Summary of Hospice Changes

<table>
<tr><th>CR #</th><th>Title</th><th>Eff/Impl Date</th><th>Summary</th></tr>
<tr><td>CR 7675
One-Time Notification</td><td>Revisions to the Hospice Medicare Summary Notice</td><td>Eff: 07/01/12
Imp: 07/02/12</td><td>http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1032OTN.pdf
1. Revises Medicare Summary Notices (MSNs) to accurately reflect description of services reported and correct total charges report for claim.
a. Use revenue code description for level of care lines, with visit lines and description directly below each level of care.
b. Visits with same revenue code/HCPCS will be rolled up onto one line with the number of visits before the description.
c. Visit charges will be suppressed.
d. New MSN message for visit lines: “Payment for this hospice services is included in the payment for the hospice daily level of care; therefore, you should not be billed for this service.”</td></tr>
<tr><td>CR 7677
Medicare Claims Processing Manual updates</td><td>New Hospice Condition Code for Out of Service Area Discharges</td><td>Eff: 07/01/12
Imp: 07/02/12</td><td>http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2410CP.pdf
1. Revises billing instructions for hospice discharges.
a. Occurrence Code (OC) 42 is only used for patient revocations.
b. New condition code 52 is for discharge due to patient’s unavailability/inability to receive hospice services (moved out of service area).
<table>
<tr><th>Discharge Reason</th><th>Occurrence Code (OC)</th><th>Condition Code (CC)</th><th>Patient Status Code</th></tr>
<tr><td>Patient revokes</td><td>OC 42</td><td>None</td><td>Appropriate code</td></tr>
<tr><td>Patient transfers hospices</td><td>None</td><td>None</td><td>50 or 51</td></tr>
<tr><td>Patient no longer terminal</td><td>None</td><td>None</td><td>Appropriate code</td></tr>
<tr><td>Patient discharged for cause</td><td>None</td><td>H2</td><td>Appropriate code</td></tr>
<tr><td>Patient moves out of service area</td><td>None</td><td>52</td><td>Appropriate code</td></tr>
</table>
2. New instructions for billing for denial of hospice room and board
a. Revenue code = 659
b. HCPCS = A9270
c. Modifier = GY
d. Charges = reported as noncovered
3. Clarifies payment of attending physician services by nurse practitioner as lesser of:
• Submitted charge; or
• 85% physician fee schedule</td></tr>
<tr><td>CR 7755</td><td>Medicare System Update: Claim Level Referring Physician Data and Hospice Certifying Physician</td><td>Eff: 01/01/12
Imp: 10/01/12</td><td>http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2448CP.pdf
Requires hospice to report the physician certifying the terminal illness on a claim in the Referring Physician field, when different than the attending physician.</td></tr>
<tr><td>CR 7792
One-Time Notification</td><td>New Occurrence Code to Report Date of Death</td><td>Eff: 10/01/12
Imp: 10/01/12</td><td>http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1079OTN.pdf
1. Creates new occurrence code 55 to be used to report date of death.
a. New edit requires occurrence code 55 used when patient discharge status is:
i. 40 (expired at home)
ii. 41 (expired in a medical facility)
iii. 42 (expired-place unknown)</td></tr>
</table>

CR #	Title	Eff/Impl Date	Summary
CR 7838 Medicare Claims Processing Manual and Medicare Benefit Policy Manual updates	Updates to Caps and Limitations on Hospice Payments	**Eff:** 04/14/11 (for Cap Years 2011 and prior) and 10/01/11 (for Cap Years 2012 and later) **Imp:** 07/02/12	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2482CP.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R156BP.pdf **1.** Revises Medicare policy to allow the aggregate cap calculation using either of the following: **a.** Streamlined method **i.** When beneficiary receives care from only one hospice, include those beneficiaries who have not previously been included in the calculation of any hospice cap, and who have filed an election to receive hospice care during the period **ii.** When a beneficiary receives care from more than one hospice, this method is identical to the proportional method calculation. **b.** Proportional method – includes that fraction of beneficiaries which represents the portion of a patient's total days of care in all hospices and all years **2.** For new hospices, the initial cap calculations must cover a period of at least 12 months but less than 24 months. **3.** Hospices whose cap calculation is determined using the proportional method for any cap year prior to the 2012 cap year will continue to have their cap calculated using the proportional method. **a.** All other hospices will have their cap determinations for 2012 and later calculated using the proportional method. **i.** Unless a one-time election for cap year 2012 and later to be calculated using the streamlined method
CR 8142 Medicare Claims Processing Manual updates	Hospice Monthly Billing Requirement	**Eff:** 07/01/13 **Imp:** 07/01/13	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2642CP.pdf **1.** Creates new system (FISS) edits to enforce the monthly billing requirement for hospices. Claims will be returned (RTP) to the hospice when: **a.** The claim has a patient status code of 30 (still a patient) and the 'thru' date on the claim is not the last day of month. **b.** The claim's 'from' and 'thru' date spans multiple months.
CR 8358 Medicare Claims Processing Manual updates	Additional Data Reporting Requirements for Hospice Claims	**Eff:** Voluntary reporting effective 01/01/14 Mandatory reporting effective 04/01/14 **Imp:** 01/06/14	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2864CP.pdf **1.** Creates additional data reporting requirements **a.** Hospice staff visits provided under GIP are line item reported when place of service is Q5004, Q5005, Q5007, or Q5008 **b.** Facility NPI is reported in Loop 2310E (5010) when place of service is Q5003, Q5004, Q5005, Q5006 (and is not the billing hospice), Q5007 and Q5008 **c.** Post-mortem visits provided by hospice staff on the date of death are reported with a PM modifier **d.** Injectable drugs are reported on a line-item basis per fill with revenue code 0636 and the appropriate HCPCS **e.** Non-injectable prescriptions are reported on a line-item basis per fill with revenue code 0250 and the National Drug Code (NDC) **f.** Infusion pumps and medication refills are reported on a line-item basis per pump order and per medication refill with 029X (pump) and 0294 (drug), and the appropriate HCPCS.

CR #	Title	Eff/Impl Date	Summary
CR 8371 Medicare Claims Processing updates	Demand Billing of Hospice General Inpatient Level of Care	**Eff:** 01/01/14 **Imp:** 01/06/14	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals-Items/R2748CP.html **1.** Provides billing instructions when an ABN is given for a level of care the hospice determines to not be reasonable or medically necessary. **a.** Occurrence code 32 is reported with the date the ABN was provided to the beneficiary **b.** Services in question are submitted as covered services **c.** Add GA modifier to lines related to ABN (when claim includes both ABN and non-ABN related services) **2.** Provides instructions to Medicare contractors to add a routine home care line in lieu of the denied GIP services.
CR 8877	Hospice Manual Update for Diagnosis Reporting and Filing Hospice Notice of Election (NOE) and Termination or Revocation of Election. This CR rescinds and fully replaces CR 8877.	**Eff:** 10/01/14 **Imp:** 10/01/14	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3032CP.pdf **1.** Prohibits billing of certain diagnosis codes as the principal diangosis on hospcie claims, including debility, adult failure to thrive, as well as certain dementia codes. **2.** Clarifies reporting of place of service codes Q5003 and Q5004. **3.** Notices of Election (NOEs) must be submitted and accepted within 5 calendar days after the hospice admission date. **4.** Notices of Termination/Revocation (NOTR) must be submitted and accepted within 5 calendar days after the effective date of the discharge/revocation.
CR 9114	Updates on Hospice Election Form, Revocation, and Attending Physician	**Eff:** 10/01/14 **Imp:** 05/04/15	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R209BP.pdf **1.** Hospice elections must include: • If a patient or representative designates an attending physician, include enough detail to clearly identify the attending physician. This may include, but is not limited to, the physician's full name, office address, or National provider Identifier (NPI). • The patient's or representative's acknowledgement that the designated attending physician was their choice. **2.** If the patient/representtive wants to change their designated attending physician they must file a signed statement witht the hospice, that includes: • Identification of the new attending physician, including enough detail to cleary identify the attending physician. This may include, but is not limited to, the physician's full name, office address, or NPI; • The date the change is effective; • An acknowledgtement that the change in attending physician was their choice; • The pateint's or representative's signature; and • The date the statement was signed.