



Related MLN Matters Article #: MM5745

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### *Billing Instructions Regarding Payment for Hospice Care Based on Location Where Care is Furnished*

#### Key Words

MM5745, CR5745, R1352CP, Hospice

#### Provider Types Affected

Providers who bill Regional Home Health Intermediaries (RHHI) for inpatient hospice care for Medicare beneficiaries

#### Key Points

- The effective date of the instruction is January 1, 2008.
- The implementation date is January 7, 2008.
- Change Request (CR) 5745 instructs hospices how to bill for the location where the hospice provides inpatient levels of hospice care.
- Currently, not all Medicare payments for hospice services are wage adjusted based on the location where the service is furnished.
- For example, Medicare now uses the core based statistical area (CBSA) on the hospice facility's provider file as the basis for the wage adjustment of inpatient hospice levels of care. This assumes that any inpatient levels of care are provided at an inpatient facility (either at the hospice itself or under arrangements with a facility within the same CBSA).
- Alternatively, Medicare uses the CBSA of the beneficiary's residence as the basis for wage adjustment of Routine Home Care (RHC) and Continuous Home Care (CHC) levels of care (revenue code 651 and 652).
- The beneficiary's residence CBSA (whether or not it is an inpatient setting) is currently reported on the claim using value code 61 (defined by the National Uniform Billing Committee (NUBC) as "Location Where Service is Furnished (Home Health Agency and Hospice))."
- However, while this definition of value code 61 is broad enough to include both home and facility settings, the code itself does not distinguish between the two locations.
- There may be circumstances where RHC and CHC are provided in inpatient settings, as these settings may serve as the beneficiary's place of residence.

- Since hospice providers frequently bill both home and inpatient levels of care on the same claim, when multiple instances of value code 61 are reported, the claim would not distinguish which CBSA code corresponded to which level of care.
- While requiring hospices to bill separately for home versus inpatient levels of care would meet Medicare's need in terms of making accurate payment without making a value code change, this could create unnecessary administrative burden on hospices.
- Moreover, by artificially increasing the number of hospice claims, it would increase Medicare's administrative costs.
- To avoid these impacts, the Centers for Medicare & Medicaid Services (CMS) asked the NUBC to approve a new value code to distinguish a facility CBSA from the currently reported residence CBSA.
- This code allows providers to continue the current practice of billing all hospice services on a single monthly claim while enabling Medicare to wage adjust the services on that claim accurately under the new regulation.
- The NUBC approved this new code (value code G8) effective January 1, 2008. The NUBC also redefined value code 61 to apply to residence locations only. These codes and their definitions are displayed in Table 1 on page 3 of MLN Matters 5745.

### Important Notes

- If hospice services are provided to the beneficiary in more than one CBSA area during the billing period, the provider should report the CBSA that applies at the end of the billing period.
- This applies for either RHC and CHC (e.g., the beneficiary's residence changes between locations in different CBSAs) or for general inpatient and inpatient respite care (e.g., the beneficiary is served in inpatient facilities in different CBSAs.).
- Providers should enter the five digit CBSA on their claims with two trailing zeroes placed in the "amount" field (i.e., if the CBSA is 10180, the provider should enter 1018000).

### Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5745.pdf> on the CMS website.

The official instruction (CR5745) regarding this change may be viewed at

<http://www.cms.gov/Transmittals/downloads/R1352CP.pdf> on the CMS website. Providers will find the updated *Claims Processing Manual*, Chapter 11 (Processing Hospice Claims), Section 30.3 (Data Required on Claim to FI) as an attachment to that CR.

Providers may want to review related MLN Matters articles MM5567 (Reporting of Additional Data to Describe Services on Hospice Claims) at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5567.pdf> and CR5245 (Reporting of Additional Data to Describe Services on Hospice Claims) at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm5245.pdf> on the CMS website.

If providers have questions regarding this issue, they may contact their RHHI at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.