# Medicare Hospice Billing 2015 & Beyond!

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## Sequential Claim Billing

The NOE must be in S/LOC P B9997 prior to submitting the first 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 claim (in S/LOC "S") does not meet the sequential billing requirement.
- Claims must be consecutive. This means there cannot be a skip in days between the prior claim and the subsequent claim.
- Claims must be submitted monthly. The Medicare Claims Processing Manual (Pub. 100-04), Chapter 11, Section 90 states **"Hospices must bill for their Medicare beneficiaries on a monthly basis."** This will significantly reduce errors related to sequential billing.

# 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 |

# 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

## Continuous Home Care

- 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 nurses (RN or LPN) and home health aides; however, at least half (50%) of the care must be provided by a nurse.
- 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.

## 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 routine rate.
- 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 routine home care 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

# Occurrence & Condition Codes

| Occurrence Codes (FL 31-34) | |
|---|---|
| **27** | Date of certification or recertification |
| **42** | Date of revocation (ONLY) |
| **55** | Date of death (when patient status = 40, 41 or 42) |
| ***CMS Pub. 100-04, Chapter 11, Section 30.3*** | |

| Occurrence Span Codes (FL 35-36) | |
|---|---|
| **77** | Noncovered days due to untimely recertification (Not for FTF) |
| **M2** | Multiple respite stays, From/To dates of each stay |
| ***CMS Pub. 100-04, Chapter 11, Section 30.3*** | |

# Occurrence & Condition Codes

| Discharge Reason | Occurrence Code | Condition Code | Patient Status Code |
|---|---|---|---|
| Patient revokes | 42 | None | Appropriate code |
| Patient transfers hospices | None | None | 50 or 51 |
| Patient no longer terminal | None | None | Appropriate code |
| Patient discharged for cause | None | H2 | Appropriate code |
| Patient moves out of service area | None | 52 | Appropriate code |
| Death | 55 | None | 40, 41, or 42 |

# 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

| Discipline Visit Description | REV | HCPCS, Modifiers (PM if post-mortem on/after 1/1/14) |
|---|---|---|
| Physical therapy | 0421 | G0151, PM |
| Occupational therapy | 0431 | G0152, PM |
| Speech language pathology | 0441 | G0153, PM |
| Skilled nursing | 0551 | G0154, PM |
| Medical social service (visit) | 0561 | G0155, PM |
| Medical social service (phone call) | 0569 | G0155, PM |
| Home health aide | 0571 | G0156, PM |

# Location Codes

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

# Location Codes

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

## 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

## Claim Form Locators

| | | | | |
|---|---|---|---|---|
| Tot Unit | 46 | Total units | N | R |
| Cov Unit | 46 | Covered units | N | R |
| Tot Charge | 47 | Total charges | N | R |
| Ncov Charge | 48 | Noncovered charges | N | C |
| Serv Date | 45 | Service date | N | R |
| CD | 50 | Payer code | R | R |
| Payer | 50 | Payer name | R | R |
| RI | 52 | Release of information | R | R |
| SERV FAC NPI | N/A | NPI of Facility | N | C[8] |
| Medical Record Nbr | 3b | Medical Record Number | O | O |
| Diag Codes | 67 | Diagnosis codes | R | R |
| Att Phys NPI | 76 | Attending physician's NPI | R | R |
| L | 76 | Attending physician's last name | R | R |
| F | 76 | Attending physician's first name | R | R |

# *Attending Physician Update

- 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.**

# *Attending Physician Update

- **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.

## *Attending Physician Update

- 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.

## New Hospice Claim Requirements

- **General Inpatient Care (GIP) Visits**
- **Inpatient Facility Identification**
- **Post-Mortem Visits**
- **Injectable Drugs**
- **Non-Injectable Drugs**
- **Infusion Pumps**

## General Inpatient (GIP) Visit Changes

- 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

## General Inpatient (GIP) – Q5006

- **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

# GIP UB04 Claim Detail - 2014

### GIP - Facility OTHER THAN Hospice Inpatient Facility

| 42 REV.CD | 43 DESCRIPTION | 44 HCPCS/RATE/HIPPS | 45 SERV. DATE | 46 SERV. UNITS |
|---|---|---|---|---|
| 0656 | GIP- SNF | Q5004 | 060114 | 2 |
| 0551 | Skilled Nursing | G0154 | 060114 | 3 |
| 0551 | Skilled Nursing | G0154 | 060214 | 2 |

### GIP - Hospice Inpatient Facility

| 42 REV.CD | 43 DESCRIPTION | 44 HCPCS/RATE/HIPPS | 45 SERV. DATE | 46 SERV. UNITS |
|---|---|---|---|---|
| 0656 | GIP- Inpatient Hospice | Q5006 | 060114 | 2 |
| 0551 | Skilled Nursing | G0154 | 060114 | 2 |

# 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

# Inpatient Facility Identification

- Reported in HIPAA 5010 electronic claim format - 'Other Provider Location Loop 2310 E'
- Claims billed with inpatient facility location codes will be returned (RTP) ("T" Status) for corrections if inpatient facility identifying information missing
- When the patient has received care in more than one facility during the billing month, the hospice shall report the NPI of the facility where the patient was last treated.

# Page 3 – DDE Entry Hospice

```
MAP1713   PAGE 03          CGS J15 MAC - HHH REGION          ACPFA052 MM/DD/YY
AB01CD    SC              INST CLAIM ENTRY                  C201413F HH:MM:SS
 HIC               TOB      S/LOC          PROVIDER
 NDC CODE                                                OFFSITE ZIPCD:
  CD ID    PAYER                    OSCAR        RI AB            EST AMT DUE
 A
 B
 C
 DUE FROM PATIENT                          SERV FAC NPI
 MEDICAL RECORD NBR                    COST RPT DAYS      NON COST RPT DAYS
 DIAG CODES 01          02          03          04          05
 06          07          08          09                END OF POA IND
 ADMITTING DIAGNOSIS           E CODE            HOSPICE TERM ILL IND
 IDE
 PROCEDURE CODES AND DATES 01              02
 03              04              05              06
 ESRD HOURS     ADJUSTMENT REASON CODE     REJECT CODE        NONPAY CODE
 ATT PHYS        NPI              L                  F          M    SC
 OPR PHYS        NPI              L                  F          M    SC
 OTH OPR         NPI              L                  F          M    SC
 REN PHYS        NPI              L                  F          M    SC
 REF PHYS        NPI              L                  F          M    SC
```

# 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**
  - Requires visits to be reported in 15-minute increments

# Post–Mortem Visits

  - 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

- **Q&A #5 -** Would an on call nurse pronouncement visit be considered a post-mortem visit?
- **Answer:** Any time prior to the pronouncement would be reported as an actual visit. Time from the pronouncement and beyond would be reported as a post-mortem visit.

Source: CGS
www.cgsmedicare.com/hhh/education/faqs/act/act_qa101713.htm

# GIP UB04 Claim Detail - 2014

**GIP - Facility with Post-Mortem Visit**

| 42 REV.CD | 43 DESCRIPTION | 44 HCPCS/RATE/HIPPS | 45 SERV. DATE | 46 SERV. UNITS |
|---|---|---|---|---|
| 0656 | GIP- SNF | Q5004 | 060114 | 2 |
| 0551 | Skilled Nursing | G0154 | 060114 | 3 |
| 0551 | Skilled Nursing | G0154 | 060214 | 2 |
| 0551 | Skilled Nursing-Post-Mortem | G0154PM | 060314 | 5 |

**GIP - Facility with SPLIT Post-Mortem Visit**

| 42 REV.CD | 43 DESCRIPTION | 44 HCPCS/RATE/HIPPS | 45 SERV. DATE | 46 SERV. UNITS |
|---|---|---|---|---|
| 0656 | GIP- SNF | Q5004 | 060114 | 2 |
| 0551 | Skilled Nursing | G0154 | 060114 | 3 |
| 0551 | Skilled Nursing | G0154 | 060214 | 2 |
| 0551 | Skilled Nursing | G0154 | 060314 | 2 |
| 0551 | Skilled Nursing-Post-Mortem | G0154PM | 060314 | 3 |

# 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

# GIP UB04 Claim Detail - 2014

**GIP - Facility with Injectable Drugs**

| 42 REV.CD | 43 DESCRIPTION | 44 HCPCS/RATE/HIPPS | 45 SERV. DATE | 46 SERV. UNITS |
|---|---|---|---|---|
| 0656 | GIP- SNF | Q5004 | 060114 | 2 |
| 0551 | Skilled Nursing | G0154 | 060114 | 3 |
| 0551 | Skilled Nursing | G0154 | 060214 | 2 |
| 0636 | Inj – Lorazepam, 2 mg | J2060 | 060214 | 2 |

# 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

# GIP UB04 Claim Detail - 2014

### GIP - Facility with Non-Injectable & Injectable Drugs

| 42 REV.CD | 43 DESCRIPTION | 44 HCPCS/RATE/HIPPS | 45 SERV. DATE | 46 SERV. UNITS |
|---|---|---|---|---|
| 0656 | GIP- SNF | Q5004 | 060114 | 2 |
| 0551 | Skilled Nursing | G0154 | 060114 | 3 |
| 0551 | Skilled Nursing | G0154 | 060214 | 2 |
| 0636 | Inj – Lorazepam, 2 mg | J2060 | 060214 | 2 |
| 0250 | N400172375760UN100 | (not applicable) | 060214 | 1 |

- Begin by entering the qualifier N4 immediately followed by the 11-digit NDC code.
- The NDC codes must be in the 5-4-2 format required by HIPAA guidelines, do not report hyphens. It may be necessary to pad NDC numbers with zeroes in order to report eleven digits.
- Next enter the two digit unit of measurement qualifier immediately followed by the. numeric quantity administered to the patient (amount of fill). **Measurement Qualifiers:**
  F2 International Unit - - GR Gram - - ML Milliliter - - UN Units

# CR 8358 Revisions – 01/31/14

- ***New Clarification*** *- Hospices shall report multi-ingredient compound prescription drugs (non-injectable) using revenue code 0250. The hospice shall specify the same prescription number for each ingredient of a compound drug according to the 837i guidelines in loop 2410. In addition, the hospice shall provide the NDC for each ingredient in the compound; the NDC qualifier represents the quantity of the drug filled (meaning the amount dispensed) and shall be reported as the unit measure.*

## 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 Pumps

- 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

# GIP UB04 Claim Detail - 2014

**GIP - Facility with Injectable Drugs & Infusion Pump**

| 42 REV.CD | 43 DESCRIPTION | 44 HCPCS/RATE/HIPPS | 45 SERV. DATE | 46 SERV. UNITS |
|---|---|---|---|---|
| 0656 | GIP- SNF | Q5004 | 060114 | 2 |
| 0551 | Skilled Nursing | G0154 | 060114 | 3 |
| 0551 | Skilled Nursing | G0154 | 060214 | 2 |
| 0636 | Inj – Lorazepam, 2 mg | J2060 | 060214 | 2 |
| 0291 | Infusion Pump Rental | E0738 | 060214 | 1 |
| 0294 | Infusion – Saline 1000cc | J7030 | 060214 | 1 |


# Hospice Coding Edits & Issues

## Symptoms, Signs & Ill-Defined Conditions

- CMS has stated that the following are NOT acceptable as Primary Diagnosis for Hospice (edits in place 10/01/14)
  - 783.41 Failure to thrive
  - 783.7 Adult failure to thrive
  - 799.3 Debility Unspecified
  - 799.89 Other ill-defined conditions
  - 799.9 Other unknown and unspecified cause of morbidity or mortality
- "Symptoms, Signs, and Ill-Defined Conditions", such as "debility" or "adult failure to thrive," does not encompass the comprehensive, holistic nature of the assessment and care to be provided under the Medicare hospice benefit.

## Coding Edits for Primary Diagnosis

- "claims received with these codes in the principal diagnosis field will be returned to the provider for more definitive coding of the principal diagnosis and additional diagnoses, effective for claims dated on or after October 1, 2014. This will not affect claims submitted before October 1, 2014. "Debility" and "adult failure to thrive" may be reported on the hospice claims as additional diagnoses in the appropriate claim fields. Although claims will not be returned to the provider until the start of FY 2015, we remind hospices that they are currently, and have always been, required to code *all* related diagnoses in the additional coding fields on the hospice claim and thus should be doing so now."

*Federal Register Center for Medicare & Medicaid Services42 CFR Part 418 Medicare Program; FY 2014 Hospice Wage Index and Payment Rate Update; Hospice Quality Reporting Requirements; and Updates on Payment Reform; Final Rule

## CR 8877 Attachment A
## Codes Not Allowed as Principal

| | Description |
|---|---|
| • 290.0 | Senile Dementia Uncomplicated |
| • 290.10 | Presenile Dementia Uncomplicated |
| • 290.11 | Presenile Dementia with Delirium |
| • 290.12 | Presenile Dementia with Delusional Feat |
| • 290.13 | Presenile Dementia w/Depressive Feat |
| • 290.20 | Senile Dementia with Delusional Feat |
| • 290.21 | Senile Dementia with Depressive Feat |
| • 290.3 | Senile Dementia with Delirium |
| • 290.40 | Vascular Dementia Uncomplicated |
| • 290.41 | Vascular Dementia with Delirium |
| • 290.42 | Vascular Dementia with Delusions |
| • 290.43 | Vascular Dementia w/Depressed Mood |
| • 290.8 | Other Specified Senile Psychotic Conditions |
| • 290.9 | Unspecified Senile Psychotic Condition |

## CR 8877 Attachment A
## Codes Not Allowed as Principal

| | Description |
|---|---|
| • 293.0 | Delirium Due to Conditions Classified Elsewhere |
| • 293.1 | Subacute Delirium |
| • 293.81 | Psychotic Disorder with Delusions in Conditions Classified Elsewhere |
| • 293.82 | Psychotic Disorder with Hallucinations in Conditions Classified Elsewhere |
| • 293.83 | Mood Disorder in Conditions Classified Elsewhere |
| • 293.89 | Other Specified Transient Organic Mental Disorders Due Conditions Classified Elsewhere |
| • 294.20 | Dementia, Unspecified, Without Behavioral Disturbance |
| • 294.21 | Dementia, Unspecified, With Behavioral Disturbance |
| • 294.8 | Other Persistent Mental Disorders Due to Conditions |
| • 310.0 | Frontal Lobe Syndrome |
| • 310.1 | Personality Change Due to Conditions Classified Elsewhere |
| • 310.89 | Other Specified Nonpsychotic Mental Disorders Following Organic Brain Damage |
| • 310.9 | Unspecified Nonpsychotic Mental Disorder Following Organic Brain Damage |

# Related Conditions Defined

- Clinically, related conditions are any physical or mental condition(s) that are related to or caused by either the terminal illness or the medications used to manage the terminal illness.

*Paolini, DO, Charlotte. (2001). Symptoms Management at End of Life. JAOA. 101(10). p609–615

- CMS' Hospice Claims Processing manual requires that hospice claims include other diagnoses "as required by ICD-9-CM Coding Guidelines" (IOM 100-04, chapter 11, section 30.1, available at): *http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf*

# Coding Guidelines – Hospice

- "Other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring:
  - Clinical evaluation; or
  - therapeutic treatment; or
  - diagnostic procedures; or
  - extended length of hospital stay; or
  - increased nursing care and/or monitoring.

*Official Guidelines for Coding and Reporting

- Hospices should report on hospice claims all coexisting or additional diagnoses *that are related to* the terminal illness; they should not report coexisting or additional diagnoses that are unrelated to the terminal illness.

*Coding Clinic - AHIMA

# Proposed 2016 Changes

- **Changes in County Designations:** CMS reports that the use of the new delineations will result in new CBSAs, 37 counties that were urban and are now rural, 105 counties that were rural and are now urban, and existing CBSAs that have been split apart.
- **Transition Period:** CMS proposes that there will be a one year transition period to the new delineations, at 50% at the old CBSA or rural value and 50% at the new value.
- **Rural Floor:** The 0.8 rural floor has been maintained and applies to counties designated as rural. For rural counties with a wage index value under 0.8, the hospice's wage index receives a 15% increase up to 0.8

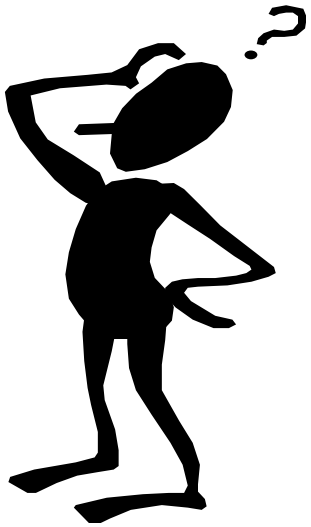
# Proposed 2016 Changes

- **Tiered Routine Home Care Rate:** CMS is proposing to establish two tiers of routine home care payments, one payment for days 1-60 and a reduced payment for days 61+. This two-tiered approach is a proposed rule!
- **Service Intensity Add-on:** CMS also proposes to establish a service intensity add-on (SIA) for patients in the last 7 days of life, if certain criteria are met. The rate is proposed to be established at the hourly continuous home care rate of $39.44 and limited to:
  - a minimum of 1 hour and a maximum of 4 hours in a 24 hour period.
  - The proposed criteria include services provided only by an RN or social worker
  - services provided to patients not residing in a skilled nursing facility or nursing facility

## MSP

- http://www.cgsmedicare.com/hhh/education/materials/msp.html
- http://www.cgsmedicare.com/hhh/education/materials/MSPResources.html
- http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c03.pdf

## Questions



# *Thank You For Listening!*

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