenue Code**	**HCPCS Code**
Physical Therapy	042X	G0151
Occupational Therapy	043X	G0152
Speech Language Therapy	044X	G0153
Skilled Nursing Services	055X	G0154
Medical Social Services	056X	G0155
Medical Social Services -Telephone Calls	0569	G0155
Hospice Aide Services	057X	G0156

RHC, CHC, and Respite Discipline Reporting

- Required detail for visits/calls:
  - Service date
    - Date of visit or telephone call (social worker)
  - Service units
    - Time per visit or length of call (in 15-minute increments)
  - Charge amount

CR 8358

- Issued to implement additional data reporting requirements for hospice claims
  - Mandatory reporting effective for DOS on or after April 1, 2014

Reporting GIP Visits in SNFs and Hospitals

- For GIP provided in SNFs (Q5004) or hospitals (Q5005, Q5007, Q5008), hospices must report:
  - Each visit performed by nurses, aides, social workers, physical therapists, occupational therapists, and speech-language therapists who are employed by the hospice
    - Includes certain calls by hospice social workers (as described in CR 6440)
  - Associated HCPCS G-code

GIP Visits in SNFs and Hospitals Discipline Reporting

- Required detail for visits/calls:
  - Service date
    - Date of visit or telephone call (social worker)
  - Service units
    - Time per visit or length of call (in 15-minute increments)
  - Charge amount

Reporting GIP Visits in Hospice Inpatient Units

- CMS is not changing the existing GIP visit reporting requirements when the site of service is a hospice inpatient unit (Q5006)
  - Report total number of visits per week performed by nurses, aides, and social workers, who are employed by the hospice
    - For each week, beginning on Sunday and ending on Saturday, indicate the number of services/visits provided by nurses (registered, licensed and/or nurse practitioner), aides, and social workers

Discipline Revenue Coding for GIP Visits in Hospice Inpatient Units

Discipline	Revenue Code
Skilled Nursing Services	055X
Medical Social Services	056X
Aide Services	057X

Reporting GIP Visits in Hospice Inpatient Units

- Required detail for visits:
  - Service date
    - Earliest visit date per week
  - Service units
    - The number of visits per week
  - Charge amount

Reporting GIP Visits Based on Location

HCPCS	Definition	CR	Visit Reporting Description
Q5004	Hospice care provided in SNF	8358	Report each visit with associated HCPCS G-code
Q5005	Hospice care provided in inpatient hospital	8358	Report each visit with associated HCPCS G-code
Q5006	Hospice care provided in inpatient hospice facility	5567	Report total number of visits per week (no HCPCS G-code)
Q5007	Hospice care provided in long term care hospital (LTCH)	8358	Report each visit with associated HCPCS G-code
Q5008	Hospice care provided in inpatient psychiatric facility	8358	Report each visit with associated HCPCS G-code

Did You Know?

- Detailed instructions on reporting visits can be found in the *Hospice Visit Reporting* job aid available on our website.

Physician Services

- Services furnished to patients by physician or nurse practitioner employees, or physicians or nurse practitioners receiving compensation from the hospice
  - Report the date that the service being billed was delivered

Revenue Code	Description
0657	Physician Services

  - Report the HCPCS code for the service provided with this revenue code

Nurse Practitioner Acting as the Attending Physician

- Report modifier -GV with the HCPCS code when billing physician services performed by an NP who is acting as the attending physician
- Services provided by an NP that are medical in nature must be
  - Reasonable and necessary
  - Be included in the POC and
  - Be services that, in the absence of an NP, would be performed by a physician

Did You Know?

- Valid values that are most commonly used in hospice billing are provided on the following slides; however, this is not all-inclusive
- NUBC maintains the UB-04 data element specifications and revenue code tables
- They may be contacted for subscription to the UB-04 at http://www.nubc.org/

Discharge Status Codes

DSC	Description
01	Discharged to home or self care
30	Still patient
40	Expired at home
41	Expired in a medical facility, such as a hospital, SNF, ICF, or freestanding hospice
42	Expired - place unknown
50	Discharged/Transferred to Hospice - home
51	Discharged/Transferred to Hospice - medical facility

Condition Codes

CC	Title	Description
52	Out of Hospice Service Area	Code indicates the patient is discharged for moving out of the hospice service area. This can include patients who relocate or who go on vacation outside of the hospice's service area, or patients who are admitted to a hospital or SNF that does not have contractual arrangements with the hospice.
H2	Discharge by a Hospice Provider for Cause	Used by the provider to indicate the patient meets the hospice's documented policy addressing the discharges for cause. Results only in the discharge from the provider's care, not from the hospice benefit.

Condition Code 52

- Examples
  - Patient moves to another part of the country
  - Patient leaves the area for a vacation
  - Patient is receiving treatment for a condition unrelated to the terminal illness
  - Patient is receiving treatment for related conditions in a facility with which the hospice does not have a contract, and thus is unable to provide hospice services to that patient
    - Medicare's expectation is that the hospice provider would consider the amount of time the patient is in that facility before making a determination that discharging the patient from the hospice is appropriate

Occurrence Code

OC	Title	Description
27	Date of Hospice Certification or Re-Certification	Code indicates the date of certification or re-certification of the hospice benefit period, beginning with the first two initial benefit periods of 90 days each and the subsequent 60-day benefit periods

- Code is reported on the claim for the billing period in which the certification or recertification was obtained
  - If the certification/recertification was done prior to the service dates on the claim, an OC 27 is not appropriate

Occurrence Code

OC	Title	Description
42	Date of Termination of Hospice Benefit	Enter code to indicate the date on which beneficiary terminated his/her election to receive hospice benefits. This code can be used only when the beneficiary has revoked the benefit.
55	Date of death	Code and date of death is required when the patient discharge status code indicates death (40-expired at home, 41-expired at medical facility, or 42-expired place unknown).

Occurrence Span Code

OSC	Title	Description
77	Provider Liability – Utilization Charged	Code indicates From/Through dates for a period of noncovered hospice care for which the provider accepts payment liability (other than for medical necessity or custodial care)

- Code is reported on the claim when the certification or recertification was obtained late
  - **Do not use for late face-to-face encounters**

Step-by-step guidance is provided in the Avoiding Reason Code U5181: Appropriate Use of Occurrence Code 27/Occurrence Span Code 77 Job Aid

Occurrence Span Code

OSC	Title	Description
M2	Dates of Inpatient Respite Care	Code indicates From/Through dates of a period of inpatient respite care for hospice patients to differentiate separate respite periods of less than 5 days each. M2 is used when respite care is provided more than once during a billing period.

Step-by-step guidance is provided in the Hospice Levels of Care: Inpatient Respite Care Job Aid

CR8569

- Implements system edits to prevent payment of respite care for more than five days
  - Claims submitted on or after July 1, 2014.
    - Enforces the current policy that limits payment of respite care to no more than five consecutive days
    - Claims reporting respite periods greater than five consecutive days will be returned to the provider (RTP)
      - Must report OSC M2 when more than one respite period occurs within the billing period

Occurrence Span Code Example

- Patient has more than one respite stay within the July billing period (07/01/14-07/31/14)
  - First respite stay is 07/01/14-07/03/14.
  - Second respite stay is 07/15/14-07/18/14
- Use of OSC M2 on July claim
  - OSC M2 dates: 07/01/2014-07/02/2014
  - OSC M2 dates: 07/15/2014-07/17/14

Occurrence Span Code Example

- Patient has more than one respite stay within the July billing period (07/01/14-07/31/14)
  - First respite stay is 07/02/14-07/05/14.
  - Second respite stay is 07/12/14-07/19/14*
- Use of OSC M2 on July claim
  - OSC M2 dates: 07/02/2014-07/04/2014
  - OSC M2 dates: 07/12/2014-07/16/14*

*Every day the patient is in respite beyond the fifth consecutive day must be billed at the RHC rate.

Value Codes

VC	Title	Description
61	Place of Residence where Service is Furnished (Routine and Continuous Home Care)	• CBSA number of the location where the hospice service is delivered • Hospices must report value code 61 when billing revenue codes 0651 and 0652
G8	Facility where Inpatient Hospice Service is Delivered (General Inpatient and Inpatient Respite Care)	• CBSA number of the facility where inpatient hospice services are delivered • Hospices must report value code G8 when billing revenue codes 0655 and 0656

Value Codes

- Report VC 61 and/or G8 based on the level of care codes on claim
  - Any time RHC and/or CHC is reported, there must be a VC 61 present
  - Any time GIP and/or respite is reported, there must be a VC G8 present

Step-by-step guidance is provided in the Avoiding Reason Code 32032: Appropriate Use of Value Code 61 and G8 Job Aid

CR8358: Additional Data

- Reporting the NPI of other facilities
- Reporting post mortem visits on the date of death
- Reporting injectable and non-injectable prescription drugs
- Reporting infusion pumps

Step-by-step guidance is provided in the CR8358 Webinars conducted throughout the year and in the CR8358 Question and Answer document

Reporting NPI for NFs, Hospitals and Hospice Inpatient Facilities

- Report the NPI of any NF, hospital, or hospice inpatient facility where the patient is receiving services when the service is not performed at the same location as the billing hospice's location
  - Required for hospice claims reporting site of service HCPCS Q5003, Q5004, Q5005, Q5006 (when not the same as the billing hospice), Q5007 and Q5008
    - Regardless of the level of care provided

Reporting NPI for Hospice Inpatient Facilities

- Do not report an NPI if you own the hospice inpatient facility (Q5006)
- Report the NPI if, under contract, you use another hospice agency's inpatient hospice facility (Q5006)

Reporting Post Mortem Visits on the Date of Death

- For visits that occur after death and on the date of death, report:
  - Visits and length of visits (rounded to the nearest 15 minute increment) for nurses, aides, social workers, and therapists who are employed by the hospice
    - Must be reported with a –PM modifier

Reporting Visits on the Date of Death

- The -PM modifier is NOT reported when a patient dies while in the GIP level of care at a hospice inpatient facility (Q5006)
  - Visits in this LOC/location combination are reported by week and do not utilize the HCPCS G-codes; therefore, the –PM modifier cannot be reported

Reporting Injectable Prescription Drugs

- For Injectable drugs:
  - Report on a line-item basis per fill, using revenue code 0636 and the appropriate HCPCS code, with units representing the amount filled and appropriate charges
    - (e.g., if Q1234 description is "per 100 mg" and the fill was for 200 mg, units reported = 2)
    - The HCPCS codes are listed in the Table of Drugs at www.cms.gov
      - Medicare > HCPCS Release & Code Sets > Alpha-Numeric HCPCS Items > Details for Year

Reporting Noninjectable Prescription Drugs

- For noninjectable prescriptions:
  - Report on a line-item basis per fill
    - Revenue code 0250 and the National Drug Code (NDC) along with appropriate charges
      - Units on revenue code 0250 line should equal "1"
        - » Providers may choose to report a different unit amount if doing so assists them internally
          - » Actual quantity of drug is reported in the NDC field

Reporting Noninjectable Prescription Drugs

- NDCs vary by manufacturer
  - Available on the prescription received from the pharmacy
  - NDCs are also listed in the National Drug Code Directory at http://www.fda.gov
    - Home > Drugs > Drug Approvals and Databases > National Drug Code Directory

Reporting Injectable and Noninjectable Prescription Drugs

- Over-the-counter drugs are not to be reported at this time

Reporting Infusion Pumps

- Report infusion pumps on a line-item basis for each pump order and for each medication refill
  - Report on the claim on a line-item basis per pump order and per medication refill, using revenue code 029X for the equipment and 0294 for the drugs along with the appropriate HCPCS.
- DME other than infusion pumps are not to be reported at this time

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RESOURCES

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CMS Resources

- CMS Web site, Hospice Center
  - http://www.cms.gov/center/hospice.asp
- CMS Transmittals
  - http://www.cms.gov/Transmittals/
- CMS Internet-Only Manuals
  - http://www.cms.gov/manuals
    - Publication 100-02, *Medicare Benefit Policy Manual,* Chapter 9
    - Publication 100-04, *Medicare Claims Processing Manual,* Chapter 11

National Government Services Resources

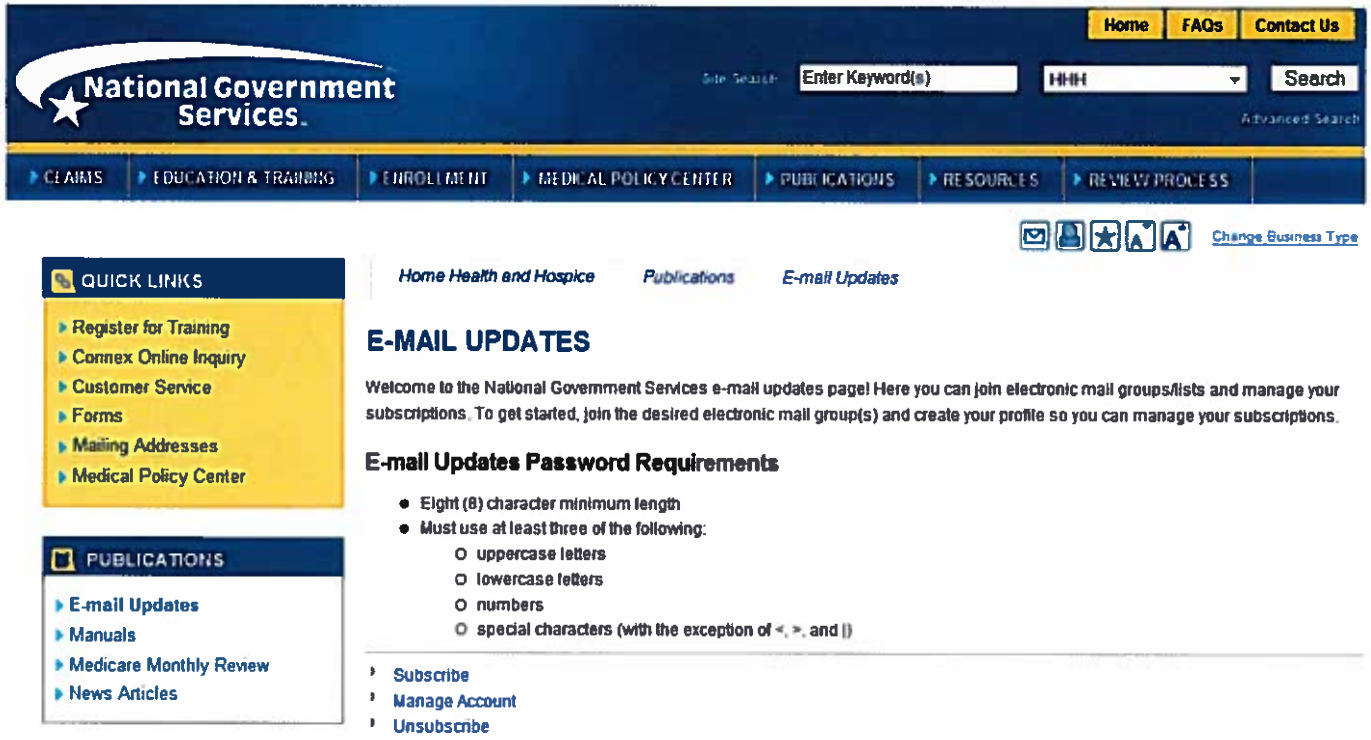
- http://www.NGSMedicare.com
  - Home Health and Hospice portal
    - Acronym Search
      - Resources > Acronym Search
    - Fiscal Intermediary Standard System/Direct Data Entry Provider Online Guide
      - Publications > Manuals
    - Health Insurance Query Access Manual
      - Publications > Manuals
    - Hospice Job Aids
      - Resources > Tools and Materials

National Government Services Resources

- http://www.NGSMedicare.com
  - Home Health and Hospice portal
    - Top Claims Submission Errors
      - Claims > Top Claims Submission Errors
    - Medicare Secondary Payer information
      - Claims > Medicare Secondary Payer
    - Training Events Calendar
      - Education and Training > Training Events Calendar
    - Training Summaries
      - Education and Training > Training Summaries

E-mail Updates

- Subscribe to receive the latest, up-to-date Medicare information.



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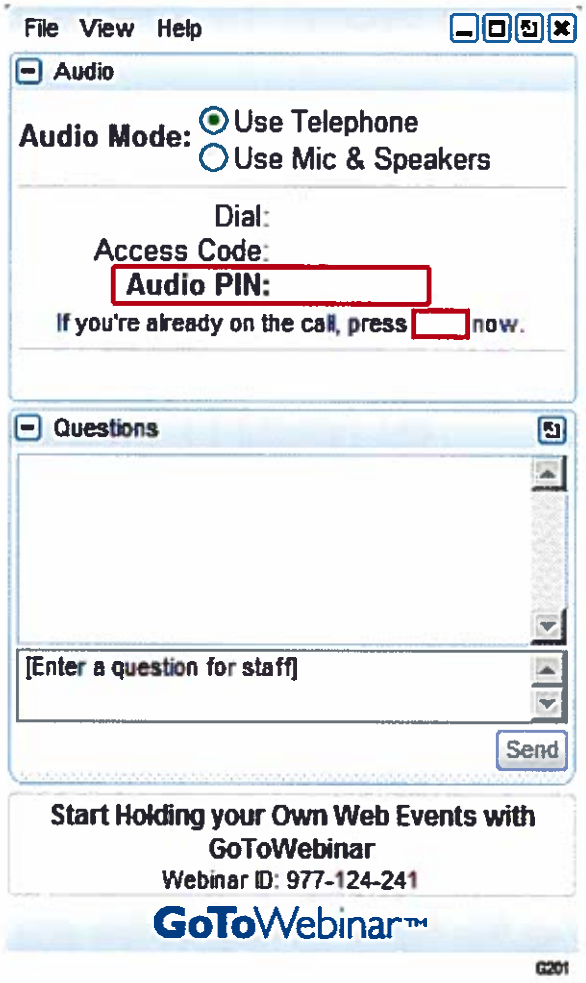
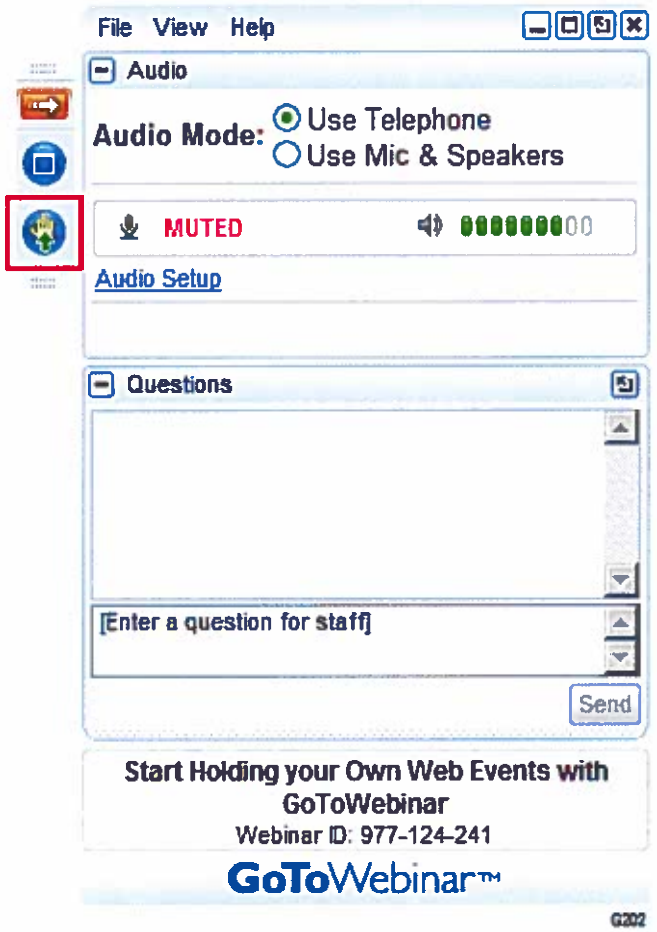
- This is your chance to have your voice heard—Say "yes" when you see this pop-up so National Government Services can make your job easier!

How to Participate Today

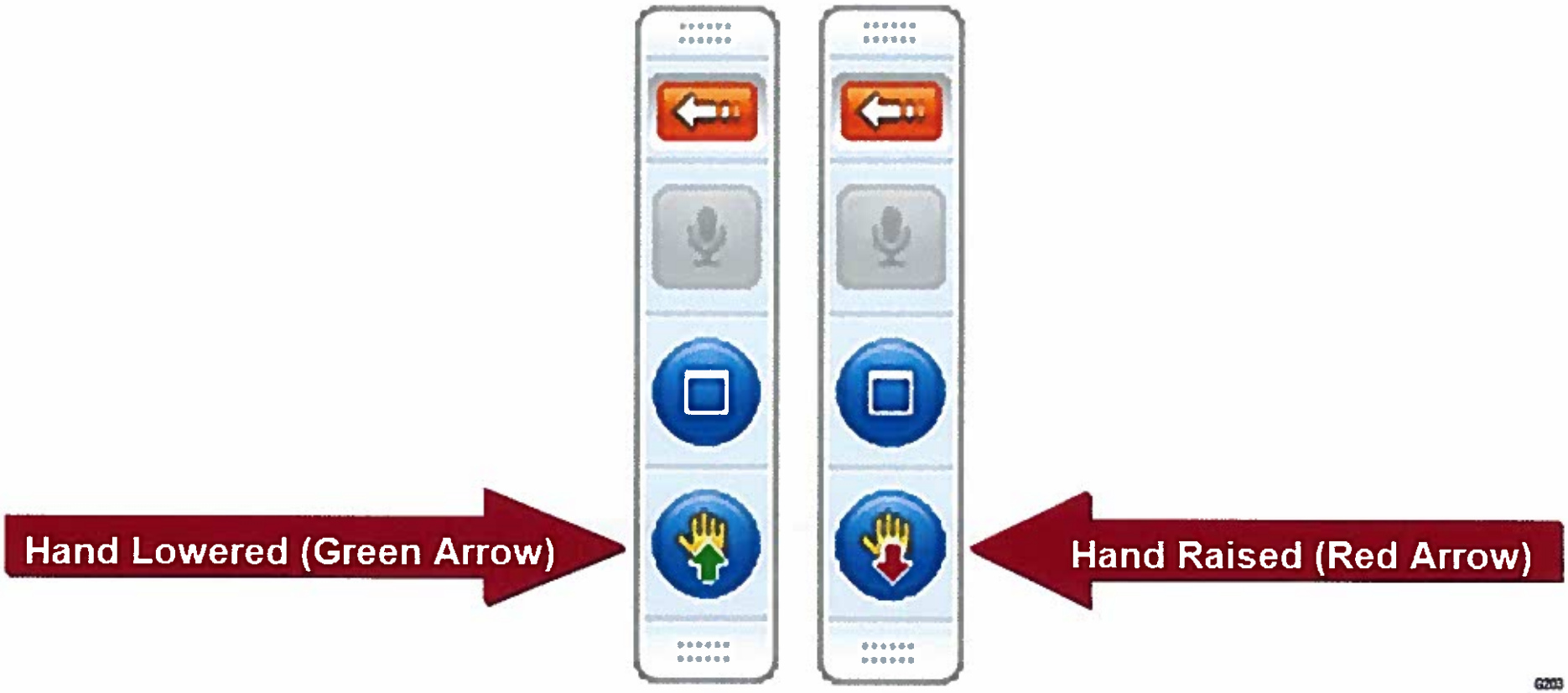


How to Participate Today

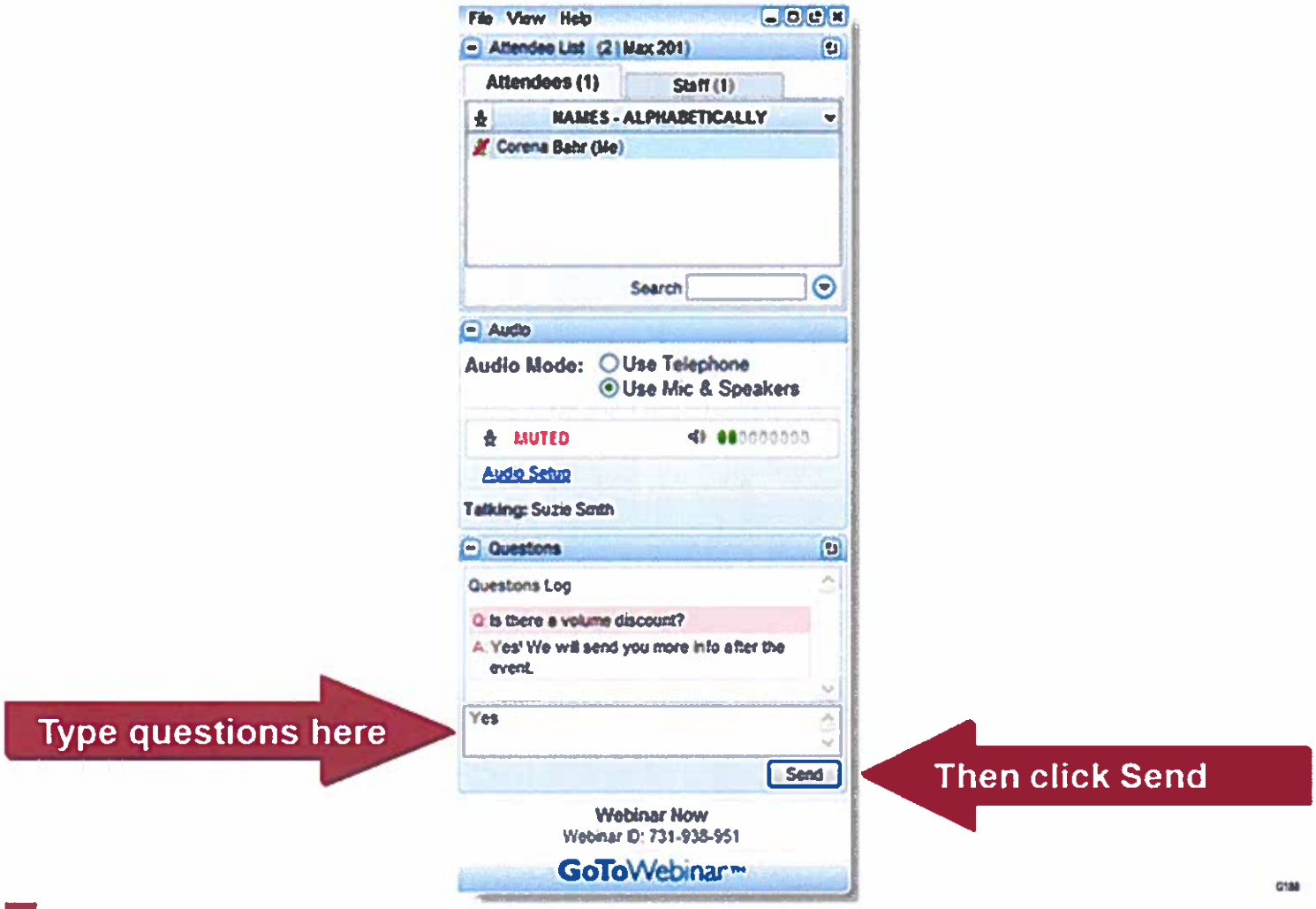
- To Ask a Verbal Question: Raise your hand
- The **Green Arrow** means your hand is not raised (Click to raise your hand)
- The **Red Arrow** means your hand is raised (Click to lower your hand)



To Ask a Question By Raising Your Hand



To Ask a Question Using the Question Box



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- http://www.MedicareUniversity.com
- Interactive online system available 24/7
- Educational opportunities available
  - Computer-based training courses
  - Teleconferences, webinars, live seminars/ face-to-face training
- Self-report attendance

Medicare University Self-Reporting Instructions

- Log on to the National Government Services Medicare University site at http://www.MedicareUniversity.com
  - Topic = Hospice Billing Scenarios: Billing Basics
  - Medicare University Credits (MUCs) = 1
  - Catalog Number = To be provided
  - Course Code = To be provided
  - For step-by-step instructions on self-reporting please visit the Accessing the Self-Reporting Tool page on the NGSMedicare.com website

Thank You!