



News Flash – Medicare will cover immunizations for H1N1 influenza also called the "swine flu." There will be no coinsurance or copayment applied to this benefit, and beneficiaries will not have to meet their deductible. For more information, go to <http://www.cms.gov/About-CMS/Agency-Information/H1N1/index.html> on the CMS website.

MLN Matters® Number: MM6778 Revised

Related Change Request (CR) #: 6778

Related CR Release Date: February 5, 2010

Effective Date: Claims submitted on or after July 6, 2010

Related CR Transmittal #: R121BP and R1907CP

Implementation Date: July 6, 2010

Medicare Systems Edit Refinements Related to Hospice Services

Note: This article was updated on November 20, 2012, to reflect current Web addresses. This article was previously revised on October 29, 2010, to add a reference to related CR6905 (New Hospice Site of Service Code) in the Additional Information section below. All other information remains the same.

Provider Types Affected

Providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors (A/B MACs), Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries that have elected the hospice benefit.

Provider Action Needed

This article is based on Change Request (CR) 6778 which:

1. Revises existing Medicare standard systems edits to **allow Medicare fee for service (FFS) claims to process for beneficiaries in a Medicare Advantage plan on the date of a Medicare hospice election.**
2. Adds new edits ensuring the **appropriate place of service is reported for hospice general inpatient care (GIP), respite, and continuous home care (CHC); and**
3. **Provides a technical correction to the Medicare Benefit Policy Manual**

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regarding the requirement for nursing care related to hospice continuous home care.

Be certain your billing staffs are aware of these Medicare changes.

Background

Claims for Medicare Advantage (MA) Plan Beneficiaries Electing Hospice

In an effort to alleviate the often timely process involved for providers to resolve claim disputes on payment responsibility between MA plans and FFS Medicare, The Centers for Medicare & Medicaid Services (CMS) is revising the Medicare hospice and MA enrollment edit(s) for claims submitted on or after July 6, 2010 to allow claims to be processed by FFS Medicare for services occurring on the date of the hospice election. This will prevent services provided on the date of the election from rejecting as MA Plan responsibility. Providers that have claims being disputed may resubmit their claims on or after July 6, 2010 to FFS Medicare for payment consideration. Contractors will not be required to provide automated adjustments.

Place of Service for General inpatient care (GIP, Respite, and Continuous Home Care CHC)

Medicare hospice patients are able to receive hospice care in a variety of settings. CMS began collecting additional data on hospice claims in January 2007 with CR 5245, available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1011CP.pdf>, which required reporting of a Healthcare Common Procedure Coding System (HCPCS) code on the claim to describe the location where services are provided. Coverage and payment regulations at 42 CFR 418.202 and 418.302 define the locations where certain levels of care can be provided. GIP is described in the regulations at 42 CFR 418.202(e) as "short term inpatient care provided in a participating hospice inpatient unit, or a participating hospital or skilled nursing facility (SNF)..." Additionally, the regulations at 42 CFR 418.202(e) require that respite care be furnished in an inpatient setting, as described in 418.108, which limits care settings to a participating Medicare or Medicaid hospital, SNF, hospice facility, or nursing facility (NF). Finally, payment regulations at 42 CFR 418.302(a)(2) define CHC as "a day on which an individual who has elected to receive hospice care is not in an inpatient facility and receives hospice care consisting predominantly of nursing care on a continuous basis at home." Because CMS now has site-of-service data on hospice claims, they are able to use system edits to ensure more accurate billing of Medicare claims. CMS now edits claims to ensure that the level of care billed, for hospice, was provided at an appropriate site.

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To facilitate more accurate billing of Medicare hospice claims, CMS is implementing several edits within the claims processing system to return to providers (RTP), claims submitted on types of bill 81x or 82x for which hospice days are billed for services provided in non-covered settings. Claims for days of GIP care (revenue code 0656) will be RTP'd if HCPCS site of service locations Q5001 (patient's home/residence), Q5002 (assisted living facility), or Q5003 (nursing long term care facility of non-skilled nursing facility) are reported on the same line, as these are not appropriate settings for payment of GIP. GIP may only be provided at Medicare certified hospice facilities, hospitals, or SNFs.

Similarly, claims for respite days (revenue code 0655) will be RTP'd if HCPCS site of service codes Q5001 (patient's home/residence) or Q5002 (assisted living facility) are reported on the same line, as these are not appropriate settings for payment of this level of care. Respite care may only be provided in a Medicare or Medicaid participating hospital, SNF, hospice facility, or NF.

Finally, claims for days of CHC care (revenue code 0652) will be RTP'd if HCPCS site of service locations Q5004 (skilled nursing facility), Q5005 (inpatient hospital), Q5006 (inpatient hospice), Q5007 (long term care hospital), or Q5008 (inpatient psychiatric facility) are reported on the same line, as these locations are not appropriate settings to bill for payment of CHC. CHC may only be provided in the patient's home, and may not be provided in these types of facilities. We believe these edits will improve the accuracy of Medicare billing and payment for hospice services.

Technical Correction

Regulations at 42 CFR 418.204 describe CHC as being provided during periods of crisis as necessary to maintain an individual at home. The regulation requires that care provided on days billed as CHC be "predominantly nursing care". This means that more than half of the time the nurse, aide, or homemaker spends providing care must be nursing hours.

Manual Clarification Regarding Ambulance Transport on the Date of Hospice Election

CR 6778 also revises the Medicare Benefit Policy Manual to clarify policy regarding payment of ambulance transports on the effective date of hospice election. Hospices do not feel that they are responsible for an ambulance transport which occurs on the effective date of hospice election, if the hospice has not yet conducted their initial assessment.

The deciding factor in determining whether a hospice is financially responsible for an ambulance transport on the effective day of hospice election is when the transport occurred, relative to when all the hospice coverage and eligibility criteria are met. If an ambulance transport occurs on the date of hospice election, but

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before all the criteria for hospice eligibility and coverage are met (i.e. the initial assessment has been conducted and the plan of care has been developed and includes the ambulance transport), the hospice is not responsible for the transport and the ambulance transport is covered through the ambulance benefit.

Additional Information

If you have questions, please contact your MAC, carrier, RHHI or FI 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.

The official instruction, CR6778, was issued to your MAC, carrier, RHHI or FI regarding this change via two transmittals. The first, located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R121BP.pdf>, contains revisions to the Medicare Benefit Policy Manual. The second transmittal at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1907CP.pdf> contains revisions to the Medicare Claims Processing Manual.

MM5245, *Instructions for Reporting Hospice Services in Greater Line Item Detail*, is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5245.pdf> on the CMS website. For additional information regarding the Hospice Payment System see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/hospice_pay_sys_fs.pdf on the CMS website.

For information, regarding the addition of site of service code Q5010 for use when routine home care or continuous home care is provided at a hospice residential facility or a hospice facility certified to provide inpatient care, refer to MLN Matters® article MM6905 (*New Hospice Site of Service Code*) at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6905.pdf> on the CMS website.

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