

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services



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MLN Matters® Number: MM8569 **Revised**

Related Change Request (CR) #: CR 8569

Related CR Release Date: April 10, 2014

Effective Date: July 1, 2014

Related CR Transmittal #: R2928CP

Implementation Date: July 7, 2014

### **Enforcement of the 5 Day Payment Limit for Respite Care under the Hospice Medicare Benefit**

**Note: This article was revised on April 10, 2014, to reflect the revised CR8569, issued on April 10. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.**

#### **Provider Types Affected**

This MLN Matters® Article is intended for providers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

#### **Provider Action Needed**

This article, based on Change Request (CR) 8569, instructs MACs to implement system edits to prevent payment of respite care for more than 5 days at a time for any hospice claim submitted on or after July 1, 2014. This instruction will enforce the current policy that limits payment of respite care to no more than 5 consecutive days. Make sure your billing staffs are aware of this update.

#### **Disclaimer**

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## Background

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The Code of Federal Regulations (CFR) 42, Part 418.302, states that payment for inpatient respite care is subject to the requirement that it may not be provided consecutively for more than 5 days at a time. Payment for the sixth and any subsequent day of respite care is made at the appropriate home care rate. In an effort to prevent potential overpayments in the Medicare Hospice benefit, CR8569 implements new edits to prevent payment of respite care for more than 5 days at a time for any hospice claim submitted on or after July 1, 2014.

Since respite care is payable only for periods of respite up to 5 consecutive days, claims reporting respite periods greater than 5 consecutive days will be Returned to the Provider (RTP). Days of respite care beyond 5 days must be billed at the appropriate home care rate for payment consideration. When a MAC RTPs a claim, it will include an external narrative on the RTP reason code stating that respite care exceeding 5 consecutive days must be billed as routine home care and are not to be included in the M2 occurrence span code.

For example: If the patient enters a respite period on July 1 and is returned to routine home care on July 6, the units of respite reported on the line item would be 5 representing July 1 through July 5, July 6 is reported as a day of routine home care regardless of the time of day entering respite or returning to routine home care.

When there is more than one respite period in the billing period, the provider must include the M2 occurrence span code for all periods of respite. The individual respite periods reported shall not exceed 5 days, including consecutive respite periods.

For example: If the patient enters a respite period on July 1 and is returned to routine home care on July 6 and later returns to respite care from July 15 to July 18, and completes the month on routine home care, the provider must report two separate line items for the respite periods and two occurrence span code M2, as follows:

### Revenue Line items:

- Revenue code 0655 with line item date of service 07/01/XX (for respite period July 1 through July 5) and line item units reported as 5
- Revenue code 0651 with line item date of service 07/06/XX (for routine home care July 6 through July 14) and line item units reported as 9
- Revenue code 0655 with line item date of service 07/15/XX (for respite period July 15 through 17<sup>th</sup>) and line item units reported as 3
- Revenue code 0651 with line item date of service 07/18/XX (for routine home care on date of discharge from respite through July 31 and line item units reported as 14).

### Occurrence Span Codes:

- M2 0701XX – 0705XX
- M2 0715XX – 0717XX

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## Additional Information

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The official instruction, CR8569, issued to your MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2928CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. If you have any questions, please contact your MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

**News Flash** - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- [MLN Matters® Article #MM8433](#), “Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season”
- [MLN Matters® Article #SE1336](#), “2013-2014 Influenza (Flu) Resources for Health Care Professionals”
- [HealthMap Vaccine Finder](#) - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community.
- [Free Resources](#) can be downloaded from the CDC website including prescription-style tear-pads that will allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu. On the CDC order form, under “Programs”, select “Immunizations and Vaccines (Influenza/Flu)” for a list of flu related resources.

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