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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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 their 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.

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.**

2016 Hospice Payment Reform

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.

2016 Hospice Payment Rates

FY2016 PAYMENT RATES:

Code/Description	Labor portion	Non-labor portion	Final FY2016 Rate
651 -- Routine Home Care (10/1 - 12/31/15)	68.71%	31.29%	$161.89
651/Routine Home Care days 1 - 60 (eff. 1/1/2016)	68.71%	31.29%	$186.84
651/Routine Home Care days 61+ (eff. 1/1/2016)	68.71%	31.29%	$146.83
652 -- Continuous Home Care	68.71%	31.29%	$944.79 ($39.37/hr.)
655 -- Inpatient Respite	54.13%	45.87%	$167.45
656 -- General Inpatient Care	64.01%	35.99%	$720.11

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 seven 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

The SIA policy necessitates the creation of two new G codes for nursing that distinguish between nursing care provided by a RN and nursing care provided by a Licensed Practical Nurse (LPN). During periods of crisis such as the precipitous decline before death, patient needs typically surge and more intensive services are warranted. The Medicare Conditions of Participation (CoPs) at 42 CFR 418.56(a) state that an RN is responsible for ensuring that the needs of the patient and family are continually assessed. CMS would expect that at end of life the needs of the patient and family would need to be frequently assessed and thus the skills of an RN are required. RNs are more highly trained clinicians with commensurately higher wage rates.

Since the existing codes do not distinguish between services provided by an RN and a LPN, CMS will obtain new codes to distinguish between RN services and LPN services by January 1, 2016.

The SIA daily payment calculated by the Hospice PRICER will be entered on the first applicable visit line item for each date of service payable.

2016 Hospice Payment Reform

- CMS posted CR 9369 containing the new G codes for distinguishing RN and LPN visit and are required for implementation of service-intensity add-on (SIA) as part of the new payment system in January. Please note that these codes apply to both hospice and home health, so the changes in the CR relate to both the Home Health and Hospice chapters of the Claims Processing Manual.
- The CR is available here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3378CP.pdf.

Key information:

- For dates of service on or after January 1, 2016, G0154 is retired and visits previously reported with this code will now use:

- G0299 Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting

OR

- G0300 Direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting

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.

Revenue Code	HCPCS	Line Item Date of Service	Units
0651	Q5001	12/01/XX	9
0551	G0299	12/01/XX	4
0571	G0156	12/02/XX	6
0561	G0155	12/05/XX	4
0571	G0156	12/05/XX	3
0551	G0299	12/06/XX	3
0571	G0156	12/06XX	4
0551	G0299	12/09/XX	4
0561	G0155	12/09/XX	6
0571	G0156	12/09/XX	2

2016 Hospice Payment Reform

- ✓ 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.

Questions

Thank You For Listening!

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