

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3326	Date: August 14, 2015
	Change Request 9201

NOTE: This Transmittal is no longer sensitive and is being re-communicated August 19, 2015. The Transmittal Number, date of Transmittal and all other information remain the same. This instruction may now be posted to the Internet.

SUBJECT: Implementation of the Hospice Payment Reforms

I. SUMMARY OF CHANGES: The CR implements service intensity add-on payments for hospice social worker and nursing visits provided during the last 7 days of life when provided during routine home care. In addition, this instruction will implement two routine home care rates, paying a higher rate in the first 60 days of a hospice election and a lower rate for days 61 and later.

EFFECTIVE DATE: January 1, 2016

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

IMPLEMENTATION DATE: January 4, 2016

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-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	11/ 20.1.2 - Completing the Uniform (Institutional Provider) Bill (Form CMS 1450) for Hospice Election
R	11/ 30.1 - Levels of Care Data Required on the Institutional Claim to Medicare Contractor
R	11/ 30.2 - Payment Rates
N	11/ 30.2.2 – Service Intensity Add-on (SIA) Payments

III. FUNDING:

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**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3326	Date: August 14, 2015	Change Request: 9201
-------------	-------------------	-----------------------	----------------------

NOTE: This Transmittal is no longer sensitive and is being re-communicated August 19, 2015. The Transmittal Number, date of Transmittal and all other information remain the same. This instruction may now be posted to the Internet.

SUBJECT: Implementation of the Hospice Payment Reforms

EFFECTIVE DATE: January 1, 2016

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

IMPLEMENTATION DATE: January 4, 2016

I. GENERAL INFORMATION

A. Background: Section 3132(a) of the Patient Protection and Affordable Care Act of 2010 (Pub. L 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L 111-152) (collectively referred to as the “Affordable Care Act”) amended section 1814(i)(6) of the Social Security Act. This amendment requires, no earlier than October 1, 2013, revisions to be made to the methodology for determining the payment rates for routine home care and other hospice services. Such revisions may include adjustments to per diem payments that reflect changes in resource intensity in providing such care and services during the course of hospice care.

Analysis of recent Medicare hospice utilization data demonstrates that hospice costs are markedly higher both at the beginning and the end of a hospice episode. Specifically, higher resource costs are observed in the first two days of an episode and once again in the seven days preceding the death of a hospice patient. We consider a hospice “episode” of care to be a hospice election period or series of election periods separated by no more than a 60 day gap.

In the 2014 Report to Congress presented by the Medicare Payment Advisory Commission (MedPAC), [http://www.medpac.gov/documents/reports/mar14_entirereport.pdf], the Commission’s summary of analyses of the Medicare hospice benefit showed that “the structure of Medicare’s hospice payment system makes longer stays in hospice more profitable for providers than shorter stays. Hospice visits tend to be more frequent at the beginning and end of a hospice episode and less frequent in the intervening period. The Medicare payment rate, which is constant over the course of the episode, does not take into account the different levels of effort that occur during different periods in an episode. This payment structure may be spurring some providers to pursue business models that maximize profit by enrolling patients more likely to have long stays (Medicare Payment Advisory Commission 2009, Medicare Payment Advisory Commission 2008).”

In short, because short stay hospice episodes may lead to financial losses and reduced margins, providers may be seeking ways to maximize long stays in their beneficiary population and mechanisms to avoid the costliness of both the early and late portions of hospice episodes.

Additionally, the Centers for Medicare & Medicaid Services (CMS) has also found through its own analyses of recent claims data that hospice decedents receiving care at home received few skilled visits the last two to four days of life. We found some hospice providers did not provide any skilled visits in the last two days of life to over 50 percent of their patients.

In order to address these concerns, two different Routine Home Care (RHC) per diem payment rates for the RHC level of care depending on the timing of the day within the patient’s episode of care will be established. Days 1 through 60 will be paid at the RHC ‘High’ Rate while days 61+ will be paid at RHC ‘Low’ Rate. These differing rates will serve to capture varying levels of resource intensity during the course

of hospice care, as the beginning portion of the stay is generally more costly than the later segment.

CMS is also implementing a Service Intensity Add-On (SIA) payment for skilled visits (provided by a registered nurse and/or medical social worker) provided during last seven days of life during a hospice election (in addition to the current per diem rate for the RHC level of care). The SIA payment would be paid in addition to the current per diem rate for the RHC level of care.

B. Policy: Effective for hospice services with "Through" dates, on and after January 1, 2016, a hospice RHC level of care day will be paid one of two RHC rates based upon the following:

1. The day is a RHC level of care day.
2. If the day occurs during the first 60 days of an episode, the RHC rate will be equal to the RHC 'high' rate.
3. If the day occurs during days 61 and beyond, the RHC rate will be equal to the RHC 'low' rate.
4. For a hospice patient who is discharged and readmitted to hospice within 60 days of that discharge, his/her prior hospice days will continue to follow the patient and count toward his/her patient days for the receiving hospice in the determination of whether the receiving hospice may be paid at the high or low RHC rate, upon hospice election.
5. For a hospice patient who has been discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the patient's 60-day window, paid at the RHC 'high' rate upon the new hospice election.

Effective for hospice services with "Through" dates, on and after January 1, 2016, a hospice claim will be eligible for an end of life (EOL) SIA payment if the following criteria are met:

1. The day is a RHC level of care day.
2. The day occurs during the last seven days of life (and the beneficiary is discharged dead).
3. Service is provided by an RN or social worker that day for at least 15 minutes and up to 4 hours total.
4. The service is not provided by a social worker via telephone.

The SIA Payment amount shall equal:

The number of hours (in 15 minute increments) of service provided by an RN or social worker during the last seven days of life for a minimum of 15 minutes and up to 4 hours total per day;

- Multiplied by the current hospice Continuous Home Care (CHC) hourly rate per 15 minutes x visit units (not greater than 16).
- Adjusted for geographic differences in wages.

CMS believes that the SIA policy necessitates the creation of two new G codes for nursing. During periods of crisis such as the precipitous decline before death, patient needs typically surge and more intensive services are warranted. The Medicare Conditions of Participation (CoPs) at §418.56(a) state that a registered nurse (RN) is responsible for ensuring that the needs of the patient and family are continually assessed. CMS would expect that at end of life the needs of the patient and family would need to be frequently assessed and thus the skills of an RN are required. RNs are more highly trained clinicians with commensurately higher wage rates.

In order to quantify the amount of RN services provided to a patient, CMS believes the claims should differentiate between the levels of nursing services provided. Since the existing codes do not distinguish between services provided by an RN and a Licensed Practical Nurse (LPN), CMS expects to obtain new codes to distinguish between RN services and LPN services as soon as January 1, 2016.

The SIA daily payment calculated by the Hospice PRICER will be entered on the first applicable visit line item for each date of service payable.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC			D M E M A C	Shared- System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
9201.1	Medicare contractors shall be aware of the new policy and instructions provided in the attached Pub. 100-04 Chapter 11, sections 20.1.2, 30.1, 30.2, and 30.2.2.			X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
9201.2	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's 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		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
---	---

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wilfried Gehne, Wilfried.Gehne@cms.hhs.gov , Charles Nixon, Charles.Nixon@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 11 - Processing Hospice Claims

Table of Contents
(Rev.3326, Issued: 08-14-15)

Transmittals for Chapter 11

30.2.2 – Service Intensity Add-on Payments

20.1.2 - Completing the Uniform (Institutional Provider) Bill (Form CMS-1450) for Hospice Election

(Rev. 3326, Issued: 08-14-15, Effective: 01-01-16, Implementation: 01-04-16)

The following data elements must be completed by the hospice on the Form CMS-1450 for the Notice of Election. Data elements that are not shown are not required.

NOTE: Information regarding the form locator numbers that correspond to these data element names can be found in chapter 25.

Provider Name, Address, and Telephone Number

The minimum entry for this item is the provider's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or 9-digit ZIP codes are acceptable. Use the information to reconcile provider number discrepancies. Phone and/or FAX numbers are desirable.

Type of Bill

Enter the appropriate 3-digit numeric type of bill code, according to the following code structure:

1st Digit - Type of Facility

8 - Special (Hospice)

2nd Digit - Classification (Special Facility)

1 - Hospice (Nonhospital-Based)

2 - Hospice (Hospital-Based)

3rd Digit - Frequency

A - Hospice benefit period initial election notice

B - Termination/revocation notice for previously posted hospice election

C - Change of provider

D - Void/cancel hospice election

E - Hospice Change of Ownership

Statement Covers Period (From-Through)

On a Notice of Termination/Revocation (NOTR), the hospice enters the start date of the hospice benefit period in which the notice is effective in the "From" date field. The hospice enters the date the termination/revocation is effective in the "Through" date field.

Patient's Name

The patient's name is shown with the surname first, first name, and middle initial, if any.

Patient's Address

The patient's full mailing address including street name and number, post office box number or RFD, city, State, and ZIP code.

Patient's Birth Date

(If available.) Show the month, day, and year of birth numerically as MM-DD-YYYY. If the date of birth cannot be obtained after a reasonable effort, the field will be zero-filled.

Patient's Sex

Show an "M" for male or an "F" for female. This item is used in conjunction with diagnoses and surgical procedures to identify inconsistencies.

Admission Date

The hospice enters the admission date, which must *be the start date of the benefit period in all cases except when a transfer occurs. In transfer situations, the hospice should use their own admission date. When a new hospice admission occurs after a hospice revocation or discharge that resulted in termination of the hospice benefit, the election date cannot be the same as the revocation or discharge date.* The date of admission may not precede the physician's certification by more than 2 calendar days, and is the same as the certification date if the certification is not completed on time. On a NOTR, the hospice enters the start date of the hospice benefit period in which the discharge or revocation is effective, not the initial hospice admission date.

EXAMPLE

The hospice election date (admission) is January 1, 2014. The physician's certification is dated January 3, 2014. The hospice date for coverage and billing is January 1, 2014. The first hospice benefit period ends 90 days from January 1, 2014.

Show the month, day, and year numerically as MM-DD-YY.

Provider Number

The hospice enters their NPI.

Insured's Name

Enter the beneficiary's name on line A if Medicare is the primary payer. Show the name exactly as it appears on the beneficiary's HI card. If Medicare is the secondary payer, enter the beneficiary's name on line B or C, as applicable, and enter the insured's name on the applicable primary policy on line A.

Certificate/Social Security Number and Health Insurance Claim/Identification Number

On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown enter the patient's HICN. For example, if Medicare is the primary payer, enter this information. *To ensure accuracy and prevent a delay in posting the hospice notice of election, hospices should validate this information using the Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS). Only in the event that the HETS data is not available should the hospice show the number as it appears on the patient's HI Card, Social Security Award Certificate, Utilization Notice, EOMB, Temporary Eligibility Notice, etc., or as reported by the SSO.*

Principal Diagnosis Code

CMS accepts only HIPAA approved ICD-9-CM or ICD-10-CM/ICD-10-PCS codes, depending on the date of service. The official ICD-9-CM codes, which were updated annually through October 1, 2013, are posted at <http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html>

The official annual updates to ICD-10-CM and ICD-10-PCS codes are posted at <http://www.cms.gov/Medicare/Coding/ICD10/index.html>.

Use full diagnosis codes including all applicable digits, up to five digits for ICD-9-CM and up to seven digits for ICD-10-CM.

Attending Physician I.D.

For notice of elections effective prior to January 1, 2010, the hospice enters the National Provider Identifier (NPI) and name of the physician currently responsible for certifying the terminal illness, and signing the individual's plan of care for medical care and treatment.

The reporting requirement, optional for notice of elections effective on or after January 1, 2010, and required reporting on or after April 1, 2010, establishes that the hospice enters the NPI and name of the attending physician designated by the patient at the time of election as having the most significant role in the determination and delivery of the patient's medical care.

Other Physician I.D.

The hospice enters the NPI and name of the hospice physician responsible for certifying that the patient is terminally ill, with a life expectancy of 6 months or less if the disease runs its normal course. Note: Both the attending physician and other physician fields should be completed unless the patient's designated attending physician is the same as the physician certifying the terminal illness. When the attending physician is also the physician certifying the terminal illness, only the attending physician is required to be reported.

NOTE: for electronic claims using version 5010 or later, this information is reported in Loop ID 2310F – Referring Provider Name.

Provider Representative Signature and Date

A hospice representative must make sure the required physician's certification, and a signed hospice election statement are in the records before signing the Form CMS-1450. A stamped signature is acceptable.

30.1 - Levels of Care Data Required on the Institutional Claim to Medicare Contractor *(Rev. 3326, Issued: 08-14-15, Effective: 01-01-16, Implementation: 01-04-16)*

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 claims with date of service on or after January 1, 2016, there are two hospice routine home care (RHC) rates. A hospice day billed at the RHC level in the first 60 days of a hospice election is paid at the high RHC rate. A hospice day billed at the RHC level on day 61 or later of the hospice election is paid at the low RHC rate.

See section 30.2 of this chapter for additional instructions on the high and low RHC rates.

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 breaks, 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.

30.2 - Payment Rates

(Rev. 3326, Issued: 08-14-15, Effective: 01- 01-16, Implementation: 01-04-16)

The CMS publishes general hospice payment rates annually to be used for revenue codes 0651, 0652, 0655, and 0656. These rates must then be adjusted by the A/B MAC (A) based on the beneficiary’s locality.

National rates are issued as described below. These rates are updated annually and published in the “Recurring Update Notification.” This example is the national rates for October 1, 2004, through September 30, 2005.

Description	Revenue Code	Daily Rate	Wage Amount	Non-weighted Component
Routine Home Care	0651	\$121.98	\$83.81	\$38.17
Continuous Home Care Full Rate = 24 hours of care; \$29.66 hourly rate	0652	\$711.92	\$489.16	\$222.76
Inpatient Respite Care	0655	\$126.18	\$68.30	\$57.88
General Inpatient Care	0656	\$542.61	\$347.32	\$195.29

For claims with dates of service on or after January 1, 2016, there are two hospice routine home care (RHC) rates. A hospice day billed at the RHC level in the first 60 days of a hospice election is paid at the high RHC rate. A hospice day billed at the RHC level on day 61 or later of the hospice election is paid at the low RHC rate. Medicare systems count 60 days from the date of admission regardless of whether some days are covered or non-covered.

For a hospice patient that is discharged and readmitted to hospice services within 60 days of the discharge, the hospice days will continue to follow the patient. If the hospice patient is discharged from hospice care for more than 60 days a new election to hospice will initiate a reset of the patient’s 60-day window, paid at the RHC high rate upon the new admission.

Example:

- Patient elected hospice for the first time on 01/10/16.*
- The patient revoked hospice on 01/30/16.*
- The patient re-elected hospice on 02/16/16.*
- The patient discharged deceased from hospice care on 03/28/16.*

Since the break in hospice care from 01/30 to 02/16 was less than 60 days the patient day count continues on the second admission.

RHC provided during first election from 01/10/16 to 01/30/16 accounts for 21 days that the high RHC rate would apply. The 60 day count continues with second admission on 2/16/16 and the high RHC rate would apply for an additional 39 days. Day 61 begins the low RHC rate on 3/27/16.

Multiple RHC days are reported on a single line item on the claim. The line item date of service represents the first date at the level of care and the units represent the number of days. As a result, both high and low RHC rates may apply to a single line item.

Extending the example above, if the March claim for this patient consisted entirely of RHC days at home, the payment line item would look like this:

<i>Revenue Code</i>	<i>HCPCS</i>	<i>Line Item Date of Service</i>	<i>Units</i>
<i>0651</i>	<i>Q5001</i>	<i>03/01/16</i>	<i>31</i>

Medicare systems would:

- calculate the dates from 3/01 to 3/26 at the high RHC rate,*
- calculate the dates from 3/27 to 3/31 at the low RHC rate, and*
- sum these two amounts in the payment applied to this line item.*

These national rates are adjusted by the A/B MAC (A) as follows:

1. Rate Components

The rate is considered to have two components

A wage amount component

A non-weighted component

2. Adjustment to Wage Component

The wage amount component is adjusted (multiplied) by the wage index for the location of the place of service for all levels of care.

The hospice wage index is published in the **Federal Register** notice each year, and is effective October 1 of that year through September 30 of the following year. To select the proper index for the hospice area, first determine if the beneficiary is located in one of the Urban Areas listed in Table A of the **Federal Register** notice. If so, use the index shown for the area. If the beneficiary is not located in one of the Urban Areas, use the index number of the rural area for the State, listed in Table B of the **Federal Register** notice.

3. Adjusted Payment Rate

The adjusted wage component is then added to the non-weighted component. This is the payment rate for the year.

EXAMPLE I: If the wage index for the beneficiary's area is .87, a \$78.47 national wage amount for routine home care would be multiplied by .87 to determine the wage amount, and this amount (\$68.27) would be added to the non-weighted component of \$35.73 to provide a local rate of \$104.00.

EXAMPLE II: If the wage index for the beneficiary's area is 0.87, a \$457.97 national wage amount for continuous home care would be multiplied by 0.87 to determine the wage amount, and this amount (\$398.43) would be added to the non-weighted component of \$208.55 to provide a local daily rate for revenue code 0652 of \$606.98. Divide by 24 to get the local hourly rate of \$25.29.

Similar calculations are done for the rates for the other revenue codes.

30.2.2 – Service Intensity Add-on (SIA) Payments

(Rev. 3326, Issued: 08-14-15, Effective: 01-01-16, Implementation: 01-04-16)

Effective for hospice services with dates of service on and after January 1, 2016, a service intensity add-on payment will be made for the social worker visits and nursing visits provided by a registered nurse (RN), when provided during routine home care in the last seven days of life. The SIA payment is in addition to the routine home care rate. The SIA payment is provided for visits of a minimum of 15 minutes and a maximum of 4 hours per day, i.e. from 1 unit to a maximum of 16 units combined for both nursing visit time and/or social worker visit time per day. In addition, the time of a social worker's phone calls is not eligible for an SIA payment.

The SIA payment amount is calculated by multiplying the continuous home care (CHC) rate (per 15 minutes) by the number of units for the combined visits for the day (payment not to exceed 16 units) and adjusted for geographic differences in wages.

EXAMPLE CLAIM 1: End of Life (EOL) 7 day SIA:

Billing Period: 12/01/XX – 12/09/XX, Patient Status: 40

RHC in home, discharged deceased.

Revenue Code	HCPCS	Line Item	Date of Service	Units
0651	Q5001	12/01/XX		9
0551	G0154	12/01/XX		4
0571	G0156	12/02/XX		6
0561	G0155	12/05/XX		4
0571	G0156	12/05/XX		3
0551	G0154	12/06/XX		3
0571	G0156	12/06XX		4
0551	G0154	12/09/XX		4
0561	G0155	12/09/XX		6
0571	G0156	12/09/XX		2

*Visits reported prior to 12/03/XX are not included in the EOL 7 day SIA.

Day 1 of 7, 12/03/XX, no qualifying units reported for the EOL SIA.

Day 2 of 7, 12/04/XX, no qualifying units reported for the EOL SIA.

Day 3 of 7, 12/05/XX, qualifying units are 4. Day 3 of the EOL SIA payment is stored on the first applicable visit line for that date: 0561 G0155 12/05/XX UNITS 4

Day 4 of 7, 12/06/XX, qualifying units are 3. Day 4 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551 G0154 12/06/XX UNITS 3

Day 5 of 7, 12/07/XX, no qualifying units reported for the EOL SIA.

Day 6 of 7, 12/08/XX, no qualifying units reported for the EOL SIA.

Day 7 of 7, 12/09/XX, qualifying units are 10. Day 7 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551G0154 12/09/XX UNITS 4.