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Medicare Hospice Billing Basics

8/29/2023

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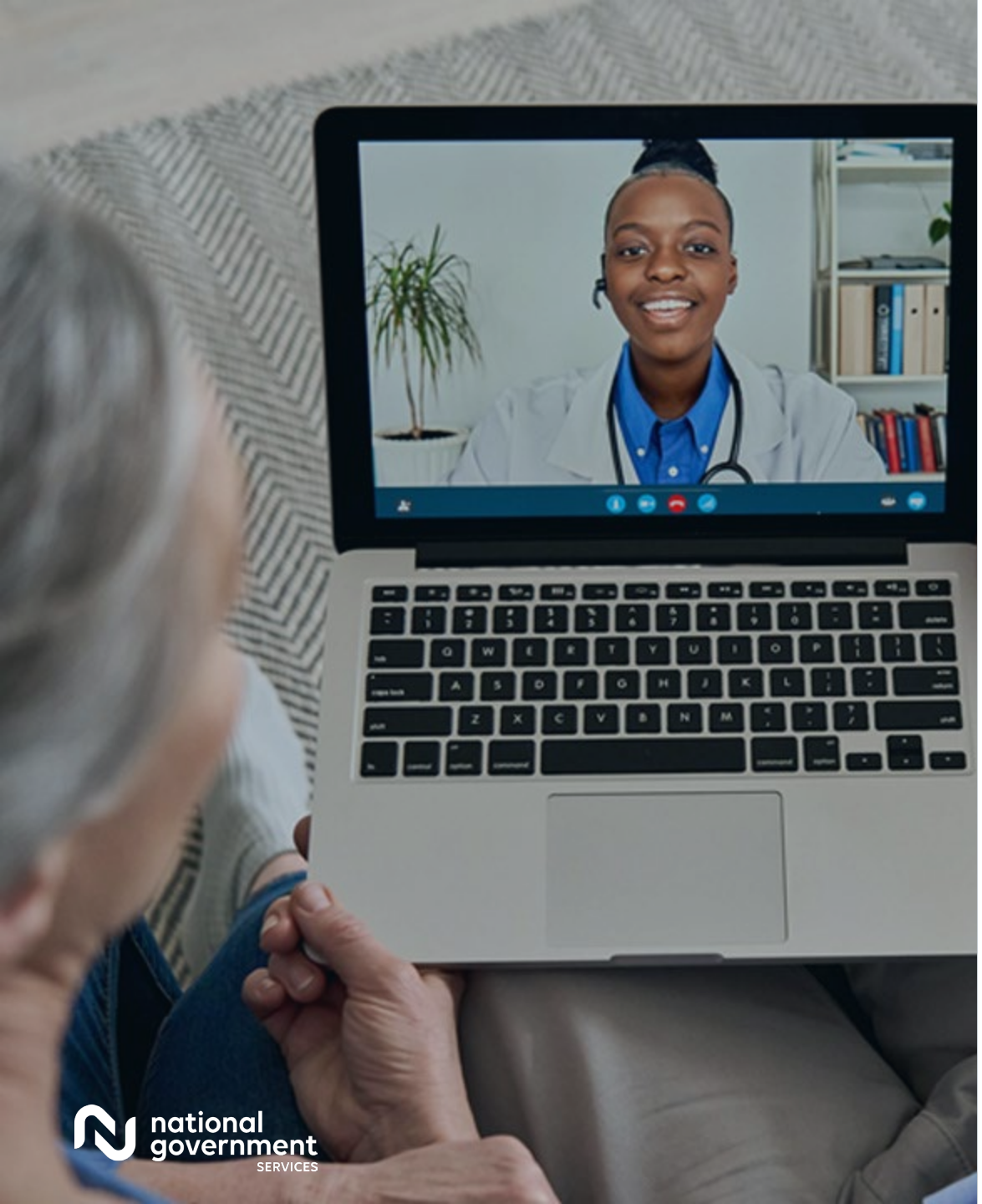

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Objective

After this session attendees will know how to properly bill Medicare for hospice services, including the frequency of billing and which fields on the claim are required to be completed. Attendees will also understand how to prevent/correct common billing errors and what resources to use to find additional information.

Today's Presenter: Andrea Freibauer

- Hospice Claim Submission
- Hospice Billing Requirements
- Common Claim Errors
- References and Resources
- Q&A

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Hospice Claim Submission

Submission Formats

- Submitted to your HHH MAC
- Submit electronically Claim data transmitted directly via
  - ✓ FISS DDE entry
  - ✓ Via EDI
    - 837I electronic claim form (via network service vendor)
    - Batch transmission
- Submit via hardcopy claim form (UB-04/CMS 1450)
  - Uniform institutional provider bill
    - ✓ Designed and maintained by NUBC
  - Must have approved ASCA waiver to use
    - ✓ ASCA Requirements for Paper Claim Submission

Claims Adjudication Process

- When submitted, claims process through FISS
- Claims follow specific path based on type and are subject to various edits
  - Status/location – where claim is in processing
  - Reason codes – indicate status of claim
- If claim passes FISS edits, subject to various CWF edits
  - Nationwide repository for Medicare patient and claim information
- If claim passes CWF edits, returns to FISS for finalization/adjudication
- "Clean" claims can pay within 14 days from submission (electronic)
  - Can RTP, reject or deny during processing

FISS Status/Locations

- S XXXXX – Claim suspended (processing)
- P B9997 – Claim finalized/adjudicated
- T B9997 – Claim RTP
  - Claim has error(s) that need to be corrected and sent back to HHH MAC via FISS (PF9)
  - Providers must check RTP bucket often as these claims not considered received by Medicare
- R B9997 – Claim rejected
  - No action may be needed, determined by reason code
  - May have to resubmit (or adjust) claim, if appropriate
- D B9997 – Claim denied
  - Determine if appeal needed
  - Documentation must support services rendered

Hospice Billing Guidelines

- NOE has to be finalized (P B9997) before any claims for payment can be submitted
- Bill claims on monthly basis (calendar month)
  - Exception if beneficiary discharges and readmits later that same month
- Claims must be submitted sequentially (in date order)
- Prior month's claim must be finalized (P B9997) before next month's claim can be submitted
  - Claim will RTP if prior claim not in FISS claims history

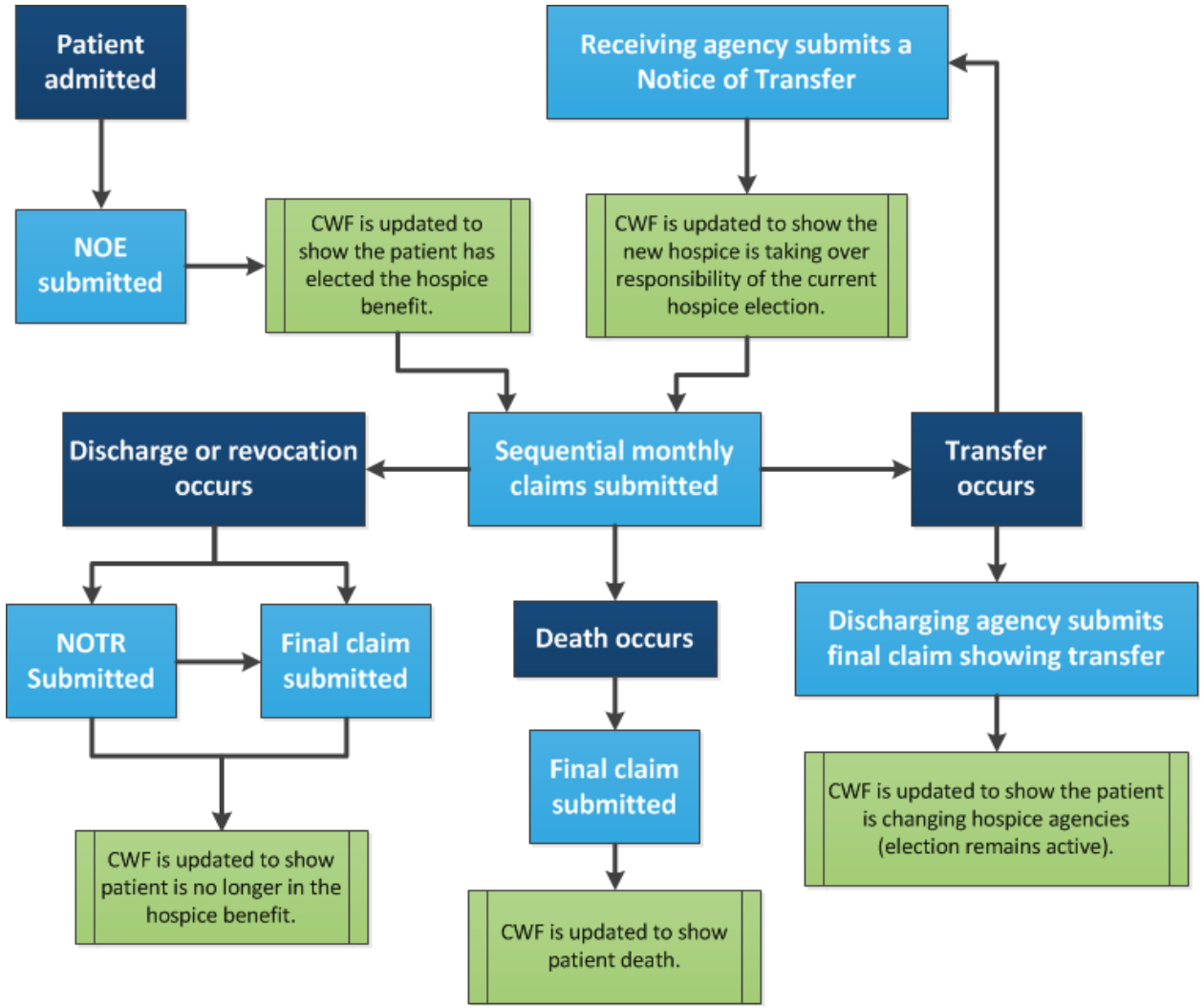
Timely Filing Requirement

- All Medicare FFS claims must be filed no later than one calendar year after date of service
  - Applies to initial submissions and adjusted/corrected claims
  - Based on date of discharge for inpatient claims
- Timely filing exceptions
  - Administrative error
  - Retroactive Medicare entitlement
  - Retroactive entitlement involving Medicaid
  - Retroactive disenrollment from MAO plan
    - ✓ CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1, Section 70 – Time Limitations for Filing Part A and Part B Claims

Hospice Billing Special Situations

- Claims for patients enrolled in MAO sent to HHH MAC
  - When patient elects hospice, traditional Medicare retains payment responsibility
- MSP - when patient has insurance primary to Medicare
  - Remember to submit MSP claims to HHH MAC to ensure benefit period kept current even if primary payer paid in full

Claim Billing Flow Chart



Hospice Billing Requirements

Hospice Claim Reporting Requirements

- Requirements include:
  - Patient information – name, address, gender, MBI
  - TOB
  - Dates of service
  - Admit date
  - Patient discharge reason
  - Patient status coding as applicable - CC, OC, OSC
  - Location(s) of care, level(s) of care
  - Disciplines (visits)
  - Prescription injectable and non-injectable drugs
  - Infusion pumps
  - Units
  - Charges

Type of Bill

- Allows FISS to process claims properly
- First digit indicates type of provider
  - 8 = Hospice
- Second digit indicates the type of hospice
  - 1 = Nonhospital-Based
  - 2 = Hospital-Based
- Third digit indicates sequence
  - 811 or 821 - Admit through discharge claim
  - 812 or 822 – First claim in series (interim billing)
  - 813 or 823 – Continuing claim in series
  - 814 or 824 – Final claim in series

Admission/Start of Care Date

- Admission date must be same date as effective date of patient's hospice election or change of election
- Stays the same on all continuing claims for the same hospice election
- May not precede physician's certification by more than two calendar days

Common Condition Codes

Code	Title	Definition
20	Beneficiary Requested Billing	Hospice realizes services at noncovered level of care or otherwise excluded from coverage, but patient requested formal determination
21	Billing for Denial Notice	Hospice realizes services at noncovered level of care or otherwise excluded from coverage, but needs denial notice from Medicare in order to bill Medicaid or other insurers
H2	Discharge by Hospice Provider for Cause	Used by hospice to indicate patient meets hospice's documented policy addressing discharges for cause
52	Out of Hospice Service Area	Patient discharged for moving out of hospice service area, including: • Relocate or go on vacation outside of hospice's service area • Admitted to hospital or SNF without contractual arrangement
85	Delayed recertification of hospice terminal illness	Hospice received recertification of terminal illness later than 2 days after first day of new benefit period • Report with OSC 77 and non-covered (provider-liable) days

Common Occurrence Codes

Code	Title	Definition
23	Cancellation of Hospice Election Period	Date on which hospice period of election cancelled by HHH MAC as opposed to revocation by beneficiary (HHH MAC USE ONLY)
24	Date Insurance Denied	Date of receipt of denial of coverage by higher priority payer (MSP)

27	Date of Hospice Certification or Recertification	Date of certification or recertification of hospice benefit period
		• If patient in first certification period when they transfer to another hospice
		  • Receiving hospice uses same certification date as transferring hospice until next certification period
		  • If patient in next certification at transfer, enter that date with OC 27

42	Date of Termination of Hospice Benefit	Indicates the date on which beneficiary terminated his/her election to receive hospice benefits (not used for transfers) • Used on NOTR only when correcting revocation date (use for original date)
55	Beneficiary is Deceased	Date of death, reported with appropriate discharge status code that best describes place in which beneficiary died (40, 41, or 42)

Common Occurrence Span Codes

Code	Title	Definition
M2	Dates of Inpatient Respite Care	Used when inpatient respite care provided more than once during benefit period • Enter from/through dates of periods of inpatient respite care to differentiate separate respite periods of less than 5 days each
77	Provider Liability – Utilization Charged	From/Through dates for period of non-covered hospice care for which hospice accepts payment liability (other than for medical necessity or custodial care)

Common Value Codes

Code	Title	Definition
61	Place of Residence where Service Furnished	Hospices must report when billing revenue codes 0651 (routine home care) or 0652 (continuous home care) • Enter MSA or CBSA number (or rural State code) of location where hospice service delivered • Residence can be inpatient facility if patient uses that facility as place of residence
G8	Facility where Inpatient Hospice Service Delivered	Hospices must report when billing revenue codes 0655 (general inpatient care) or 0656 (inpatient respite care) • Enter MSA or CBSA number (or rural State code) of facility where inpatient hospice services delivered

- FY 2023 Final Hospice Wage Index

Patient Discharge Coding

Patient Status Code	Description
01	Discharged to home or self-care
30	Still patient
40	Expired at home
41	Expired in a medical facility
42	Expired – place unknown
50	Discharged/transferred to hospice – home
51	Discharged/transferred to hospice – medical facility

Patient Discharge Coding

Discharge Reason	Coding Required in Addition to Patient Status Code
Patient moves out of service area	Condition Code 52
Patient transfers hospice agencies	No other indicator
Patient no longer terminally ill	No other indicator
Patient discharged for reason	Condition Code H2
Patient revokes hospice	Occurrence Code 42

Hospice Levels of Care

- RHC
  - Most common, used when no other level of care appropriate

Hospice Levels of Care

- CHC
  - Care provided at home during crisis
  - Hospice provides minimum of eight hours of nursing, hospice aide, and/or homemaker care during a 24-hour day
    - ✓ 24 hours begins and ends at midnight
  - Services provided must be predominantly nursing care
    - ✓ Provided by either RN, LPN or LVN
  - Services provided by NP included under nursing care
    - ✓ When NP not patient's attending physician
    - ✓ Services performed by NP instead of RN, LPN, or LVN so cannot be billed separately
  - Homemaker or hospice aide services may be provided to supplement nursing care

Hospice Levels of Care

- Inpatient Respite Care
  - Short term inpatient care to relieve family members or others caring for hospice beneficiary at home
  - Must be arranged by hospice and provided in Medicare participating facility
    - ✓ Hospital
    - ✓ Hospice inpatient facility
    - ✓ Nursing facility (includes facilities participating in Medicaid)
  - Cannot be covered by Medicare for more than five consecutive days at a time
  - Can be covered more than once per hospice benefit period
    - ✓ Report OSC M2

Hospice Levels of Care

- GIP
  - Provided only when beneficiary requires intensity of care directed towards pain control and symptom management that cannot be managed in any other setting
  - Inpatient care provided in Medicare participating:
    - ✓ Acute hospital
    - ✓ Skilled nursing facility
    - ✓ Hospice inpatient facility

How to Report Level of Care

- Changes in levels of care reported in chronological order as they occur in monthly billing period
- Levels of care incorrectly reported on claims cause of hospice high/low payment rates issues for routine home care
  - May also affect SIA payments

Levels of Care – Claim Coding

- Revenue codes 0651, 0655 and 0656
  - Reported per day
  - Separately dated line item for level of care each time level of care/location changes
    - ✓ Routine home care, inpatient respite care, general inpatient care
- Revenue code 0652
  - Reported using number of hours of continuous home care provided on date
    - ✓ Parts of hours rounded to 15-minute increments
  - Separately dated line item for each day that continuous home care provided

Levels of Care – Claim Coding

Level of Care	Revenue Code	Applicable Place or Service HCPCS Code	Service Units Measurements
Routine Home Care	0651	Q5001 – Q5010	Day
Continuous Home Care	0652	Q5001 – Q5003; Q5009 – Q5010	15-minute increments
Inpatient Respite Care	0655	Q5003 – Q5009	Day
General Inpatient Care	0656	Q5003 – Q5009	Day

Level of Care Claim Example #1

- Correct reporting of changes in patient's level of care
  - Routine home care
    - ✓ 8/1/23 – 8/11/23
  - Inpatient respite care
    - ✓ 8/12/23 – 8/16/23
  - Routine home care
    - ✓ 8/17/23 – 8/30/23

Revenue Code	HCPCS Code	Service Date	Units
0651	Q5001	080123	11
0655	Q5006	081223	5
0651	Q5001	081723	14

Level of Care Claim Example #2

Revenue Code	HCPCS Code	Service Date	Units
0651	Q5001	080123	25
0655	Q5006	081223	5

- Incorrect reporting of changes in patient's level of care
  - Grouped onto one line item instead of breaking out into two different start dates for RHC
  - Will cause FISS to assign days incorrectly
    - ✓ Routine home care days as first 25 days of care for reporting period
    - ✓ Inpatient respite days as last 5 days of period

Type of Service/Location Coding

HCPCS Code	Description
Q5001	Hospice care provided in patient's home/residence
Q5002	Hospice care provided in assisted living facility
Q5003	Hospice care provided in nursing LTC or non-skilled nursing facility
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 hospice facility

Calculating CHC Units

Units	Minutes (< means less than)
1	< 23 minutes
2	= 23 minutes to < 38 minutes
3	= 38 minutes to < 53 minutes
4	= 53 minutes to < 68 minutes
5	= 68 minutes to < 83 minutes
6	= 83 minutes to < 98 minutes
7	= 98 minutes to < 113 minutes
8	= 113 minutes to < 128 minutes
9	= 128 minutes to < 143 minutes
10	= 143 minutes to < 158 minutes

Hospice Physician, NP & PA Services

- Physician, NP or PA services on hospice claims
  - Services performed by physician/NP/PA employed by or under contract with the hospice or is volunteer
  - Must be medically necessary and related to terminal diagnosis
- Billed along with the levels of care and discipline visits
- Reported w/ revenue code 0657
  - Must be accompanied by physician procedure code
    - ✓ HCPCS
- MAC Collaboration Job Aide Flow Chart
  - Billing Hospice Physician, Nurse Practitioner (NP) and Physician Assistant (PA) Services (Related to Terminal Diagnosis) Job Aid

Visit Coding

Revenue Code	Description	HCPCS Code	Required Detail
0250	Non-injectable Prescription Drugs	N/A	Report a monthly charge total for all drugs
029X	Infusion Pumps	Applicable HCPCS	Report on line-item basis per pump order and per medication refill, using revenue code 029X for the equipment and 0294 for the drugs along with appropriate HCPCS
042x	Physical Therapy	G0151	Each visit identified on separate line item with appropriate line-item date of service and charge amount
044x	Speech Language Pathology	G0153	Each visit identified on separate line item with appropriate line-item date of service and charge amount

Visit Revenue and HCPCS Codes

Revenue Code	Description	HCPCS Code	Required Detail
055x	Skilled Nursing	G0299 or G0300	Each visit identified on separate line item with appropriate line-item date of service and charge amount
056x	Medical Social Services	G0155	Each visit identified on separate line item with appropriate line-item date of service and charge amount
0569	Other Medical Social Services	G0155	Each social service phone call is identified on a separate line item with the appropriate line-item date of service and a charge amount.
057x	Aide	G0156	Each visit identified on separate line item with appropriate line-item date of service and charge amount

Common Modifiers

Modifier	Description

PM	Post-mortem visits
	• Date of death as reported on death certificate
	• Report visits and length of visits that occur on the date of death after the patient has passed away
	  • Visits by nurses, aides, social workers, and therapists employed by the hospice
	  • Length of visits rounded to the nearest 15-minute increment
	• Post-mortem visits occurring on date after date of death are not to be reported
	• Report hospice visits that occur before death on separate line from those which occur after death

KX	Late NOE exception request • Report modifier with “Q” HCPCS code on earliest dated level of care line on claim • Also report OSC 77 with non-covered (provider-liable) days

Service Intensity Add-on Payment

- Social worker visits and nursing visits provided by RN provided during routine home care in last seven days of life
- Provided for visits of minimum of 15 minutes and maximum of four hours per day
  - From one unit to maximum of 16 units combined for both nursing visit time and/or social worker visit time per day
  - Time of a social worker's phone calls not eligible for SIA payment
- SIA payment in addition to routine home care rate

Deductible and Coinsurance

- No deductibles are applied to hospice services
- Coinsurance can only be charged in certain instances
  - Outpatient drugs and biologicals
    - ✓ 5% of the reasonable cost of the drug or biological, but not more than $5, for each prescription furnished
    - ✓ If hospice will charge coinsurance on drugs/biologicals, must establish a "drug copayment schedule" that specifies each drug and the copayment to be charged
      - Must submit this schedule to the HHH MAC in advance for approval
  - Inpatient respite care
    - ✓ 5% coinsurance amount up to inpatient hospital deductible amount
    - ✓ Based on national Medicare respite care rate after adjusting national rate for local wage differences

Services Hospices Do Not Bill For

- Physician/NP not employed or contracted by the hospice and is not volunteer
  - Physician/NP bills their Medicare FFS Part B MAC
  - Claims must include modifier
    - ✓ GV (attending physician)
    - ✓ GW (services unrelated to terminal condition)
- Services not related to terminal illness (facility settings)
  - Provider bills their Medicare FFS Part A MAC
    - ✓ Claims must include CC 07 (services unrelated to terminal condition)

Common Claim Errors

Reason Code 37402 – Return to Provider

- Hospice claim submitted, but either
  - Previous claim not found
  - Gap exists between “To” date of previous claim and “From” date on this claim
- Avoiding/Correcting This Error
  - Ensure prior month’s claim is in finalized status/location (PB9997)
  - Verify dates of service on claim
  - Verify claims submitted in date order (no missing months)

Reason Code U5181 - RTP

- Hospice claim generates new hospice benefit period and one of the following applies:
  - No NOE submitted/finalized prior to claim
  - NOE date not during dates on claim/during dates of OSC 77 when CC 85 on claim
  - CC 85 present but OC 27 date not day after OSC 77 thru date
- Avoiding/Correcting This Error
  - Ensure NOE submitted and finalized (PB9997)
  - Verify claims submitted in date order (no missing months)
  - Verify claim submitted with correct coding

Reason Code U5194 - RTP

- OSC 77 either missing or contains invalid dates and one of the following applies:
  - Initial hospice claim (from date = admit date) received but NOE not received timely
  - Receipt date on CWF HOSP file falls within from and thru date of incoming hospice claim
- Avoiding/Correcting This Error
  - When NOE not filed timely, hospice care days from hospice admission date to date NOE submitted to and processed by HHH MAC not covered
    - ✓ Must be identified on claim with OSC 77 with corresponding noncovered charges
    - ✓ Provider liable for days billed with OSC 7 - beneficiary cannot be billed
  - If exception requested, also report
    - ✓ KX modifier with site of service code (Q HCPCS) associated with earliest dated level of care line on claim
    - ✓ Remarks to explain valid reason for late NOE

Reason Code 38200 - Reject

- Claim exact duplicate of previously submitted claim
  - MBI number
  - TOB (all three positions of any TOB)
  - Provider number
  - Dates of service
  - Total charges (0001 revenue line)
  - Revenue code
  - HCPCS and modifiers (if required by revenue code file)
- Avoiding/Correcting This Error
  - All additions and/or corrections to processed claims must be adjustment claims
  - Before submitting claim, ensure it has not been previously submitted by reviewing remittance advice or using self-service tools

Reason Code U5600 - Reject

- Dates of service reported on this claim duplicate to another claim with same dates of service that previously processed
- Avoiding/Correcting This Error
  - All additions and/or corrections to processed claims must be adjustment claims
  - Before submitting a claim, ensure it has not been previously submitted by reviewing remittance advice or using self-service tools

Reason Code U5211 - Reject

- Claim from/through date greater than date of death on beneficiary master record
- Avoiding/Correcting This Error
  - Verify MBI and dates of service
    - ✓ If appropriate, correct information and submit new claim
  - If actual date of death was reported in error to Social Security office, that office must be contacted to correct the date
  - If beneficiary still alive, they must contact Social Security to correct

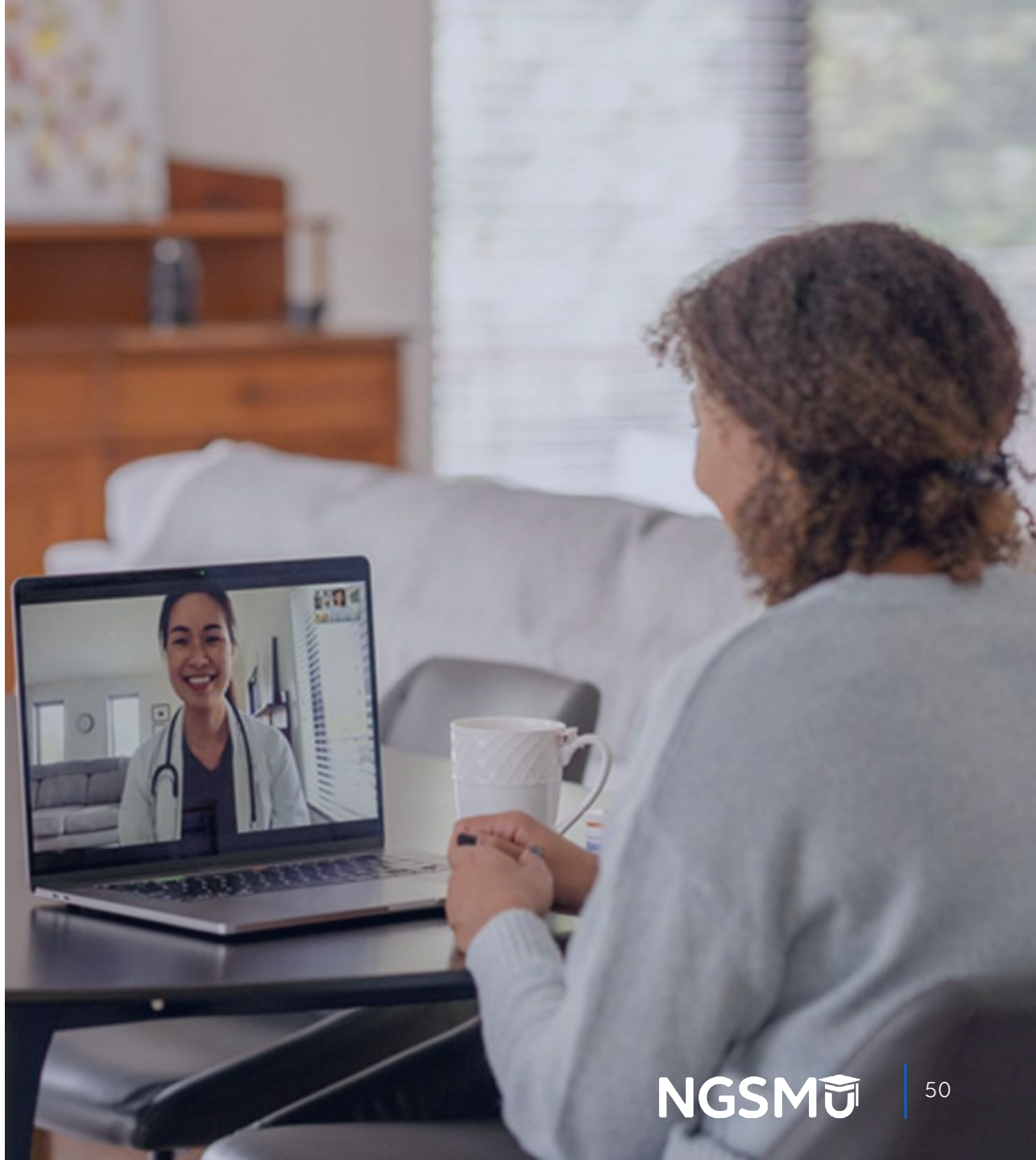
References and Resources

CMS Resources

- CMS website
  - IOMs
    - ✓ CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 1
    - ✓ CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 9
    - ✓ CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 11
  - Hospice Center
  - Medicare and Medicaid Programs: Hospice Conditions of Participation
  - Hospice Payment Rate Updates
  - The Medicare Learning Network®
    - ✓ Resource Materials
    - ✓ Training
    - ✓ MLN Matters Articles

National Government Services Web Resources

- NGS website
- Events
  - Upcoming education sessions
  - Material from prior webinars
- Education
  - Medicare Topics
    - ✓ Hospice Billing (job aids)
- Medicare University
    - ✓ CBT courses



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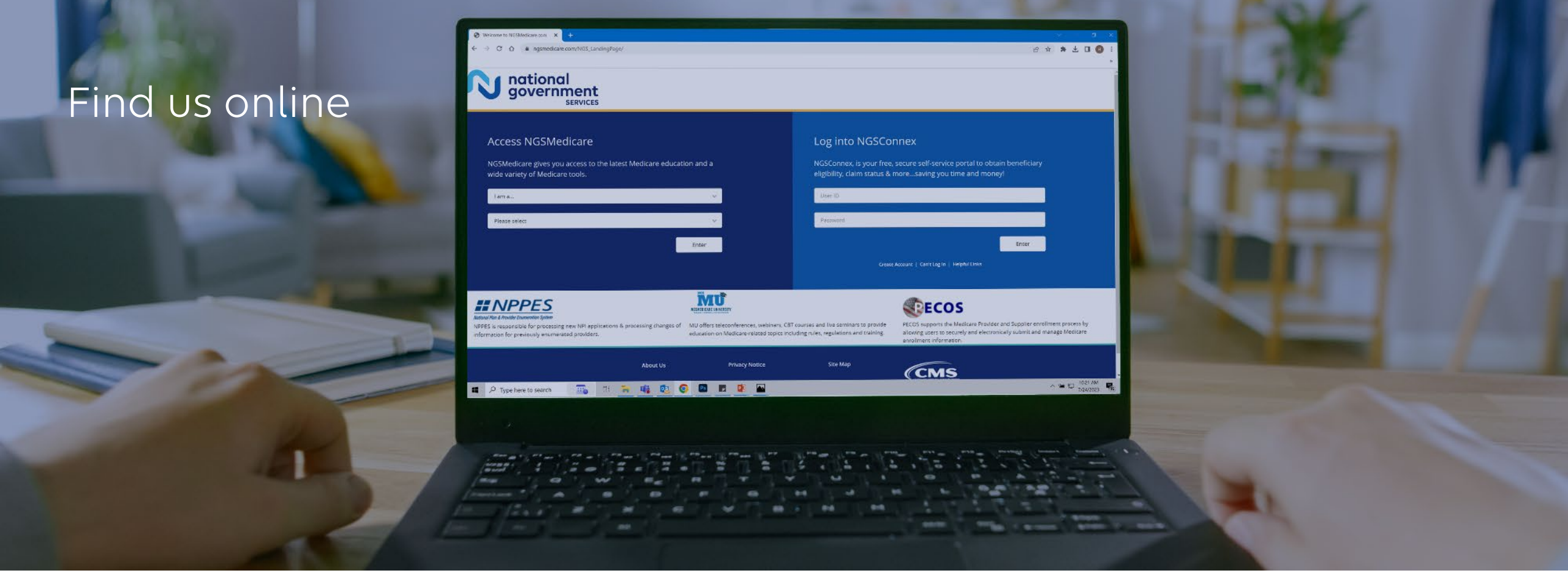

www.NGSMedicare.com
Online resources, event calendar, LCD/NCD, and tools

IVR System
The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries

NGSConnex
Web portal for claim information

Sign up for Email Updates
Subscribe for Email updates at the top of any NGSMedicare.com webpage to stay informed of news

PCC – To Call or Not to Call?

- YES
  - Clarify why claim processed (paid, rejected, denied) the way it did
  - Obtain assistance with general Medicare information/billing questions
  - How to use the IVR system, NGSConnex or NGSMedicare.com website
  - Other complex issues that cannot be addressed through self-service tools
- NO
  - Obtain beneficiary eligibility, claim status, or any other information available through self-service tools
  - Ask what modifiers, diagnosis codes, CPT codes or HCPCS to use for specific claims or beneficiaries
  - Note - PCC not allowed to answer inquiries from beneficiaries or their representatives

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9/13–15/2023

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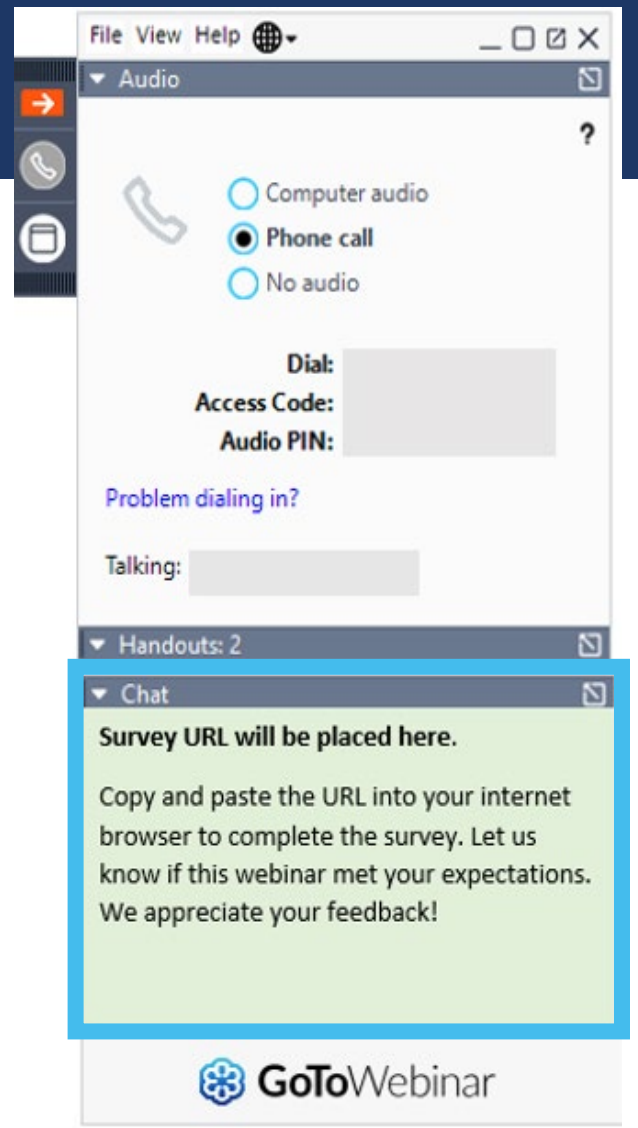

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