2022 Home Health & Hospice Medicare Administrative Contractors Collaborative Summit: *One Program, One Voice*

Session #: 8

Session Title: Hospice Billing Workshop – Billing Monthly Claims and Transfers

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Session Presenter(s)

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Objectives

- Cover basic information on properly submitting hospice billing for payment
- Focus on billing period of care claims after an election is opened
- Review reminders for completing a transfer, proper billing and the requirements for monthly claim submissions, including: level of care changes, ensuring use of the proper Core-Based Statistical Areas (CBSAs) Code, required coding for proper claim filing and additional topics that focus on claims and transfers

Agenda

- Hospice Transfers
- Proper Claim Coding
  - Levels of Care
  - Service Locations
  - Core-Based Statistical Areas (CBSAs) Codes
  - Modifiers
  - Patient Discharge Status
  - And More

Hospice Transfers

Transfer- Definition

- A patient may change, once in each benefit period, the designation of the particular hospice from which he or she elects to receive hospice care
- The change of the designated hospice is not considered a revocation of the election, but is a transfer
- Where one hospice discharges a patient and another hospice admits the same patient on the same day, each hospice is permitted to bill, and each will be reimbursed at the appropriate level of care (LOC) for its respective day of discharge or admission

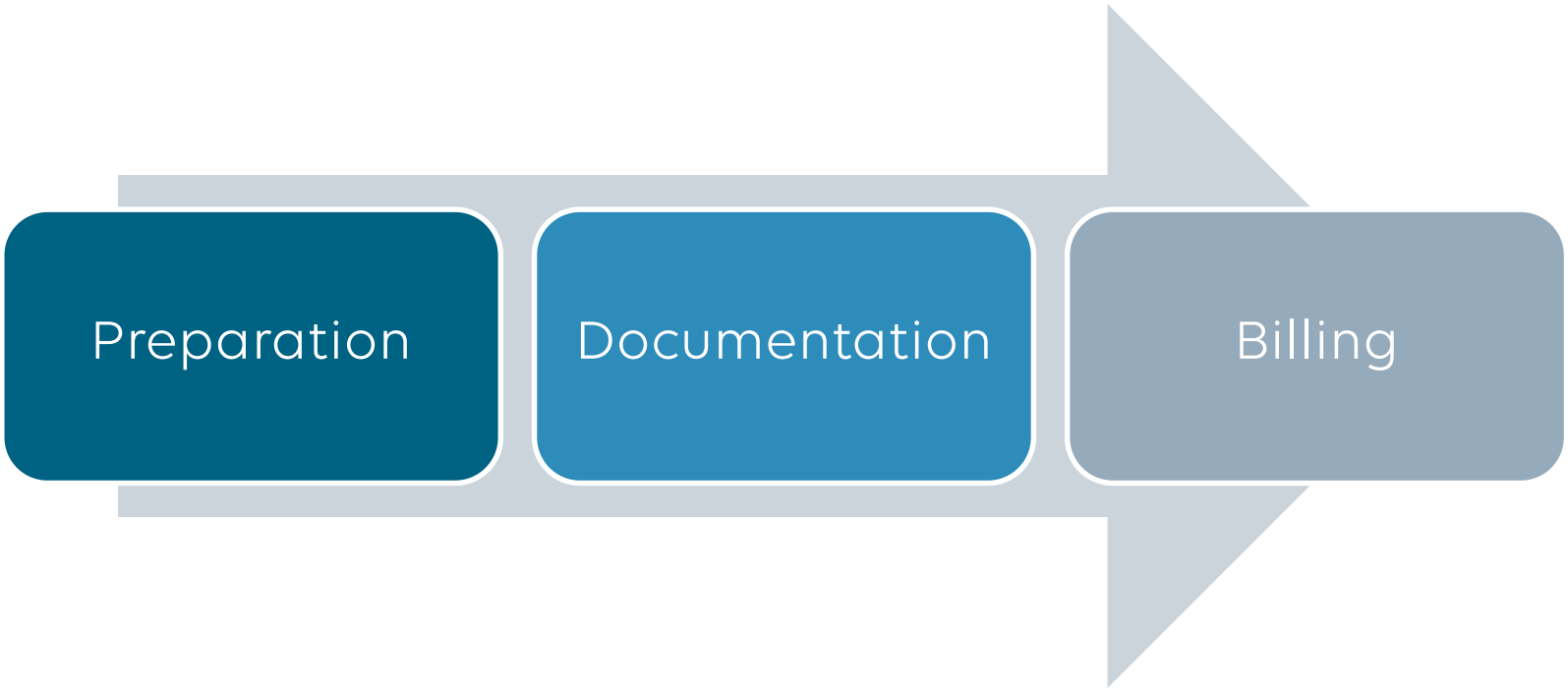
Transfer Statement Requirements

- To change hospice agencies, the patient/representative must file a transfer statement with both agencies
  - Either hospice agency may obtain the transfer statement
- The expectation is that the receiving and/or the transferring hospice agency will assist the patient/representative with completing the transfer agreement
- Both hospice agencies should agree on date of transfer
  - —Valid transfer must occur on the same day as of 7/1/2022
  - —No gaps in dates of service

Transfer Statement Requirements

- An individual must file with the hospice agency from which he or she has received care and with the newly designated hospice agency, a signed statement that includes the following information
  - —The name of the hospice agency from which the individual has received care
  - —The name of the hospice agency from which they plan to receive care, and
  - —The date the change is to be effective

Transfer Process



Communication is Key!

Transferring Agency Documentation Responsibilities

- Provide documentation of care to receiving hospice agency
  - Copy of transfer agreement (if initiating)
  - **Any documentation** to assist in the transition of care
    - FTF (if applicable)
    - Plan of care
    - Beneficiary election statement
    - Physician certification/recertification of terminal illness

Transferring Agency Billing Responsibilities

- Submit the final claim (TOB 8X4) as quickly as possible
  - Even if the patient admits and transfers in the same month you must submit a bill type of 8X4
    - Ensure the following are included on the 8X4
      - "Through" Date is the last day that the patient was on service with the hospice agency
      - Patient Discharge Status Code must be 50 or 51
        - 50 – Discharged/transferred to hospice (home)
        - 51 – Discharged/transferred to hospice (medical facility)
    - Do **not** submit an occurrence code 42

Receiving Agency Documentation Responsibilities

The hospice agency receiving the patient **must have a signed transfer agreement** to assume care of the patient and bill Medicare

- Receiving agency may request
  - Beneficiary election statement
  - Physician certification/re-certification
  - Plan of care
  - Face-to-face (if applicable)
    - *If the patient is in a third or later benefit period and transfers hospice agencies, a FTF encounter is not required if the receiving hospice agency can verify that the originating agency had the encounter*

CMS IOM Publication 100-02, *Medicare Benefit Policy Manual.*
Chapter 9 Coverage of Hospice Services Under Hospital Insurance, Section 20.2.1

Receiving Agency Documentation Responsibilities

- Review all documentation received for completeness and accuracy
- When **incomplete** or **inaccurate** information is received the receiving hospice agency may obtain or create the documentation; this would include the
  - Beneficiary election statement
  - Physician certification/recertification
  - FTF untimely/invalid
    - Consider admission, NOT transfer

Receiving Agency Billing Responsibilities

- Notice of Change (TOB 8XC)
  - Ensure previous (transferring)hospice agency has submitted their final claim (8X4) before submitting the 8XC
  - An 8XC must be entered prior to submitting the first claim
  - The 8XC notifies the contractor and CWF that the admission is a continuation of the current hospice benefit period

CMS IOM Publication 100-04, *Medicare Claims Processing Manual,*
Chapter 11 Processing Hospice Claims, Section 20.1.3

Receiving Agency Billing Responsibilities

- Complete either the Medicare Secondary Payer (MSP) questionnaire or MSP screening with the beneficiary
  - If unable to answer the questions, the hospice agency can reach out to the spouse, family member, legal guardian, power of attorney
  - Completed questions do not transfer between hospice agencies

CMS IOM Publication 100-05 *Medicare Secondary Payer (MSP) Manual,*
Chapter 3 MSP Provider, Physician, and Other Supplier Billing Requirements , Section 20 & Section 20.1

Receiving Agency Billing Responsibilities

- Notice of Change (TOB 8XC)
  - Ensure that the following are correctly reported on the 8XC
    - Statement Covers Period (From-Through)
      - "From" date is the date of the change is effective
    - Admission date
      - Admit date is the date of the transfer (must match the "From" date)
    - Occurrence Code 27 and date
      - Is not required on a transfer notice, unless the date of transfer is also the first day of the next benefit period

CMS IOM Publication 100-04 *Medicare Claims Processing Manual,*
Chapter 11 Processing Hospice Claims, Section 20.1.3 change of Provider/Transfer Notice

Receiving Agency Billing Responsibilities

- Occurrence Code 27 Example
  - Example: benefit period (0302XX–0501XX)
    - Transfer date: 0302XX
    - OC27 0302XX
  - Example: benefit period (0302XX–0501XX)
    - Transfer date: 0405XX
    - OC27 not entered on the 8XC
      - CMS IOM Publication 100-04 *Medicare Claims Processing Manual*, Chapter 11 Processing Hospice Claims, Section 20.1.3 Change of Provider/Transfer

Gap Billing Between Hospice Transfers

- MLN Matters Number: MM12619
- Related Change Request (CR) Number 12619
- Effective Date: 7/1/2022
- Implementation Date: 7/5/2022

Gap Billing Between Hospice Transfers

- CR 12619 creates a new CWF edit that no longer allows gaps of care to occur during a transfer.
- The CWF edit will reject the hospice transfer if the transfer doesn't occur immediately and there's a gap in the number of billing days between one hospice and the next.
  - If the receiving hospice's claim "from date" is not the same as the transferring hospice's "through date" with "patient status" indicating a transfer (codes 50 or 51), the transfer will be rejected.
    - The 8XC date will need to match the transferring hospice's "through date"

Gap Billing Between Hospice Transfers

- Additionally, CR 12619 states:
  - Transfers aren't allowed from the same provider. Hospices must not send an 8XC if the CMS Certification Number (CCN) is the same. In this case, the patient isn't transferred to another hospice, they're transferred to another location of the same hospice.
  - CR 12619 also updates CMS IOM Publication 100-04, *Medicare Claims Processing Manual, C*hapter 11, - Processing Hospice Claims, Section 20.1.3 - Change of Provider/Transfer Notice to include additional instructions about hospice transfers.

Transferring Outside the Service Area

- Additionally, CR 12619 states:
  - If the patient is transferring from outside the service area and the transferring hospice can't arrange care until the patient reaches the new hospice, the hospice may discharge the patient.
  - This way, if the patient requires medical treatment while in the process of transferring, he or she can access it under his or her Original Medicare coverage
  - This would end the patient's current benefit period and require the patient to re-elect hospice coverage

Claim Coding

Levels of Care Data Reporting on a Claim

- Changes in the levels of care need to be reported in chronological order as they occur in the monthly billing period.
  - Levels of care incorrectly reported on claims is the cause of hospice high/low payment rates issues for routine home care and may also affect Service Intensity Add-on (SIA) payments

Levels of Care Data Reporting on a Claim

Revenue Code	Revenue Code	Place or Service	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

Levels of Care Data Reporting on a Claim

Correct reporting of changes in a patient's levels of care

Revenue Code	HCPC	Service Date	Units
0651	Q5001	0601	11
0655	Q5006	0612	5
0651	Q5001	0617	14

Levels of Care Data Reporting on a Claim

Incorrect reporting of changes in a patient's levels of care

Revenue Code	HCPC	Service Date	Units
0651	Q5001	0601	25
0655	Q5006	0612	5

This coding will cause the system to count 25 RHC days as the first 25 days of care for the reporting period and the respite days to the last 5 days of the period.

Continuous Home Care (CHC)

- Hospice must provide a minimum of 8 hours of nursing, hospice aide, and/or homemaker care during a 24-hour day, which begins and ends at midnight
- Services provided must be predominantly nursing care, provided by either an RN, an LPN, or an LVN
  - Services provided by a nurse practitioner that would be performed by an RN, LPN, or LVN, are nursing services and are paid at the same CHC rate
- Homemaker or hospice aide services may be provided to supplement the nursing care

Calculating 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

Type of Service Location for Hospice Services

HCPCS Code	Definition
Q5001	Hospice care provided in patient's home/residence
Q5002	Hospice care provided in assisted living facility
Q5003	Hospice care provided in nursing long term care facility (LTC) or non-skilled nursing facility (NF)
Q5004	Hospice Care Provided In Skilled Nursing Facility (SNF)
Q5005	Hospice care provided in inpatient hospital
Q5006	Hospice care provided in inpatient hospice facility
Q5007	Hospice Care Provided In Long Term Care Hospital (LTCH)
Q5008	Hospice care provided in inpatient psychiatric facility
Q5009	Hospice care provided in place not otherwise specified (NOS)
Q5010	Hospice home care provided in a hospice facility

Core-Based Statistical Area (CBSA)

- Value code 61 w/ CBSA code
  - Hospices must report when billing revenue codes 0651 and 0652
- Value code G8 w/ CBSA code
  - Hospices must report when billing revenue codes 0655 and 0656

FY 2022 Final Hospice Wage Index

FY 2023 Final Hospice Wage Index

Patient Discharge 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

Visit Revenue Codes

Revenue Code	Required HCPCS	Required Detail
250 Non-injectable Prescription Drugs	N/A	On and after 10/1/2018: Report a monthly charge total for all drugs
029X Infusion pumps	Applicable HCPCS	Report 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.
042x Physical Therapy	G0151	Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount.
044x Speech Therapy – Language Pathology	G0153	Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount.

Visit Revenue Codes (CONT)

Revenue Code	Required HCPCS	Required Detail
055x Skilled Nursing	G0299 or G0300	Each visit is identified on a separate line item with the appropriate line item date of service and a charge amount.
056x Medical Social Services	G0155	Each visit is identified on a separate line item with the appropriate line item date of service and a 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 is identified on a separate line item with the appropriate line item date of service and a charge amount.

Modifiers

Modifier	Description
PM	Post-mortem visits • Hospices shall 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, that occur on the date of death, after the patient has passed away. • Visits occurring on a date subsequent to the date of death are not to be reported
KX	Late NOE exception request • Report a KX modifier with the Q HCPCS code on the earliest dated level of care line on the claim • Reported with occurrence span code 77 used to identify the non-covered, provider liable days

Billing Hospice Physician, Nurse Practitioner and Physician Assistant Services (Related to Terminal Diagnosis)

- When medically necessary, related to terminal diagnosis physician/NP/PA services preformed by a physician/NP/PA employed by, or under contract with the hospice can be billed on hospice claims (81x or 82x), along with the levels of care and discipline visits.
- Reported w/ revenue code 0657
  - Must be accompanied by a physician procedure code

MAC Collaboration Job Aide: Billing Hospice Physician, Nurse Practitioner (NP) and Physician Assistant (PA) Services (Related to Terminal Diagnosis) Job Aid

Home Health & Hospice References & Resources

CMS Home Health Resources

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 7
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 10
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 6
- Medicare & Medicaid Program: Conditions of Participation for Home Health Agencies

CMS Hospice Resources

- *Medicare Contractor Beneficiary and Provider Communications Manual*
- CMS IOM Publication 100.02, *Medicare Benefit Policy Manual,* Chapter 9, Coverage of Hospice Services Under Hospital Insurance
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 11, Processing Hospice Claims
- Hospice Code of Federal Regulations
- Model Hospice Election Statement Example
- Model Hospice Election Statement Addendum Example

CMS Home Health & Hospice Resources

- HH PPS web page
- Home Health Agency (HHA) Center
- MLN® Publication, “Home Health Prospective Payment System”
- Hospice Center Webpage
- Hospice Code of Federal Regulations
- The Medicare Learning Network®

MAC Contact Information

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Jurisdiction 15

- Website
  - LCDs and Policy Articles – See website, LCDs/Medical Policies Tab
- IVR Unit – 877-220-6289
- myCGS Web Portal
- Customer Service – 877-299-4500
  - Option 1 – Customer Service
  - Option 2 – Electronic Data Interchange (EDI)
  - Option 3 – Provider Enrollment
  - Option 4 – Overpayment Recovery (OPR)

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- CMS MLN Web page: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo
  This includes the MN Connects, MLN articles, and more.
- Electronic Mailing List page at: https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Electronic-Mailing-Lists
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- Website
- IVR Unit – 877-277-7287
- Provider Contact Center – 866-590-6724
- LCDs and Policy Articles – See website, Medical Policy & Review Tab, Medical Policy Center

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- Website
- IVR & Provider Contact Center – 855-696-0705
  - TDD: 866-830-3188
  - Palmetto GBA IVR HHH Call Flow
- eServices Portal
  - Palmetto GBA's free Internet-based, provider self-service portal.
- LCDs and Policy Articles – See website, Medical Policy & Review Tab, Medical Policy Center

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Medicare University Self-Reporting Instructions

- Log on to the National Government Services Medicare University site
  - Course Topic/Title = 2022 HHH Medicare Administrative Contractors Collaborative Summit: *One Program One Voice*
  - Session #: 8
  - Session Title: Hospice Billing Workshop: Billing Monthly Claims & Transfers
  - Medicare University Credits (MUCs) = 1
  - Catalog Number = AA-C-06674
  - Participant Code = 22256SRSRS8
  - For step-by-step instructions on self-reporting please visit the Get Credit for Completed Courses on the NGS website

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