Medicare Hospice Billing Webinar Part 3 - 2015

Presented By:
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Hospice Face-to-Face

Regulatory changes effective January 1, 2011:

Enforcement: April 1, 2011

Face-to-Face/Attestation:

Encounter with hospice physician/NP for patients whose total stay across all hospices will extend into the 3rd or subsequent benefit period

Attestation of the encounter includes patient name, date of visit, signed and dated; must be separate and distinct section of or addendum to recertification form; clearly titled and identifiable

Hospice Face-to-Face

Face-to-Face/Attestation

If NP conducts encounter - - must attest that clinical findings were provided to certifying physician

If physician conducts encounter - - should also compose narrative and sign certification

Face-to-face must be conducted within the 30 calendar days prior to recertification – unless exceptions apply - - see next screen

Physician narrative:

Narrative statement must be directly above physician signature

Narrative for 3rd or later benefit period must include explanation of clinical findings from face-to-face and how they support 6 month life expectancy

Hospice Face-to-Face

No payment for encounter, BUT appropriate physician-level services provided in conjunction may be billed through hospice (NP must be attending)

Encounter may occur in home or at physician office if safe for patient (transport must optimize comfort; cost of special transport covered by hospice per diem)

Note: entire time on hospice care applies -- use CWF, patient/representative

If patient/family refuse face-to-face, potential for discharge for cause

Hospice Face-to-Face

Physician can be contract, employee or volunteer; medical resident or fellow Ok if employed/contracted (narrative, certification requirements apply)

NP must be employee or volunteer so can be FT, PT, per diem

Prior face-to-face by another hospice can't substitute; transfers **within** benefit period do not require face-to-face if records verify previous face-to-face

No Telehealth

Electronic signatures are acceptable

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.
- http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c11.pdf

Physician Services

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

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MAP1712   PAGE 02      CAHABA GBA - RHHI            ACPFAT01 MM/DD/YY
AB01CD    SC         INST CLAIM ENTRY              C20094AS HH:MM:SS
                                                REV CD PAGE 01
  HIC              TOB 811  S/LOC S B0100  PROVIDER

                                TOT   COV
CL  REV  HCPC  MODIFS  RATE UNIT  UNIT  TOT CHARGE NCOV CHARGE SERV DT
    0651 Q5001              19    19    2000.00                 0113XX
    0551 G0154              3     3     150.00                  0115XX
    0551 G0154              2     2     150.00                  0117XX
    0657 99232              1     1     200.00                  0118XX
    0571 G0156              4     4     100.00                  0119XX
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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.

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MAP1712   PAGE 02          CAHABA GBA - RHHI            ACPFAT01 MM/DD/YY
AB01CD    SC             INST CLAIM ENTRY              C20093YE HH:MM:SS
                                                  REV CD PAGE 01
  HIC 111222333A    TOB 812  S/LOC S B0100  PROVIDER

                                  TOT   COV
CL  REV  HCPC MODIFS       RATE UNIT  UNIT  TOT CHARGE NCOV CHARGE SERV DT
   651  Q5001                   31    31    3100.00                 010110
   551  G0154                   2     2     200.00                  010110
   571  G0156                   2     2     100.00                  010310
   657  99222 GV                1     1     100.00                  010410
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CAP Calculation

- **Example 1.** Jane Smith, a Medicare beneficiary, initially elected hospice care from
- Hospice A beginning on June 1, 2011. Her condition improved, and she was discharged from Hospice A on August 15, 2011, as she was no longer terminally ill. However, in January 2012 Ms. Smith's condition worsened; she re-elected hospice at Hospice A on January 15, 2012, and subsequently died on February 26, 2012.

- Streamlined Method: Hospice A would count Ms. Smith as 1 in its 2011 cap year, but would not count Ms. Smith again in its 2012 cap year. Medicare payments for hospice care provided would be counted in the cap year in which those services were provided, regardless of when payments were actually made, using the best data available at the time of the calculation.

- Proportional Method: Ms. Smith would be counted as follows:

2011 cap year (June 1st – August 15th):	76 days	=	76/119 =	0.64
2012 cap year (Jan 15th – Feb 26th):	43 days	=	43/119 =	0.36
Total days:	119 days	=		1.00

New CAP Calculation Requirement

- **CMS is finalizing the proposal to require hospices to submit the aggregate cap calculation no later than 5 months after the end of the cap year and refund any overpayment with the filed cap determination.**

- **CMS is NOT requiring that hospices calculate their inpatient cap, given concerns about the complexity of this calculation and the limited number of hospices that exceed the inpatient cap.**

- **CMS will require hospices to wait at least 3 months following the end of the cap year to calculate the self-determined aggregate cap.**

- **Hospices that fail to file their self-determined aggregate cap determination will have payments suspended.**
  - **Pro forma spreadsheet has been made available from CMS.**

Palliative Care

The Center to Advance Palliative Care (CAPC) defines palliative care as "specialized care for people with serious illnesses," with the following characteristics:

- ***Focuses on relief from the symptoms, pain, and stress*** of a serious illness
- Aims to improve ***quality of life*** for both the ***patient and the family***
- Provides an ***extra layer of support*** at any age and ***at any stage*** in a serious illness and can be provided along with curative treatment
- Supports patient and family, not only by controlling symptoms, but also by helping to ***understand treatment options and goals***

Palliative Care

- **NHPCO - Palliative care** is patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice.
- The following features characterize palliative care philosophy and delivery:
  - Care is provided and services are coordinated by an interdisciplinary team;
  - Patients, families, palliative and non-palliative health care providers collaborate and communicate about care needs;
  - Services are available concurrently with or independent of curative or life-prolonging care;
  - Patient and family hopes for peace and dignity are supported throughout the course of illness, during the dying process, and after death

Palliative Care

NHPCO - If state licensing laws do not allow a hospice to provide non-hospice palliative care, consider a joint venture relationship.

- Under federal regulations, it is permissible for a hospice to unbundle its services and provide non-hospice palliative care to another licensed entity, such as a hospital, home health agency, nursing facility or physician practice.

Example: A local hospital wishes to furnish palliative care to its patients.

- The hospital may contract with the hospice to provide direct care to hospital patients and/or the clinical expertise necessary to establish the program, develop policies, etc.

Palliative Care

NHPCO - Billings to patients are based on fair market value. The decision to provide free care or care at below market rates should be based solely on an individual's ability to pay and subject to a sliding fee scale.

- It is impermissible to provide anything of value to a beneficiary for purposes of inducing the person to elect a Medicare covered service/benefit. One of the most important ways that hospices blunt the inference of an impermissible inducement is to charge patients fair market value for provided services. This means, for example, that care provided to a patient who may later become a hospice patient should be billed at the value of the services, unless the hospice has organized a program to provide uncompensated care to those who are unable to pay for needed care and instituted a sliding fee scale which is based on ability to pay. Such programs and fee scales should be well documented and consistently administered.

Palliative Care

NHPCO - Billings to other contract health care providers (e.g. hospital systems) reflect fair market value and there structure has been reviewed by legal counsel.

- The federal anti-kickback prohibitions apply to referral sources, and once again, it is impermissible to provide anything of value to a referral source such as a hospital, nursing facility or physician, in order to induce referrals into the hospice program. If the hospice is providing services to a facility such as a nursing home or a hospital, the amount billed must reflect fair market value for the services and must not take into account the volume or value of referrals.

Questions

Thank You For Listening!

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PROVIDER SELF-DETERMINED AGGREGATE CAP LIMITATION

PROVIDER NAME:
PROVIDER NUMBER:
NPI NUMBER:
CAP YEAR ENDING:

CAP ON OVERALL MEDICARE REIMBURSEMENT

1. MEDICARE BENEFICIARIES UNDER HOSPICE CARE PER THE PS&R
   a. Identify the method used for countying beneficiaries: (Streamlined or Patient by Patient Proportional)
   b. Paid through date of report used:
2. STATUTORY CAP AMOUNT FOR THE CAP YEAR
3. ALLOWABLE MEDICARE PAYMENTS (line 1 x line 2)
4. NET PAYMENTS PER THE PS&R
5. PAYMENTS IN EXCESS OF THE AGGREGATE CAP AMOUNT (line 3 - line 4)

THE CONTRACTOR WILL MAKE THE ADJUSTMENT FOR SEQUESTRATION AT THE FINAL CAP DETERMINATION

CERTIFICATION

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED ON THIS REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW

Certification of Officer or Authorized Representative of the Hospice:

I hereby certify that I have read the above statement and that I have examined this report for the above name hospice and to the best of my knowledge and belief, it is a true, correct and complete report.

Signature of Officer or Authorized Representative of Hospice

Typed or printed name and title of above signature

Name and number of person to contact for additional information:

Printed Name: Telephone Number: