Medicare Claims Processing Manual

Chapter 11 - Processing Hospice Claims

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(Rev. 304, 09-24-04)

10 - Overview

(Rev. 304, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

Medicare beneficiaries entitled to hospital insurance (Part A) who have terminal illnesses and a life expectancy of six months or less have the option of electing hospice benefits in lieu of standard Medicare coverage for treatment and management of their terminal condition. Only care provided by a Medicare certified hospice is covered under the hospice benefit provisions.

Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the hospice patient's lifetime. However, a beneficiary may voluntarily terminate his hospice election period. Election/termination dates are retained on CWF.

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an attending physician, *which may include a nurse practitioner.* If the attending physician, *who may be a nurse practitioner*, is an employee of the designated hospice, he or she may not receive compensation from the hospice for those services under Part B. These physician professional services are billed to Medicare Part A by the hospice.

To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a certification that the individual is terminally ill must be completed by the patient's attending physician (if there is one), and the Medical Director (or the physician member of the Interdisciplinary Group (IDG)). *Nurse practitioners serving as the attending physician may not certify or re-certify the terminal illness.* A plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. Certification of terminal illness is based on the physician's or medical director's clinical judgment regarding the normal course of an individual's illness. *It should be noted that predicting life expectancy is not always exact*.

See the Medicare Benefit Policy Manual, Chapter 9, for additional general information about the Hospice benefit.

See Chapter 29 of this manual for information on the appeals process that should be followed when an entity is dissatisfied with the determination made on a claim.

See Chapter 9 of the Medicare Benefit Policy Manual for hospice eligibility requirements and election of hospice care.

20 - Hospice Notice of Election

(Rev. 1, 10-01-03)

HSP-201

20.1 - Procedures for Hospice Election

(Rev. 1, 10-01-03)

See Chapter 9 of the Medicare Benefit Policy Manual for hospice eligibility requirements and election of hospice care.

20.1.1 - Notice of Election (NOE) - Form CMS-1450

(Rev. 304, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

When a Medicare beneficiary elects hospice services, hospices must complete FLs 1, 4, 12, 13, 14, 15, 17, 51, 58, 60, 67, 82, 83, and 85 of the Uniform (Institutional Provider) Bill (Form CMS-1450), which is an election notice. In addition, the hospice must complete the Form CMS-1450 when the election is for a patient who has changed an election from one hospice to another.

Hospices must send the Form CMS-1450 Election Notice to the FI by mail, messenger, or *direct data entry (DDE)* depending upon the arrangements with the FI.

If a patient enters hospice care before the month he/she becomes entitled to Medicare benefits, e.g., before age 65, the hospice should not send the election notice before the first day of the month in which he/she becomes 65.

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

(Rev. 304, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

The following fields must be completed by the hospice on the Form CMS-1450 for the Notice of Election:

Form Locator (FL) 1. (Untitled) - 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.

FL 4. Type of Bill

Enter the 3-digit numeric type of bill code: 81A, B, C, D, *E* or 82A, B, C, D, as appropriate. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

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

FL 12. Patient's Name

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

FL 13. 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.

FL 14. 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.

FL 15. Patient's Sex

Show an "M" for male or an "F" for female. This item is used in conjunction with FLs 67-81 (diagnoses and surgical procedures) to identify inconsistencies.

FL 17. Admission Date

Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than two calendar days, and is the same as the certification date if the certification is not completed on time.

EXAMPLE

The hospice election date (admission) is January 1, 1993. The physician's certification is dated January 3, 1993. The hospice date for coverage and billing is January 1, 1993. The first hospice benefit period ends 90 days from January 1, 1993.

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

FLs 51A, B, and C. Provider Number

This is the 6-digit number assigned by Medicare. It must be entered on the same line as "Medicare" in FL 50.

FLs 58A, B, C. 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.

FLs 60A, B, C. 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 in FL 58, enter the patient's HICN. For example, if Medicare is the primary payer, enter this information in FL 60A. 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.

FL 67. Principal Diagnosis Code

The full ICD-9-CM diagnosis code is required. The principal diagnosis is defined as the condition established after study to be chiefly responsible for the patient's admission. The CMS accepts only ICD-9-CM diagnostic and procedural codes using definitions contained in DHHS Publication No. (PHS) 89-1260 or CMS approved errata and supplements to this publication. The CMS approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee. Use full ICD-9-CM diagnoses codes including all five digits where applicable.

FL 82. Attending Physician I.D.

Enter the UPIN and name of the physician currently responsible for certifying *the terminal illness.* The UPIN is shown in the first six positions followed by two spaces, the physician's last name, one space, first name, one space, and middle initial.

Claims Where Physician Not Assigned a UPIN - Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete. In addition, numbers are not assigned to physicians who limit their practice to the Public Health Service, Department of Veterans Affairs or Indian Health Services. Use the following UPINs to report those physicians not assigned UPINs:

- INT000 for each intern;
- RES000 for each resident;
- PHS000 for Public Health Service physicians, including the Indian Health Services;
- VAD000 for Department of Veterans Affairs' physicians;
- RET000 for retired physicians; and
- OTH000 for all other unspecified entities not included above. The OTH000 ID may be audited.

FL 83. Other Physician I.D.

If the attending physician is a nurse practitioner, enter the UPIN and name of the nurse practitioner. The UPIN is shown in the first six positions followed by two spaces, the nurse practitioner's last name, one space, first name, one space, and middle initial.

The word "employee" or "nonemployee" must be entered here to describe the relationship the patient's attending physician has with the hospice. "Employee" also refers to a volunteer under the hospice jurisdiction.

FL 85-6. 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.

20.1.3 - FI Reply to Notice of Election

(Rev. 1, 10-01-03)

HSP-302.2

The reply to the notice of election is furnished according to hospice arrangements with the FI. Whether the reply is given by telephone, mail, or wire, it is based upon the FI's query to CMS master beneficiary records, and it contains the necessary Medicare Part A eligibility information.

30 - Billing and Payment for General Hospice Services

(Rev. 1, 10-01-03)

30.1 - Levels of Care

(Rev. 1, 10-01-03)

HSP-401, HSP-402-402.5, A3-3143.2, A-03-016, Hospice Transmittal 66

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 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. 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 eight hours must be provided. Nursing care must be provided for at least half of the period of care and must be provided by either a registered nurse or licensed practical nurse. For every hour or part of an hour of continuous care furnished, the hourly rate is paid for up to 24 hours a day.

The hospice provides a minimum of eight hours of care during a 24-hour day, which begins and ends at midnight. This care need not be continuous, i.e., four hours could be provided in the morning and another four hours in the evening. 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 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 Chapter 9 of the Medicare Benefit Policy Manual.

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 five 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 five 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.

General Inpatient Care - Payment at the inpatient rate is made when general inpatient care is provided.

30.2 - Payment Rates

(Rev. 304, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

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 FI based on the beneficiary's locality.

National rates are issued as described below. These rates are updated annually and published in the "Federal Register." This example is the national rates for October 1, 2002, through September 30, 2003.

Description	**Revenue Code**	**Daily Rate**	**Wage Amount**	**Unweighted Component**
Routine Home Care	0651	$118.080	$ **81.13**78.47	$ 36.95
Continuous Home Care	0652	$689.18	$476.5457.97	$215.64
Inpatient Respite Care	0655	$122.15	$ 66.12	$56.03
General Inpatient Care	0656	$525.28	$336.23	$189.05

These national rates are adjusted by FI as follows:

1 - Rate Components

The rate is considered to have two components

- A wage amount component
- An unweighted component

2 - Adjustment to Wage Component

The wage amount component is adjusted (multiplied) by the wage index for the location of the beneficiary's home to provide for regional differences in wages.

The hospice wage index is published in the **"**Federal Register" 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 unweighted 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 unweighted component of $35.73 to provide a local rate for *code* 0651 of $100.68104.00.

EXAMPLE II: If the wage index for the beneficiary's area is .87, **a** $457.97 national wage amount for continuous home care would be multiplied by .87 to determine the wage amount, and this amount ($398.43) would be added to the unweighted 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.

30.3 - Data Required on Claim to FI

(Rev. 304, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

See the Medicare Benefit Policy Manual, Chapter 9 for coverage requirements for Hospice benefits.

This section addresses only the submittal of claims. See *section 20*, of this chapter for information on Notice of Election (NOE) transaction types (81A,C,E and 82A,C,E).

Before billing, the hospice must submit an admission notice to the FI *(see section 20)*.

Hospices use the Uniform (Institutional Provider) Bill (Form CMS-1450) or electronic equivalent to bill the FI for all covered hospice services.

This form, also known as the Uniform Bill 92 (UB-92), is suitable for billing most third party payers (both Government and private). Because it serves the needs of many payers, some data elements may not be needed by a particular payer. Detailed information is given only for items required for Medicare hospice claims. For a complete list of instructions for all Medicare claims see the general instructions for completing the UB-92 at http://www.cms.hhs.gov/providers/edi/edi5.asp. Items not listed need not be completed although hospices may complete them when billing multiple payers.

FL 1 (Field Locator 1) - (Untitled) - Provider Name, Address, and Telephone Number

FL 4 - Type of Bill

This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third

indicates the sequence of this bill in this particular benefit period. It is referred to as a **"**frequency" code.

Code Structure

1st Digit - Type of Facility
8 - Special facility (Hospice)

2nd Digit - Classification (Special Facility Only)
1 - Hospice (Nonhospital based)
2 - Hospice (Hospital based)

3rd Digit Frequency	**Definition**
0 - Nonpayment/Zero Claims	Used when no payment from Medicare is anticipated.
l - Admit Through Discharge Claim	This code is used for a bill encompassing an entire course of hospice treatment for which the provider expects payment from the payer, i.e., no further bills will be submitted for this patient.
2 - Interim – First Claim	This code is used for the first of an expected series of payment bills for a hospice course of treatment.
3 - Interim - Continuing Claim	This code is used when a payment bill for a hospice course of treatment has already been submitted and further bills are expected to be submitted.

3rd Digit Frequency	Definition
4 - Interim - Last Claim	This code is used for a payment bill that is the last of a series for a hospice course of treatment. The "Through" date of this bill (FL 6) is the discharge date, transfer date, or date of death.
5 - Late Charges	Use this code for late charges that need to be billed. Late charges can be submitted only for revenue codes not on the original bill. For additional information on late charge bills see Chapter 3.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct (other than late charges) a previously submitted bill. This is the code used on the corrected or "new" bill. For additional information on replacement bills see Chapter 3.
8 - Void/Cancel of a Prior Claim	This code is used to cancel a previously processed claim. For additional information on void/cancel bills see Chapter 3.

FL 6 - Statement Covers Period (From-Through)

Show the beginning and ending dates of the period covered by this bill in numeric fields (MM-DD-YY). Do not show days before the patient's entitlement began. Since the 12-month hospice "cap period" (see §80.2) ends each year on October 31, submit separate bills for October and November.

FL 12 - Patient's Name

Enter the beneficiary's name exactly as it appears on the Medicare card.

FL 13 - Patient's Address

FL 14 - Patient's *Birth date*

FL 15 - Patient's Sex

FL 17 - Admission Date

Enter the admission date, which must be the same date as the effective date of the hospice election or change of election. The date of admission may not precede the physician's certification by more than 2 calendar days.

EXAMPLE: The hospice election date (admission) is January 1, 1993. The physician's certification is dated January 10, 1993. The hospice admission date for coverage and billing is January 8, 1993. The first hospice benefit period will end 90 days from January 8, 1993.

The admission date stays the same on all continuing claims for the same benefit period.

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

FL 22 - Patient Status

This code indicates the patient's status as of the **"**Through" date (FL 6) of the billing period

Code Structure

01 Discharged to home or self care (revocation, de-certification**,** or transfer from the agency)

30 Still patient

40 Expired at home

41 Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice

42 Expired - place unknown

50 Hospice - home

51 Hospice - medical facility

FL 23 - Medical Record Number (Optional)

FLs 24, 25, 26, 27, 28, 29, and 30 - Condition Codes

Code(s) identifying conditions related to this bill that may affect processing.

Codes listed are only those specific to Hospice; see the general instructions for completing the UB-92 at http://www.cms.hhs.gov/providers/edi/edi5.asp for a complete list of codes.

07	Treatment of Non-terminal Condition for Hospice	Code indicates the patient has elected hospice care but the provider is not treating the terminal condition, and is, therefore, requesting regular Medicare payment.
20	Beneficiary Requested Billing	Code indicates the provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination.
21	Billing for Denial Notice	Code indicates the provider realizes services are at a noncovered level of care or excluded, but requests a denial notice from Medicare in order to bill Medicaid or other insurers.

FLs 32, 33, 34, and 35 - Occurrence Codes and Dates

Enter code(s) and associated date(s) defining specific event(s) relating to this billing period. Event codes are two numeric digits, and dates are six numeric digits (MM-DD-YY). If there are more occurrences than there are spaces on the form, use FL 36 (occurrence span) or FL 84 (remarks) to record additional occurrences and dates.

Use the following codes where appropriate:

Code	**Title**	**Definition**
23	Cancellation of Hospice Election Period (FI USE ONLY)	Code indicates date on which a hospice period of election is cancelled by an FI as opposed to revocation by the beneficiary.
24	Date Insurance Denied	Code indicates the date of receipt of a denial of coverage by a higher priority payer.
27	Date of Hospice Certification or Re-Certification	Code indicates the date of certification or re-certification of the hospice benefit period, beginning with the first 2 initial benefit periods of 90 days each and the subsequent 60-day benefit periods.
42	Date of Termination of Hospice Benefit	Enter code to indicate the date on which beneficiary terminated his/her election to receive hospice benefits. This code can be used only when the beneficiary has revoked the benefit, has been decertified or discharged. **It cannot** be used in transfer situations.

FL 36 - Occurrence Span Code and Dates

Code(s) and associated beginning and ending date(s) defining a specific event relating to this billing period are shown. Event codes are two alphanumeric digits and dates are shown numerically as MM-DD-YY. Use the following code(s) where appropriate:

Code	Title	Definition
M2	Dates of Inpatient Respite Care	Code indicates From/Through dates of a period of inpatient respite care for hospice patients to differentiate separate respite periods of less than 5 days each. M2 is used when respite care is provided more than once during a benefit period.

FLs 39, 40, and 41 - Value Codes and Amounts

The most commonly used value code on hospice claims is value code 61, which is used to report the location of the site of hospice services. Otherwise, value codes are commonly used only to indicate Medicare is secondary to another payer. For detailed information on reporting Medicare secondary payer information see the Medicare Secondary Payer Manual.

Code	Title	Definition
61	Location Where Service is Furnished	MSA number (or rural state code) of the location where the hospice service is delivered. Reporting of value code 61 is required when billing revenue codes 0651 and 0652 or when another insurance carrier is primary to Medicare. The hospice enters the four digit MSA, with two trailing zeroes, in the "amount" field (i.e., if the MSA is 1900, enter 190000

FL 42 - Revenue Code

Assign a revenue code for each type of service provided. Enter the appropriate four-digit numeric revenue code on line FL42 to explain each charge in FL47.

NOTE: Hospices use revenue code 0657 to identify hospice charges for services furnished to patients by physician *or nurse practitioner* employees, or physicians *or nurse practitioners* receiving compensation from the hospice. *Physician services performed by a nurse practitioner require the addition of the modifier GV* in conjunction with revenue code 0657, the procedure HCPCS code is entered in FL44. Procedure codes

are required in order for the FI to determine the reimbursement rate for the physician services. Appropriate procedure codes are available from the FI.

Hospices use these revenue codes to bill Medicare.

Code	**Description**	**Standard Abbreviation**
0651*	Routine Home Care	RTN Home
0652*	Continuous Home Care	A minimum of 8 hours of primarily nursing care within a 24-hour period. The 8-hours of care does not need to be continuous within the 24-hour period, but a need for an aggregate of 8 hours of primarily nursing care is required. Nursing care must be provided by a registered nurse or a licensed practical nurse. If skilled intervention is required for less than 8 aggregate hours within a 24 hour period, then the care rendered would be covered as a routine home care day. *Services provided by a nurse practitioner as the attending physician are not included in the CHC computation.*
0655	Inpatient Respite Care	IP Respite
0656	General Inpatient Care	GNL IP
0657**	Physician Services	PHY SER (must be accompanied by a physician procedure code)
• Reporting of value code 61 is required with these revenue codes. • ***Reporting of modifier GV is required with this revenue code when billing physician services performed by a nurse practitioner.*		

FL 43 - Revenue Description (Not Required)

FL 44 - HCPCS/Rates

FL 46 - Units of Service

Enter the number of units for each type of service. Units are measured in days for codes 651, 655, and 656, in hours for code 652, and in procedures for code 657.

FL 47 - Total Charges

FLs 50A, B, and C - Payer Identification

FL 51A, B, and C - Provider Number

FLs 58A, B, and C - Insured's Name

FLs 60A, B, and C - Certificate/Social Security Number and Health Insurance Claim/Identification Number

FL 67 - Principal Diagnosis Code

FL 82 - Attending Physician I.D.

Enter the UPIN 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 Enter the UPIN in the first six positions followed by the physician's last name, first name, and middle initial (optional).

See the general instructions for completing the UB-92 at http://www.cms.hhs.gov/providers/edi/edi5.asp for information about Physicians that have not been assigned a UPIN.

FL 83 - Other Physician I.D.

Enter the word **"**employee" or **"**nonemployee." (See §§40 for definition.)

FL 84 - Remarks (Not Required)

FL 85-6 - Provider Representative Signature and Date

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

40 - Billing and Payment for Hospice Services Provided by a Physician

(Rev. 1, 10-01-03)

HSP-406, B3-4175, B3-2020, B3-15513

40.1 - Types of Physician Services

(Rev. 1, 10-01-03)

HSP-406

Payment for physician services provided in conjunction with the hospice benefit is made based on the type of service performed.

40.1.1 - Administrative Activities

(Rev. 304, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

Payment for physicians' administrative and general supervisory activities is included in the hospice payment rates. These activities include participating in the establishment, review and updating of plans of care, supervising care and services and establishing governing policies.

These activities are generally performed by the physician serving as the medical director and the physician member of the interdisciplinary group *(IDG)*. *Nurse practitioners may not serve as or replace the medical director or physician member of the IDG*.

40.1.2 - Patient Care Services

(Rev. 304, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

Payment for physicians or *nurse practitioner serving as the attending physician, who provide direct* patient care services *and who are* hospice employees or under arrangement with the hospice**,** is made in the following manner:

- Hospices establish a charge and bill the FI for these services.

- The FI pays the hospice at the lesser of the actual charge or 100 percent of the Medicare physician fee schedule for *physician services or 85% of the fee schedule amount for nurse practitioner services.* This payment is in addition to the daily hospice rates.

- Payment for physician and *nurse practitioner* services is counted with the payments made at the daily payment rates to determine whether the overall hospice cap amount has been exceeded.

- No payment is made for physician *or nurse practitioner* services furnished voluntarily. However, some physicians *and nurse practitioners* may seek payment for certain services while furnishing other services on a volunteer basis. Payment may be made for services not furnished voluntarily if the hospice is obligated to pay the physician *or nurse practitioner* for the services. A physician *or nurse practitioner* must treat Medicare patients on the same basis as other patients in the hospice; a physician *or nurse practitioner* may not designate all services rendered to non-Medicare patients as volunteer and at the same time bill the hospice for services rendered to Medicare patients.

- *No payment is made for nurse practitioner services that can be performed by a registered nurse, nor is payment made for nurse practitioner services that are performed outside of the attending physician role. Nurse practitioner services are generally encompassed in the per diem payment rate. The only payment that can be made for services of a nurse practitioner is made for services furnished in the role of an attending physician.*

  EXAMPLE: Dr. Jones has an agreement with a hospice to serve as its medical director on a volunteer basis. Dr. Jones does not furnish any direct patient care services on a volunteer basis. A Medicare beneficiary enters the hospice and designates Dr. Jones as her attending physician. When he furnishes a direct service to the beneficiary, he bills the hospice for this service and the hospice in turn bills the FI and is paid for the service. Dr. Jones may not bill Medicare Part B as an independent attending physician because as a volunteer he is deemed to be a hospice employee.

40.1.3 - Attending Physician Services

(Rev. 304, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for professional services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an **"**attending physician," who is not an employee of the designated hospice nor receives compensation from the hospice for those services. For purposes of administering the hospice benefit provisions, an **"**attending physician" means an *individual* who:

- Is a doctor of medicine or osteopathy or

- *A nurse practitioner (for professional services related to the terminal illness that are furnished on or after December 8, 2003); and*

- Is identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of their medical care.

Even though a beneficiary elects hospice coverage, he/she may designate and use an attending physician, who is not employed by nor receives compensation from the hospice for professional services furnished, in addition to the services of hospice-employed physicians. The professional services of an attending physician, *who may be a nurse practitioner as defined in Chapter 9,* that are reasonable and necessary for the treatment and management of a hospice patient's terminal illness are not considered hospice services.

Where the service is considered a hospice service (i.e., a service related to the hospice patient's terminal illness that was furnished by someone other than the designated "attending physician" [or a physician substituting for the attending physician]) the physician or other provider must look to the hospice for payment.

Professional services related to the hospice patient's terminal condition that were furnished by the "attending physician", *who may be a nurse practitioner*, are billed to carriers. When the attending physician furnishes a terminal illness related service that includes both a professional and technical component (e.g., x-rays), he/she bills the professional component of such services to the carrier and looks to the hospice for payment for the technical component. Likewise, the attending physician*, who may be a nurse practitioner, would* look to the hospice for payment for terminal illness related services furnished that have no professional component (e.g., clinical lab tests). The remainder of this section explains this in greater detail.

When a Medicare beneficiary elects hospice coverage he/she may designate an attending physician, *who may be a nurse practitioner*, not employed by the hospice, in addition to receiving care from hospice-employed physicians. The professional services of a non-hospice affiliated attending physician for the treatment and management of a hospice patient's terminal illness are not considered "hospice services." These attending physician services are billed to the carrier, provided they were not furnished under a payment arrangement with the hospice. The attending physician codes services with the GV modifier "Attending physician not employed or paid under agreement by the patient's hospice provider" when billing his/her professional services furnished for the treatment and management of a hospice patient's terminal condition. Carriers make payment to the attending physician or beneficiary, as appropriate, based on the payment and deductible rules applicable to each covered service.

Payments for the services of attending physician *are not* counted in determining whether the hospice cap amount has been exceeded because services provided by an independent attending physician are not part of the hospice's care.

Services provided by an independent attending physician *who may be a nurse practitioner* must be coordinated with any direct care services provided by hospice physicians.

Only the direct professional services of an independent attending physician, *who may be a nurse practitioner,* to a patient may be billed; the costs for services such as lab or x-rays are not to be included in the bill.

If another physician covers for a *hospice patient's* designated attending physician, the services of the substituting physician are billed by the designated attending physician under the reciprocal or locum tenens billing instructions. In such instances, the attending physician bills using the GV modifier in conjunction with either the Q5 or Q6 modifier.

When services related to a hospice patient's terminal condition are furnished under a payment arrangement with the hospice by the designated attending physician *who may be a nurse practitioner*, the physician must look to the hospice for payment. In this situation the physicians' services are hospice services and are billed by the hospice to its FI.

Carriers must process and pay for covered, medically necessary Part B services that physicians furnish to patients after their hospice benefits are revoked even if the patient remains under the care of the hospice. Such services are billed without the GV or GW modifiers. Make payment based on applicable Medicare payment and deductible rules for each covered service even if the beneficiary continues to be treated by the hospice after hospice benefits are revoked.

The CWF response contains the period of hospice entitlement. This information is a permanent part of the notice and is furnished on all CWF replies and automatic notices. Carriers use the CWF reply for validating dates of hospice coverage and to research, examine and adjudicate services coded with the GV or GW modifiers.

40.1.3.1 - Care Plan Oversight

(Rev. 304, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

The attending physician may bill for care plan oversight services for a hospice enrollee. The physician must bill for these services using Form CMS-1500*;* these services are not to be included on the hospice bill

Care plan oversight (CPO) exists where there is physician supervision of patients under care of hospices that require complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans. Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the hospice during the month for which CPO services were billed.

Claims for CPO must be submitted with no other services billed on that claim and may be billed only after the end of the month in which the CPO services were rendered. CPO services may not be billed across calendar months. One unit of service is shown for the month.

Services not countable toward the 30 minutes threshold that must be provided in order to bill for CPO include, but are not limited to, time associated with discussions with the patient, his or her family or friends to adjust medication or treatment, time spent by staff getting or filing charts, travel time, and/or physician's time spent telephoning prescriptions in to the pharmacist unless the telephone conversation involves discussions of pharmaceutical therapies.

For CPO claims submitted on or after January 1, 1997, physicians must enter on the Medicare claim form the 6-character Medicare provider number of the hospice providing Medicare covered services to the beneficiary for the period during which CPO services were furnished and for which the physician signed the plan of care. Physicians are responsible for obtaining the hospice Medicare provider numbers.

For additional information on CPO, see the Medicare Benefit Policy Manual, Chapter 15.

40.2 - Carrier Processing of Claims for Hospice Beneficiaries

(Rev. 304, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

Professional services of attending physicians, *who may be nurse practitioners*, *furnished to* hospice beneficiaries are *coded* with modifier GV. Attending physician not employed or paid under arrangement by the patient's hospice provider. This modifier must be retained and reported to CWF.

Local Part B carriers shall presume that hospice benefits are not involved unless the biller codes services on the claim to indicate that the patient is a hospice enrollee (e.g. the GV modifier is billed by the attending physician, who may be a nurse practitioner, or the GW modifier is billed for services unrelated to the terminal illness) or the trailer information on the CWF reply shows a hospice election. The carrier shall use the hospice enrollment trailer information on the CWF reply to examine and validate the claim information.

For beneficiaries enrolled in hospice, carriers *shall* deny any services furnished on or after January 1, 2002, that are submitted without either the GV or GW modifier. For services furnished to a hospice patient prior to January 1, 2002, the attending physician is to include an attestation statement that is the written equivalent of the GV modifier and carriers are responsible for determining whether or not a service is related to the patient's terminal condition.

Deny claims for all other services *related to the terminal illness* furnished by *individuals or entities* other than the designated attending physician*, who may be a nurse practitioner. Such claims* include bills for any DME, supplies or independently practicing speech or physical therapists that are related to the terminal condition. These services are included in the hospice rate and paid through the FI.

See §110 for MSN and Remittance Advice (RA) coding.

40.2.1 - Claims After the End of Hospice Election Period

(Rev. 1, 10-01-03)

A3-3141.1

Upon revocation of Medicare coverage of hospice care for a particular election period, an individual resumes Medicare coverage of the benefits waived when hospice care was elected. After revocation, carriers process and pay for covered Part B services that hospice employed physicians may furnish. Services provided before the hospice termination date may not be paid.

40.2.2 - Claims From Medicare + Choice Organizations

(Rev. 1, 10-01-03)

B3-4175.3

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).

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 M+CO 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.

M + C organizations may bill the Medicare carrier for nonhospice services provided to M + C 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. **Revised requirements for such billing were set forth in Transmittal 1728 CR 1910 in Pub. 14-4 (Medicare Carriers Manual) effective April 2002 and specifies use of modifiers –GV and –GW.** 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. Managed care 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.

50 - Billing and Payment for Services Unrelated to Terminal Illness

(Rev. 1, 10-01-03)

HSP-303.2, B3-4175.2, AB-02-015

Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and which are furnished during a hospice election period, may be billed by the rendering provider to the FI or carrier for non-hospice Medicare payment. These services are coded with the GW modifier "service not related to the hospice patient's terminal condition" when submitted to a carrier or with condition code 07 "Treatment of Non-terminal Condition for Hospice" when submitted to an FI. Contractors process services coded with the GW modifier and "07" condition code in the normal manner for coverage and payment determinations. If warranted, contractors may conduct prepayment development or postpayment review to validate that services billed with the GW modifier or "07" condition code are not related to the patient's terminal condition. See the related chapter of the Medicare Claims Processing Manual chapter for the type of service involved (i.e., Chapter 12 for physician type of services) for billing rules.

60 - Billing and Payment for Services Provided by Hospices Under Contractual Arrangements With Other Institutions

(Rev. 1, 10-01-03)

A-02-102

There may be circumstances in which another health care entity may wish to "purchase" some of the highly specialized staff time or services of a hospice to better meet the needs of their specific patient population. In these cases, the services are not "hospice" services in terms of Medicare payment but become part of the service package of the provider under whose care the patient is. Examples of such circumstances are provided below.

EXAMPLE 1

A dually eligible Medicare/Medicaid beneficiary enrolled in the Program of All-Inclusive Care for the Elderly (PACE) program for approximately two years has been diagnosed with a life limiting terminal illness with a prognosis of six months or less. In the course of routine assessments, the PACE provider recognizes that the beneficiary would benefit from the specialized services of a pain management specialist or a grief counselor. The PACE provider would then enter into a contractual arrangement with a Medicare certified hospice to purchase these specialized services. The hospice provider would bill the PACE provider for the services, and the PACE provider would in turn pay the hospice provider directly. Neither provider type would be allowed to bill Medicare separately for the contracted services (which in this example are PACE services and included in the PACE provider's capitated rate). In this example, the PACE provider would maintain a medical record on the patient and the hospice provider would submit any documentation related to the care of the PACE patient to the PACE provider.

EXAMPLE 2

A Medicare beneficiary is receiving skilled services from a Medicare certified home health agency (HHA). The beneficiary has been diagnosed with a life limiting terminal illness, but chooses to continue curative treatments, thereby rendering him ineligible for the Medicare hospice benefit. The beneficiary is experiencing a period of intractable pain, and the HHA wishes to purchase specialized pain control services from the hospice provider. The HHA would then enter into a contractual arrangement with a Medicare certified hospice to purchase specialized nursing services. The hospice would bill the HHA and the HHA would pay the hospice provider directly. Neither provider type would be allowed to bill Medicare separately for the contracted services (which, in this example, are home health services and therefore included in the HHA's episode payment). In this example, the HHA would maintain a medical record on the patient, and the hospice submits any documentation related to the pain management to the HHA.

EXAMPLE 3

A Medicare beneficiary (non-dual eligible) resides in a skilled nursing facility (SNF) and has a diagnosis of Alzheimer's disease. The beneficiary's disease process has progressed to a stage in which he/she can no longer ingest food or fluids. The beneficiary's family has been approached by the SNF regarding the placement of a feeding tube and has been told, "their loved one may not live much longer." The family is struggling with this concept and has requested assistance from the SNF regarding hospice care and grief counseling. The SNF has provided information about the Medicare hospice benefit to the family, but the patient's legal representative has made a decision not to elect hospice care at this time. The SNF does not have a trained grief counselor or full-time social worker on staff, but has a business relationship with a local hospice and has requested the services of a pastoral or grief counselor. The SNF and hospice enter into a contractual arrangement for the provision of grief counseling to this beneficiary's family by a pastoral care counselor. The hospice provider would bill the SNF, and the SNF would pay the hospice provider directly. Neither provider type would be allowed to bill Medicare Part A or B separately for the pastoral care services (which in this example are included in the Medicare's Resource Utilization Group or RUG payments to the SNF). The SNF maintains the medical record on this patient and the hospice provider would submit any documentation related to the pastoral care services provided to the SNF.

60.1 - Instructions for the Contractual Arrangement

(Rev. 1, 10-01-03)

A-02-102

A contractual agreement between both parties must be on file and available for review by the state survey agency responsible for conducting surveys on behalf of CMS to assess compliance with the relevant conditions of participation for the provider contracting for the hospice services. Where a PACE organization contracts with a hospice organization, the contract, which is reviewed by CMS, must meet the requirements specified in 42 CFR 460.70. The agreement must specify each of the services to be provided, the credentials required for any of the professionals providing the services, the billing method and payment amounts, and any required documentation.

60.2 - Clarification of the Payment for Contracted Services

(Rev. 1, 10-01-03)

A-02-102

In all of the examples provided above, the billing and payment for the services are between each of the providers. It is our expectation that Medicare will not be billed separately for any of the contracted services referred to in the examples provided above.

70 - Deductible and Coinsurance for Hospice Benefit

(Rev. 1, 10-01-03)

HSP 410

70.1 - General

(Rev. 1, 10-01-03)

A3-3142

There is no deductible.

The payment rates have been reduced by a coinsurance amount on outpatient drugs and biologicals, and inpatient respite care as required by law. No other coinsurance or deductibles may be imposed for services furnished to beneficiaries during the period of an election, regardless of the setting of the services. Hospices may charge beneficiaries for the applicable coinsurance amounts only for drugs and biologicals and for inpatient respite care.

The hospice is responsible for billing and collecting any coinsurance amounts from the beneficiary.

70.2 - Coinsurance on Outpatient Drugs and Biologicals

(Rev. 1, 10-01-03)

The hospice may charge the beneficiary a coinsurance amount equal to 5 percent of the reasonable cost of the drug or biological to the hospice, but not more than $5, for each prescription furnished on an outpatient basis.

The hospice is not required to make this charge but may do so in accordance with the following.

- The hospice must establish a **"**drug copayment schedule" that specifies each drug and the copayment to be charged. The copayment charges included on the schedule must approximate 5 percent of the cost of the drugs or biologicals to the hospice, up to a $5 maximum. Additionally, the cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances. The hospice must submit this schedule to the FI in advance for approval.

70.3 - Coinsurance on Inpatient Respite Care

(Rev. 1, 10-01-03)

The hospice may charge the beneficiary a coinsurance amount equal to 5 percent of the amount CMS has estimated to be the cost of respite care, after adjusting the national rate

for local wage differences. This coinsurance is not counted toward the hospital deductible, but it is limited to the same amount.

EXAMPLE

Assume a wage adjusted inpatient respite care rate for the year (as provided by the FI) of $100. The maximum coinsurance rate would be $5. The hospice may charge any amount up to and including $5 for inpatient respite care only.

The total amount of coinsurance for inpatient respite care for any beneficiary during a hospice coinsurance period may not exceed the amount of the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began. A hospice coinsurance period begins with the first day for which an election for hospice services is in effect for the beneficiary and ends with the close of the first period of 14 consecutive days on which no such election is in effect for the beneficiary.

EXAMPLE

Mr. Brown elected an initial 90-day period of hospice care. Five days after the initial period of hospice care ended, Mr. Brown began another period of hospice care under a subsequent election. Immediately after that period ended, he began a third period of hospice care under an additional election period. Since these election periods were not separated by 14 consecutive days, they constitute a single hospice coinsurance period. Therefore, the maximum coinsurance for respite care during all three periods of hospice care may not exceed the amount of the inpatient hospital deductible for the year in which the first period began.

No other coinsurance may be charged by the hospice.

80 - Caps and Limitations on Hospice Payments

(Rev. 1, 10-01-03)

80.1 - Limitation on Payments for Inpatient Care

(Rev. 1, 10-01-03)

HSP 405

Payments to a hospice for inpatient care are subject to a limitation on the number of days of inpatient care furnished to Medicare patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicare beneficiaries during that same period. This limitation is applied once each year, at the end of the hospices' **"**cap period" (November 1 - October 31). The limitation is calculated by the FI as follows:

1. The maximum allowable number of inpatient days is calculated by multiplying the total number of days of Medicare hospice care by 0.2.

2. If the total number of days of inpatient care furnished to Medicare hospice patients is less than or equal to the maximum, no adjustment is necessary.

3. If the total number of days of inpatient care exceeded the maximum allowable number, the limitation is determined by:

    - Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

    - Multiplying excess inpatient care days by the routine home care rate.

    - Adding together the amounts calculated in bullets 1 and 2 above.

    - Comparing the amount in bullet 3 above with interim payments made to the hospice for inpatient care during the **"**cap period."

Any excess reimbursement must be refunded by the hospice.

EXAMPLE: Assume that:

40,000 total hospice days - the maximum allowable in patient days would be 8000 days.

10,000 inpatient days were paid

The ratio of maximum allowable days to the number of actual days equals 8000 to 10000 or .8.

Assume the total reimbursement for inpatient care revenue codes 0655 and 0656 is $4,000,000. Multiplying $ 4 million times .8 is $3,200,000.

Multiply the 2000 excess inpatient care days by the routine home care rate of $110.56 results in $221,120

Add $3,200,000 (80% of $4, 000,000) and $221,120 results in $3,421,120.

Compare $3,421,120 cap with $4,000,000 paid for inpatient revenue codes.

The hospice must refund $578,880.

80.2 - Cap on Overall Hospice Reimbursement

(Rev. 1, 10-01-03)

HSP 407-407.1

Overall aggregate payments made to a hospice are subject to a **"**cap amount," calculated by the FI at the end of the hospice cap period. The cap period runs from November 1st of each year through October 31 of the next year. The total payment made for services furnished to Medicare beneficiaries during this period are compared to the **"**cap amount" for this period. Any payments in excess of the cap must be refunded by the hospice.

80.2.1 - Services Counted

(Rev. 1, 10-01-03)

"Total payment made for services furnished to Medicare beneficiaries during this period" refers to payment for services rendered during the cap year beginning November 1 and ending October 31, regardless of when payment is actually made. All payments made to hospices on behalf of all Medicare hospice beneficiaries receiving services during the cap year are counted, regardless of which year the beneficiary is counted in determining the cap. For example, payments made to a hospice for an individual electing hospice care on October 5, 1997, pertaining to services rendered in the cap year beginning November 1, 1996, and ending October 31, 1997, are counted as payments made during the first cap year (November 1, 1996 - October 31, 1997), even though that individual is not counted in the calculation of the cap for that year. (The individual is, however, to be counted in the cap calculation for the following year since the election occurred after September 27 - see below).

The hospice cap is calculated in a different manner for new hospices entering the program if the hospice has not participated in the program for an entire cap year. In this situation, the initial cap calculations for newly certified hospices must cover a period of at least 12 months but not more than 23 months. For example, the first cap period for a hospice entering the program on October 1, 1997, runs from October 1, 1997 through October 31, 1998. Similarly, the first cap period for hospice providers entering the program after November 1, 1996, but before November 1, 1997, ends October 31, 1998.

The **"**cap amount" is calculated by multiplying the number of beneficiaries electing hospice care during the period by a statutory amount (See §80.2 for an explanation of how this amount is obtained each year). The hospice cap amount for the cap year ending October 31, 2003, is $18, 661.29. This amount may be adjusted in future years to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index (CPI) for all urban consumers

Hospices that began operations before January 1, 1975, are eligible for an exception to the application of this cap. The hospice must apply and be approved to receive this waiver. Send applications to:

Centers for Medicare & Medicaid Services
Chronic Care and Purchasing Policy Group, CHPP
C5-02-23
7500 Security Boulevard
Baltimore, MD. 21244-1850

The computation and application of the **"**cap amount" is made by the FI at the end of the cap period. The material is presented here for the hospice benefit as an aid to planning. Hospices are responsible for reporting the number of Medicare beneficiaries electing hospice care during the period to the FI. This must be done within 30 days after the end of the cap period.

Follow these rules in determining the number of Medicare beneficiaries who have elected hospice care during the period:

- The beneficiary must not have been counted previously in either another hospice's cap or another reporting year.

- The beneficiary must file an initial election during the period beginning September 28 of the previous cap year through September 27 of the current cap year in order to be counted as an electing Medicare beneficiary during the current cap year. This slight adjustment is necessary to produce a reasonable estimate of the proportionate number of beneficiaries to be counted in each cap period.

80.2.2 - Counting Beneficiaries for Calculation

(Rev. 1, 10-01-03)

Once a beneficiary has been included in the calculation of a hospice cap amount, he or she may not be included in the cap for that hospice again, even if the number of covered days in a subsequent reporting period exceeds that of the period where the beneficiary was included. (This could occur when the beneficiary has breaks between periods of election.)

When a beneficiary elects to receive hospice benefits from two or more different Medicare certified hospices, proportional application of the cap amount is necessary. It is inequitable to count the patient's stay in the hospices as equivalent if there were marked differences in the lengths of stay. Consequently, a calculation must be made to determine the percentage of the patient's length of stay in each hospice relative to the total length of hospice stay. The FI servicing the hospice program in which the beneficiary dies or revokes the hospice benefit is responsible for determining the proportionate lengths of stay for all preceding hospices. This FI is also responsible for disseminating this information to any other FI servicing hospices in which the beneficiary was previously enrolled. Each FI then adjusts the number of beneficiaries reported by these hospices based on the latest information available at the time the cap is applied.

EXAMPLE: John Doe, a Medicare beneficiary, initially elects hospice care from hospice A on September 2, 2001. Mr. Doe stays in hospice A until October 2, 2001 (30 days) at which time he changes his election and enters hospice B. Mr. Doe stays in hospice B for 70 days until his death on December 11, 2001. The FI servicing hospice B is responsible for determining the proportionate number of Medicare beneficiaries to be reported by each hospice that delivered hospice services to Mr. Doe. This FI determines that the total length of hospice stay for Mr. Doe is 100 days (30 days in hospice A and 70 days in hospice B). Since Mr. Doe was in hospice A for 30 days, Hospice A counts .3 of a Medicare beneficiary for Mr. Doe in its hospice cap calculation (30 days/100 days). Hospice B counts .7 of a Medicare beneficiary in its cap calculation (70 days/100 days). The FI servicing hospice B makes these determinations and notifies the FI servicing hospice A of its determination. These FI are then responsible for making appropriate adjustments to the number of beneficiaries reported by each hospice in the determination of the hospice cap.

Readjustment of the hospice cap may be required if information previously unavailable to the FI at the time the hospice cap is applied subsequently becomes available.

EXAMPLE: Using the example above, if the FI servicing hospice A had calculated and applied the hospice cap on November 30, 2001, information would not have been available at that time to adjust the number of beneficiaries reported by hospice A, since Mr. Doe did not die until December 11, 2001. The FI servicing hospice A would have to recalculate and reapply the hospice cap to hospice A based on the information it later received from the FI servicing hospice B. The cap for hospice A after recalculation would then reflect the proper beneficiary count of .3 for Mr. Doe.

An additional step is required when more than one Medicare certified hospice provides care to the same individual, and the care overlaps two cap years. In this case, each FI must determine in which cap year the fraction of a beneficiary is reported. If the beneficiary entered the hospice before September 28, the fractional beneficiary is included in the current cap year. If the beneficiary entered the hospice after September 27, the fractional beneficiary is included in the following cap year.

EXAMPLE: Continuing with the case cited in the examples above, hospice A includes .3 of a Medicare beneficiary in its cap calculation for the cap year beginning November 1, 2000, and ending October 31, 2001, since Mr. Doe entered hospice A before September 28, 2001. Hospice B includes .7 of a Medicare beneficiary in its cap calculation for the cap year beginning November 1, 2001, and ending October 31, 2002, since Mr. Doe entered hospice B after September 27, 2001.

Where services are rendered by two different hospices to one Medicare patient, and one of the hospices is not certified by Medicare, no proportional application is necessary. The FI counts one patient and uses the total cap for the certified hospice.

80.2.3 - Adjustments to Cap Amount

(Rev. 1, 10-01-03)

The original cap amount of $6,500 per year is increased or decreased for accounting years that end after October 1, 1984, by the same percentage as the percentage of increase or decrease in the medical care expenditure category of the consumer price index for all urban consumers (United States city average), published by the Bureau of Labor Statistics, from March 1984 to the fifth month of the accounting year. The hospice cap is applied on the basis of a cap year beginning November 1 and ending the following October 31.

For example, for the cap amount for the period ending October 31, 1998, calculate using the March 1998 price level in the medical care expenditures category of 239.8 and divide by the March 1984 price level of 105.4 to yield an index of 2.275 (rounded). The new hospice cap amount is the product of $6500 (base year cap) multiplied by 2.275. Therefore, the cap amount for the period ending October 31, 1997, is $14,788.

In those situations where a hospice begins participation in Medicare at any time other than the beginning of a cap year (November 1st), and hence has an initial cap calculation for a period in excess of 12 months, a weighted average cap amount is used. The following example illustrates how this is accomplished.

EXAMPLE

10/01/97 - Hospice A is Medicare certified.

10/01/97 to 10/31/98 - First cap period (13 months) for hospice A.

Statutory cap for first Medicare cap year (11/01/96 - 10/31/97) = $14,394

Statutory cap for second Medicare cap year (11/01/97 - 10/31/98) = $14,788

Weighted average cap calculation for hospice A:

One month (10/01/97 - 10/31/97) at $14,394 = $ 14,394

12 months (11/01/97 - 10/31/98) at $14,788 = $177,456

13 month period $191,850 divided by 13 = $14,758 (rounded)

In this example, $14,758 is the weighted average cap amount used in the initial cap calculation for hospice A for the period October 1, 1997, through October 31, 1998.

NOTE: If hospice A had been certified in mid-month, a weighted average cap amount based on the number of **days** falling within each cap period is used.

90 - Frequency of Billing

(Rev. 1, 10-01-03)

HSP 303.5

The hospice will bill monthly. If the care is interrupted, e.g., an inpatient hospital admission for an unrelated condition, occurrence span code 74 is used to show the period not applicable to hospice care.

100 - Medical Review of Hospice Claims

(Rev. 1, 10-01-03)

HSP 304

See Chapter 6 of the Medicare Program Integrity Manual.

110 - Medicare Summary Notice (MSN) Messages/ASC X12N Remittance Advice Adjustment Reason and Remark Codes

(Rev. 1, 10-01-03)

B3-7012, Transmittal R64-HSP, Transmittal R1846-A3

The following messages apply specifically to Hospice beneficiaries. See Chapter 21 for a list of all messages. Note that administrative appeals processes are available to beneficiaries, physicians/suppliers, or providers dissatisfied with these determinations, see Chapter 29 for more information.

MSN Code	Message	ASC Code	Message
27.1	This service is not covered because you are enrolled in a hospice.	B9	Services are not covered because the patient is enrolled in a hospice.
27.2	Medicare will not pay for inpatient respite care when it exceeds 5 consecutive days at a time.	119	Benefit maximum for this time period has been reached.
27.3	The physician certification requesting hospice services was not received timely.	B17 with MA54	Claim/service denied because this service was not prescribed by a physician, not prescribed prior to delivery, the

MSN Code	Message	ASC Code	Message
			prescription is incomplete, or the prescription is not current. Physician certification or election consent for hospice care not received timely.
27.4	The documentation received indicates that the general inpatient services were not related to the terminal illness. Therefore, payment will be adjusted to the routine home care rate.	58	Claim/service denied/reduced because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
27.5	Payment for the day of discharge from the hospital will be made to the hospice agency at the routine home care rate. (This would be shown on the RA to the hospice by payment for that date as billed by the hospice.)	No separate message would be needed. The payment rate would be shown as the allowed amount.	
27.6	The documentation indicates the level of care was at the respite level not the general inpatient level of care. Therefore, payment will be adjusted to the routine home care rate. (The level of care being paid would be indicated by the allowed amount.)	57	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
27.7	According to Medicare hospice requirements, the hospice election consent was not signed timely.	106 with MA54	Patient payment option/election not in effect. Physician certification or election consent for

MSN Code	Message	ASC Code	Message
			hospice care not received timely.
27.8	The documentation submitted does not support that your illness is terminal.	57 with zero payment for hospice.	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
27.9	The documentation indicates your inpatient level of care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.	57 (the level of care being paid would be indicated by the allowed amount)	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
27.10	The documentation indicates that the level of continuous care was not reasonable and necessary. Therefore, payment will be adjusted to the routine home care rate.	57 (the level of care being paid would be indicated by the allowed amount)	Claim/service denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, or this dosage.
27.11	The provider has billed in error for the routine home care items or services received.	97	Payment is included in allowance for the basic service/procedure.
27.12	The documentation indicates that your respite level of care exceeded five consecutive days. Therefore, payment for every day beyond the fifth day will be paid at the routine home care rate.	NA	

MSN Code	Message	ASC Code	Message
27.13	According to Medicare hospice requirements, this service is not covered because the service was provided by a non-attending physician.	NA	

120 - Contractor Responsibilities for Publishing Hospice Information

(Rev. 1, 10-01-03)

B3-4175.1, B3-4175.6

Carriers must at least annually, include in newsletters and bulletins to physicians and suppliers an explanation of the hospice program and the requirements for billing for physicians who attend a hospice patient. Include information on the use of special modifiers that are in effect at that time.

Carriers may also publish related material on Web pages.