

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 121	Date: February 5, 2010
	Change Request 6778

SUBJECT: Medicare Systems Edit Refinements Related to Hospice Services

I. SUMMARY OF CHANGES: This instruction will revise existing Medicare standard systems edits to allow for payment of covered Medicare services on the date of a hospice election. In addition, new edits ensuring the appropriate place of service is reported for hospice general inpatient care (GIP), respite and continuous home care are being implemented with this instruction. Both refinements will be effective for claims submitted on or after July 6, 2010. Additionally, a technical correction has been made to the hospice claims processing instructions.

New / Revised Material

Effective Date: For claims submitted on or after July 6, 2010

Implementation Date: July 6, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	9/40.1.9/Other Items and Services

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

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SUBJECT: Medicare Systems Edit Refinements Related to Hospice Services

Effective Date: For claims submitted on or after July 6, 2010

Implementation Date: July 6, 2010

I. GENERAL INFORMATION

A. Background: This instruction will revise 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. In addition, new edits ensuring the appropriate place of service is reported for hospice general inpatient care (GIP), respite and continuous home care are being implemented with this instruction. Both refinements will be effective for claims submitted on or after July 6, 2010. Additionally, a technical correction has been made to the hospice claims processing instructions.

Claims for Medicare Advantage Plan Beneficiaries Electing Hospice:

When a beneficiary enrolled in a Medicare Advantage (MA) plan elects the Medicare hospice benefit the claim payment responsibility shifts from the Medicare Advantage plan to FFS Medicare for all hospice and non-hospice claims. Problems arise regarding payment responsibility when services are provided on the date of election. As a result, services provided on the date of election are often rejected by both the MA plan and traditional Medicare, leaving the provider uncertain as to which entity should be responsible for the claim payment.

Place of Service for GIP, Respite, and 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 Change Request 5245, Transmittal 1101, which required reporting of a 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 regulations at 42 CFR 418.202(e) as “short term inpatient care provided in a participating hospice inpatient unit, or a participating hospital or SNF...”. Additionally, 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 NF. Finally, payment regulations at 42 CFR 418.302(a)(2) define continuous home care (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 site-of-service data on hospice claims is now available, CMS is able to use system edits to ensure more accurate billing of Medicare claims. Specifically, CMS is now able to edit claims to ensure that the level of care billed, for hospice, was provided at an appropriate site.

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

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6778.2	Medicare contractors shall return to provider (RTP) hospice bill types 81x and 82x billing for GIP revenue code 0656 with one of the following HCPCS on the same line: Q5001, Q5002, Q5003.	X				X	X				
6778.3	Medicare contractors shall return to provider (RTP) hospice bill types 81x and 82x billing for respite revenue code 0655 with one of the following HCPCS on the same line: Q5001, Q5002.	X				X	X				
6778.4	Medicare contractors shall return to provider (RTP) hospice bill types 81x and 82x billing for CHC revenue code 0652 with one of the following HCPCS on the same line: Q5004, Q5005, Q5006, Q5007, Q5008.	X				X	X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6778.5	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	X					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
6778.1	Corresponding CWF edits identified by CWF are: 5235 and 525Z. Contractors should determine if additional edits require modification.

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Hospice and Institutional claims Wendy.Tucker@cms.hhs.gov, Part B Supplier Claims Eric.Coulson@cms.hhs.gov, Hospice policy Randy.Thronset@cms.hhs.gov or Katherine.Lucas@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For *Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

40.1.9 - Other Items and Services

(Rev. 121; Issued: 02-05-10; Effective Date: For claims submitted on or after July 6, 2010; Implementation Date: 07-06-10)

Any other item or service which is included in the plan of care and for which payment may otherwise be made under Medicare, in accordance with title XVIII of the Social Security Act, is a covered service under the Medicare hospice benefit. The hospice is responsible for providing any and all services indicated in the plan of care as necessary for the palliation and management of the terminal illness and related conditions.

The hospice Interpretive Guidelines for 42 CFR 418.54(a), published via a Survey and Certification letter (S & C 09-19, Advance Copy-Hospice Program Interpretive Guidance Version 1.1), require that the initial assessment be conducted in the location where hospice services will be provided. The plan of care is developed from that initial assessment and from the comprehensive assessment. Ambulance transports which occur on the effective date of the hospice election (i.e., the date of admission), would occur prior to the initial assessment and therefore prior to the plan of care's development. As such, these transports are not the responsibility of the hospice. Medicare will pay for ambulance transports of hospice patients which occur on the effective date of hospice election through the ambulance benefit rather than through the hospice benefit. Ambulance transports of a hospice patient, which are related to the terminal diagnosis and which occur after the effective date of election, are the responsibility of the hospice.

EXAMPLE:

A hospice determines that a patient's condition has worsened and has become medically unstable. An inpatient stay will be necessary for proper palliation and management of the condition. The hospice adds this inpatient stay to the plan of care and decides that, due to the patient's fragile condition, the patient will need to be transported to the hospital by ambulance. In this case, the ambulance service becomes a covered hospice service.