CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1907	**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	11/30.1/Levels of Care Data Required on the Institutional Claim to Medicare Contractor
R	11/40.2.2/Claims From Medicare Advantage Organizations

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

Pub. 100-04	Transmittal: 1907	Date: February 5, 2010	Change Request: 6778

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

"predominantly nursing care". This means that more than half of the time the nurse, aide, or homemaker spends providing care must be nursing hours.

B. Policy:

Claims for Medicare Advantage 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 fee for service Medicare, CMS is revising the CWF 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 the appropriate FFS Medicare contractor for payment consideration. Contractors will not be required to provide automated adjustments.

Place of Service for GIP, Respite, and CHC:

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 for which hospice days are billed for services provided in non-covered settings. Claims for days of GIP care 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, 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 will be RTP'd if HCPCS site of service codes Q5001 (patient's home/residence) or Q5002 (assisted living facility) are reported, 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 nursing facility. Finally, claims for days of CHC 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), Q5008 (inpatient psychiatric facility) are reported, 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. CMS believes these edits will improve the accuracy of Medicare billing and payment for hospice services.

Technical Correction:

In describing CHC, Pub. 100-04, section 30.1, currently reads that "Nursing care must be provided for at least half of the period of care...". CMS is correcting the manual to replace "at least half" with "more than half".

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6778.1	Medicare contractors shall allow for an automated bypass of the hospice election and MA enrollment edit(s) for all claims submitted with a date of service equal to the date of the hospice election.									X	

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
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 MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
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.Throndset@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.

Medicare Claims Processing Manual

Chapter 11 - Processing Hospice Claims

Table of Contents

(Rev. 1907, 02-05-10)

30.1 - Levels of Care Data Required on the Institutional Claim to Medicare Contractor

(Rev. 1907; Issued: 02-05-10; Effective Date: For claims submitted on or after July 6, 2010; Implementation Date: 07-06-10)

With the exception of payment for physician services, Medicare payment for hospice care is made at one of four predetermined rates for each day that a Medicare beneficiary is under the care of the hospice. The four rates are prospective rates; there are no retroactive adjustments other than the application of the statutory **"**caps" on overall payments and on payments for inpatient care. The rate paid for any particular day varies depending on the level of care furnished to the beneficiary.

The four levels of care into which each day of care is classified:

Routine Home Care	Revenue code 0651
Continuous Home Care	Revenue code 0652
Inpatient Respite Care	Revenue code 0655
General Inpatient Care	Revenue code 0656

For each day that a Medicare beneficiary is under the care of a hospice, the hospice is reimbursed an amount applicable to the type and intensity of the services furnished to the beneficiary for that day. For continuous home care the amount of payment is determined based on the number of hours, reported in increments of 15 minutes, of continuous care furnished to the beneficiary on that day. For the other categories a single rate is applicable for the category for each day.

For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

A description of each level of care follows.

Routine Home Care - The hospice is paid the routine home care rate for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day, and is also paid when the patient is receiving outpatient hospital care for a condition unrelated to the terminal condition.

Continuous Home Care - The hospice is paid the continuous home care rate when continuous home care is provided *in the patient's home. Continuous home care is not paid during a hospital, skilled nursing facility or inpatient hospice facility stay.* This rate is paid only during a period of crisis and only as necessary to maintain the terminally ill individual at home. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of 8 hours must be provided. Nursing care must be provided for *more than half* of the period of

care and must be provided by either a registered nurse or licensed practical nurse. Parts of an hour are identified through the reporting of time for continuous home care days in 15 minute increments and these increments are used in calculating the payment rate. Only patient care **provided** during the period of crisis is to be reported. Payment is based upon the number of 15-minute increments that are billed for 32 or more units. Rounding to the next whole hour is no longer applicable. Units should only be rounded to the nearest increment. Billing for CHC should not reflect nursing shifts and non-direct patient increments (e.g., meal beaks, report, education of staff). **Continuous home care is not intended to be used as respite care.**

The hospice provides a minimum of 8 hours of care during a 24-hour day, which begins and ends at midnight. This care need not be continuous, i.e., 4 hours could be provided in the morning and another 4 hours in the evening, but care must reflect the needs of an individual in crisis. The care must be predominantly nursing care provided by either a registered nurse (RN) or licensed practical nurse (LPN). In other words, at least half of the hours of care are provided by the RN or LPN. Homemaker or home health aide (also known as a hospice aide) services may be provided to supplement the nursing care.

Care by a home health aide and/or homemaker may not be discounted or provided "at no charge" in order to qualify for continuous home care. The care provided by all members of the interdisciplinary and/or home health team must be documented in the medical record regardless if that care does or does not compute into continuous home care.

For more detailed information on Continuous Home Care, see Pub. 100-02, Chapter 9, §40.2.1.

Inpatient Respite Care - The hospice is paid at the inpatient respite care rate for each day on which the beneficiary is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of 5 continuous days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days is to be made at the routine home care rate. More than one respite period (of no more than 5 days each) is allowable in a single billing period. If the beneficiary dies under inpatient respite care, the day of death is paid at the inpatient respite care rate. *Payment at the respite rate is made when respite care is provided at a Medicare or Medicaid certified hospital, SNF, hospice facility, or NF.*

General Inpatient Care - Payment at the inpatient rate is made when general inpatient care is provided *at a Medicare certified hospice facility, hospital, or skilled nursing facility.*

40.2.2 - Claims From Medicare *Advantage* Organizations

(Rev. 1907; Issued: 02-05-10; Effective Date: For claims submitted on or after July 6, 2010; Implementation Date: 07-06-10)

Federal regulations require that Medicare fee-for-service contractors maintain payment responsibility for managed care enrollees who elect hospice; specifically, regulations at 42 CFR Part 417, Subpart P: 42 CFR 417.585 Special Rules: Hospice Care (b); and 42 CFR 417.531 Hospice Care Services (b). *Medicare Fee for Service retains payment responsibility for all hospice and non-hospice related claims beginning on the date of the hospice election.*

A - Covered Services

While a hospice election is in effect, certain types of claims may be submitted by either a hospice provider, a provider treating an illness not related to the terminal condition, or an *MA Plan* to a fee-for-service contractor of CMS, subject to the usual Medicare rules of payment, but only for the following services:

1. Hospice services covered under the Medicare hospice benefit if billed by a Medicare hospice;

2. Services of the enrollee's attending physician if the physician is not employed by or under contract to the enrollee's hospice;

3. Services not related to the treatment of the terminal condition while the beneficiary has elected hospice; or

4. Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again. Monthly capitation payments will begin on the first day of the month after the beneficiary has revoked their hospice election.

B - Billing of Covered Services

Medicare hospices will bill the RHHI for Medicare beneficiaries who have coverage through managed care just as they do for beneficiaries with fee-for-service coverage, beginning with a notice of election for an initial hospice benefit period, and followed by claims with types of bill 81X and 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.

MA organizations may bill the Medicare carrier for non-hospice services provided to *MA* enrollees who elect hospice benefits. These claims should be submitted with a GV or GW (for services not related to the terminal condition) modifier as applicable. Carriers process these claims in accordance with regular claims processing rules.

Medicare physicians may also bill such services directly to carriers as long as all current requirements for billing for hospice beneficiaries are met. When these modifiers are used, carriers 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.