DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters®

Information for Medicare Fee-for-Service Health Care Professionals

*News Flash –* The Centers for Medicare & Medicaid Services (CMS) has posted online the Monday, June 20, letter from CMS Administrator, Donald M Berwick, MD, that highlights opportunities for providers, Medicare beneficiaries, and patients not covered by Medicare as a result of the Affordable Care Act. The letter was sent to Medicare Fee-For-Service providers by the Medicare Administrative Contractors (MACs) during the week of Monday, June 20, and can be found at http://www.CMS.gov/MLNProducts/35_PreventiveServices.asp on the CMS website.

MLN Matters® Number: MM7473 Revised

Related Change Request (CR) #:7473

Related CR Release Date: July 29, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2258CP

Implementation Date: January 3, 2012

# Correction to Processing of Hospice Discharge Claims

Note: This article was revised on April 19, 2012, to emphasize that the implementation of this instruction is effective for claims on or after January 1, 2012. All other information is the same.

## Provider Types Affected

This MLN Matters® Article is intended for hospice providers who bill Medicare regional home health intermediaries (RHHIs) or Medicare Administrative Contractors (A/B MACs)) for hospice services provided to Medicare Beneficiaries.

## Provider Action Needed

CR 7473, from which this article is taken, contains no new policy. The requirements of CR7473 improve the implementation of longstanding policy under Medicare regulations at 42 CFR 418.26 and revise the Medicare system to ensure hospice discharge claims update the beneficiary's hospice benefit period correctly. Also, CR7473 makes various revisions to chapter 11 of the Medicare Claims Processing Manual to remove outdated language and clarify existing instructions by adding more detailed instructions for hospices in coding claims.

See the Background Section of this article for further details regarding the improvements that are effective as of January 1, 2012, and make certain your billing staffs are aware of the changes.

## Background

Medicare regulations at 42 CFR 418.26 outline three reasons for discharge from Hospice care:

1. The beneficiary moves out of the hospice's service area or transfers to another hospice;
2. The hospice determines that the beneficiary is no longer terminally ill; and
3. The hospice determines the beneficiary meets their internal policy regarding discharge for cause.

Each of these discharge situations requires different coding on Medicare claims.

Reason 1: A beneficiary may move out of the hospice's service area either with, or without, a transfer to another hospice. In the case of a discharge when the beneficiary moves out of the hospice's service area without a transfer, the hospice uses the National Uniform Billing Committee (NUBC) approved discharge status code that best describes the beneficiary's situation. The hospice does not report occurrence code 42 on their claim. This discharge claim will terminate the beneficiary's current hospice benefit period as of the "Through" date on the claim. The beneficiary may re-elect the hospice benefit at any time as long as they remain eligible for the benefit.

In the case of a discharge when the beneficiary moves out of the hospice's service area and transfers to another hospice, the hospice uses discharge status code 50 or 51, depending on whether the beneficiary is transferring to home hospice or hospice in a medical facility. The hospice does not report occurrence code 42 on their claim. This discharge claim does not terminate the beneficiary's current hospice benefit period. The admitting hospice submits a transfer Notice of Election (type of bill 8xC) after the transfer has occurred and the beneficiary's hospice benefit is not affected.

Reason 2: In the case of a discharge when the hospice determines the beneficiary is no longer terminally ill, the hospice uses the NUBC approved discharge status code that best describes the beneficiary's situation. The hospice also reports occurrence code 42 on their claim and the date of their determination. This discharge claim will terminate the beneficiary's current hospice benefit period as of the occurrence code 42 date. This coding may also be used if the beneficiary has chosen to revoke their hospice election. The beneficiary may re-elect the hospice benefit if they are certified as terminally ill and eligible for the benefit again in the future.

Reason 3: In the case of a discharge for cause, the hospice uses the NUBC approved discharge status code that best describes the beneficiary's situation. The

hospice does not report occurrence code 42 on their claim. Instead, the hospice reports condition code H2 to indicate a discharge for cause. The effect of this discharge claim on the beneficiary's current hospice benefit period depends on the discharge status.

If the beneficiary is transferred to another hospice (discharge status codes 50 or 51) the claim does not terminate the beneficiary's current hospice benefit period. The admitting hospice submits a transfer Notice of Election (type of bill 8xC) after the transfer has occurred and the beneficiary's hospice benefit is not affected. If any other appropriate discharge status code is used, this discharge claim will terminate the beneficiary's current hospice benefit period as of the "Through" date on the claim. The beneficiary may re-elect the hospice benefit if they are certified as terminally ill and eligible for the benefit again in the future and are willing to be compliant with care.

42 CFR 418.26 also specifies that any discharge from hospice care other than an immediate transfer to another hospice has the following effects:

1. The beneficiary is no longer covered under Medicare for hospice care;
2. The beneficiary resumes Medicare coverage of the benefits waived by their hospice election; and
3. The beneficiary may at any time elect to receive hospice care if he or she is again eligible.

The Centers for Medicare & Medicaid Services (CMS) realizes that certain hospice discharge claims are not having the intended effects in Medicare systems. The requirements are intended to ensure all hospice discharge claims have the required effects on the coverage status of Medicare beneficiaries.

## Key Points

Effective for claims with dates of service on or after January 1, 2012:

- Medicare contractors will set the revocation indicator on a beneficiary's hospice benefit period when a hospice claim is received with any discharge status code other than 30, 40, 41, 42, 50 or 51 and occurrence code 42 is not present.

- Medicare contractors will set the end date of the beneficiary's hospice benefit period to match the claim "Through" date when a hospice claim is received with any discharge status code other than 30, 40, 41, 42, 50 or 51 and occurrence code 42 is not present.

- Medicare contractors will set the end date of the beneficiary's hospice benefit period to match the occurrence code 42 date when a hospice claim is received

with any discharge status code other than 30, 40, 41, 42, 50 or 51 and occurrence code 42 is present.

- Hospices must bill for their Medicare beneficiaries on a monthly basis. Monthly billing should conform to a calendar month (i.e. limit services to those in the same calendar month if services began mid-month) rather than a 30 day period which could span two calendar months.

## Billing Medicare for Medicare Advantage (MA) Patients

Medicare hospices bill the Medicare fee-for-service contractor (RHHI or MAC) for beneficiaries who have coverage through Medicare Advantage just as they do for beneficiaries with fee-for-service coverage. Billing begins with a notice of election for an initial hospice benefit period and followed by claims with types of bill 81X or 82X. If the beneficiary later revokes election of the hospice benefit, a final claim indicating revocation, through use of occurrence code 42, should be submitted as soon as possible so that the beneficiary's medical care and payment is not disrupted.

Medicare physicians may also bill the Medicare fee-for-service contractor for beneficiaries who have coverage through Medicare Advantage as long as all current requirements for billing for hospice beneficiaries are met. These claims should be submitted with a GV or GW modifier as applicable. Medicare contractors process these claims in accordance with regular claims processing rules. When these modifiers are used, contractors are instructed to use an override code to assure such claims have been reviewed and should be approved for payment by the Common Working File in Medicare claims processing systems.

As specified above, by regulation, the duration of payment responsibility by fee-for-service contractors extends through the remainder of the month in which hospice is revoked by hospice beneficiaries. MA plan enrollees that have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice was revoked.

## Additional Information

The official instruction, CR 7473, issued to your RHHI and AB/MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2258CP.pdf on the CMS website.

If you have any questions, please contact your RHHI or A/B MAC at their toll-free number, which may be found at http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.

You may also want to review MLN Matters® Article MM7677 (http://www.cms.gov/MLNMattersArticles/downloads/MM7677.pdf), which requires hospices to (1) use occurrence code 42 only to indicate a discharge due to a patient revocation and not when a provider initiates the termination of hospice care; and (2) to use of condition code 52 to indicate a discharge due to the patient's unavailability.