Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-03-049 **Date: APRIL 18, 2003**

This Program Memorandum re-issues Program Memorandum AB-02-015, Change Request 2013, dated February 7, 2002. The only change is the discard date and the deletion of one contact person; all other material remains the same.

CHANGE REQUEST 2013

SUBJECT: Clarification of Payment Responsibilities of Fee-for-Service Contractors as it Relates to Hospice Members Enrolled in Managed Care Organizations (MCOs) and Claims Processing Instructions for Processing Rejected Claims

Purpose and Scope

The purpose of this Program Memorandum (PM) is to clarify existing regulations regarding payment responsibility for hospice patients enrolled in managed care plans, as well as provide specific claims processing requirements to ensure payment for such claims. Federal regulations require that Medicare fee-for-service contractors maintain payment responsibility for managed care enrollees who elect hospice; specifically, regulations at 42CFR Part 417, Subpart P, 42 CFR 417.585 Special Rules: Hospice Care (b), and 42 CFR 417.531 Hospice Care Services (b).

Since this PM is directed to Medicare fee-for-service contractors, instructions and payment information for MCOs is not provided. However, in short, CMS (formerly HCFA or the Health Care Financing Administration) released an Operational Policy Letter (OPL 2000.115) on February 24, 2000, stating the requirements for payment responsibility to MCOs for their hospice enrollees. This letter supplemented 42 CFR 422.266: Special Rules for Hospice Care. During the time the hospice election is in effect, monthly capitation payment to the MCO is reduced to an amount equal to the adjusted excess amount determined under CFR 422.312.

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 MCO 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.

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 are not disrupted.

The HMO or CMPs may directly bill for attending physician services, as listed above, to Medicare carriers in keeping with existing processes.

Medicare physicians may also bill such service directly to carriers as long as all current requirements for billing for hospice beneficiaries are met. Revised requirements for such billing were recently set forth in Transmittal 1728, Change Request 1910 of the Medicare Carriers Manual (MCM), Part 3, effective April 2002 and specifies use of modifiers -GW and -GV. 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.

For medical services for a condition not related to the terminal condition for which the beneficiary elected hospice, a claim must be submitted to the intermediary using the condition code 07. If physician services are billed to carriers, the instructions in Transmittal 1728, Change Request 1910 of the MCM should be followed and should specify the use of modifier -GW.

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.

Timely Filing

These instructions apply to all contractors for claims filed in the timely filing period for managed care enrollees who have elected hospice. The timely filing period extends from the date of service to the end of the calendar year after the year service was rendered. However, if a service was provided in the fourth quarter of a calendar year, the claim will be timely to the end of the second year after the year in which the service was rendered. Since there have been allegations of lack of compliance with the regulatory requirements for Medicare fee-for-service contractors to process hospice claims for managed care beneficiaries, exceptions to timely filing will be considered on a case-by-case basis. Exceptions to the timely filing requirements will be determined by Medicare contractors on a case-by-case basis in accordance with applicable CMS guidelines.

The *effective date* for this PM is not applicable since this is a clarification of existing instructions.

The *implementation date* for this PM is April 1, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2004.

If you have any questions contact your regional office. Your RO representative may contact Kelly Buchanan (410) 786-6132 if further information is required.