The Medicare Program: FY 2016 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (Final Rule) was published in the Federal Register on August 6, 2015. This Final Rule implements two significant reforms to Medicare hospice payments:

1. Imposition of a two-tiered payment system for the routine home care (RHC) level of care; payment level is based on a beneficiary’s hospice episode days
2. Creation of a service intensity add-on (SIA) payment for Registered Nurse (RN) and Social Work (SW) visits made in the last seven days of a beneficiary’s life if certain conditions are met. Those conditions are:
   1. The day is a RHC level of care day;
   2. The day occurs during the last 7 days of life (and the beneficiary is discharged dead); and,
   3. Direct patient care is provided by a RN or a social worker

Subsequent to the release of the Final Rule, CMS issued three change requests (CR) instructing Medicare Administrative Contractors (MACs) how to process the RHC level of care payments and the SIA payments. The change requests are:

CR 9201 Implementation of Hospice Payment Reforms
NAHC Report Coverage: August 21, 2015

CR 9301 Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2016
NAHC Report Coverage: September 10, 2015

CR 9369 Additional G-Codes Differentiating RNs and LPNs in the Home Health and Hospice Setting
NAHC Report Coverage: October 20, 2015
HOSPICE ROUTINE HOME CARE (RHC) LEVEL OF CARE PAYMENT REFORM AND SERVICE INTENSITY ADD-ON (SIA) VISIT PAYMENT Q&AS

Q: Will hospices need to have separate claim line items for RHC days to be paid at the high RHC rate and days to be paid at the low RHC rate?
A: No, hospices should not separate RHC line items unless the site of service changes. CMS indicates in the final rule:

*There will often be cases where the RHC rate changes during a period of RHC that is shown on a single line item on a claim (for example, an RHC line shows 20 days of care and the high RHC rate ends after day 10). The line item should not be split in this case. Existing instructions require that level of care revenue code lines should only be repeated if the site of service changes. A claim submitted with consecutive RHC lines reporting the same site of service HCPCS code will be returned to the provider. Medicare systems will combine the high and low RHC rates for the applicable days in the total payment for the RHC line item. No changes to the electronic remittance advice are planned as a result of this rule.*

Instructions in CR 9201 appear to be consistent with these final rule comments from CMS.

Q: How will the claim adjustments made by CMS, for the SIA and for the high and low RHC rates, show on the hospice’s remittance advice?
A: CMS will process the adjustment with an adjustment code of 8XG.

Q: Since hospices are not to change how they are billing claims, how will hospices keep track of what was billed and what was paid for the two RHC rates and the SIA?
A: Hospices already need to recognize the difference between what was billed to a payer and what was paid to the hospice. This is done through a contractual adjustment to revenue in most cases. The contractual adjustment usually reflects the sum total difference between what was billed and what was paid. It does not usually reflect line-item differences. So, if a hospice wants to track line item differences in billings and payments, it will need to develop an internal accounting structure to recognize the amount billed to Medicare per line item and the amount received by Medicare per line item.

Q: If a patient’s last seven days of life span the end of one month (billing period) and the beginning of another month (billing period), will CMS adjust payment of the previous month’s payment to include any applicable SIA visits?
A: Yes. When a patient’s final claim is submitted for payment and the final claim reflects that the patient was discharged deceased, CMS systems will automatically review the previous month’s claim and pay any applicable SIA visits.
Q: Should a hospice change its RHC charge on its Medicare claim to accommodate the two RHC rates?
A: No. The hospice should have one charge for all RHC rates on a claim. That charge should be the same for all payers. Hospices are reminded that it is Medicare policy that hospices charge Medicare the same as for all payers. Hospice claims that have more than one RHC line on the claim without there being a change in location for the patient will be returned to provider. Below is additional information regarding what hospices should be charging Medicare. This applies to all levels of care, not just RHC.

CMS' policy is for providers to bill Medicare the same that they charge other payers. There are four manual references listed below that support this position.

* Medicare Claims Processing Manual (CMS Pub. 100-04) Ch. 25, §75.5 [PDF] states "The CMS policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report. Medicare and non-Medicare charges for the same department must be reported consistently on the cost report."

* Provider Reimbursement Manual [EXT], Part 1, Ch. 22

Section 2202 defines "charges" as "the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients’ charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions."

Section 2203 states "To assure that Medicare's share of the provider’s costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program."

Section 2204 states "The Medicare charge for a specific service must be the same as the charge made to non-Medicare patients (including Medicaid, CHAMPUS, private, etc.), must be recorded in the respective income accounts of the facility, and must be related to the cost of the service."

Q: When counting episode days, are general inpatient (GIP), respite, or continuous home care (CHC) days counted?
A: Yes, all days are counted regardless of the level of care. Only days at the routine home care level of care, however, are paid at different rates (high or low rate).

Q: When counting episode days, are days the patient is in a hospital, SNF/NF, or other facility counted?
A: Yes, all days are counted regardless of site of service.

Q: If the patient revokes in the first 90-day benefit period and re-elects the hospice benefit, the patient will begin the second election at the start of the second benefit period which is day 91 for Medicare purposes. How does this impact the day count for the episode?
A: The benefit period days and episode days are completely independent of each other. (See question immediately following for further explanation of counting episode days.)

Q: How are episode days calculated?
A: The only days not included in the episode count are non-Medicare days (i.e. self-pay, commercial insurance days, etc.). All Medicare hospice days, whether or not covered/billable, are counted. For instance, days not covered due to a late CTI or untimely NOE (both of which require use of occurrence span code 77 on the claim) are included in the episode day count. For an untimely F2F encounter, the days the hospice must provide care at no charge to the patient or to Medicare are considered non-Medicare days. These are days that are not entered on the hospice claim and, therefore, are considered non-Medicare days.

Also, the episode days are tied to the beneficiary. If the beneficiary has a gap in hospice care of 61 days or more, for whatever reason, the episode count begins anew when the patient next elects the hospice benefit. If there is not a gap of 61 days or more, the episode count continues. For instance, if a patient revokes on day 23 and re-elects the hospice benefit 43 days later, the episode day count resumes with 24.

Q: How will hospices differentiate between RN and LPN visits on claims?
A: CMS has released Change Request (CR 9369) that contains two new G-codes, one for RN visits (G0299) and one for LPN (G0300) visits, to differentiate types of nursing visits on the claim beginning January 1, 2016. Concurrent with use of the new codes, the existing skilled nursing G code -- G0154 -- will be retired.

Q: The MLNMatters article, MM9201, indicated that the SIA applies to the first two days of hospice care and the last seven days of hospice care, but the CR 9201 states the SIA only applies to the last seven days of hospice care. Are the first two days of hospice care eligible for the SIA?
A: No, the first two days of hospice care are not eligible for the SIA. There was an error in the original publication of MM9201. It has since been corrected to reflect that the last seven days of hospice care only are eligible for the SIA.

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Q: If a patient’s last 7 days of hospice care are provided by two different hospices, will each hospice be able to bill the SIA?
A: No. One of the criteria for the SIA is that the patient be discharged dead from the hospice so only the last hospice serving the patient will be able to bill for the SIA.

Q: The SIA and two levels of RHC begin with claims with a January 1, 2016 “Through” date. Does this mean any days prior to January 1, 2016, i.e. December 2015 days of care, are counted towards the 60 day episode and are eligible for the SIA?
A: The only days eligible for the SIA are those days meeting all of the criteria and occurring on or after January 1, 2016. To determine what day a patient is on in an episode, a hospice is to count the days prior to January 1, 2016 without a break in care. For instance, a patient admitted on November 15, 2015 without any break in hospice care prior to January 1, 2016 would be on day 48 on January 1, 2016. A patient admitted on November 15, 2015, revoking on November 18, 2015 and returning to hospice care on November 30, 2015 would be on day 33 on January 1, 2016. A patient admitted on September 5, 2015, discharged on October 1, 2015 and admitted again on November 15, 2015 would be on day 75 on January 1, 2016. A patient admitted on September 5, 2015, revoked on September 8, 2015 and admitted again on December 23, 2015 would be on day 10 on January 1, 2016.

Q: On the date of death, hospices are required to use a post-mortem (“PM”) modifier to designate certain visit time periods that occur following the death of the patient. Is the SIA applicable to post mortem visits?
A: Medicare does not provide reimbursement for post-mortem visits under any circumstances. However, in cases where a patient dies during the time that a RN or social worker is providing services in the home, the time spent providing services prior to the patient’s death is eligible for the SIA payment. The remainder of the time would be reported with the PM modifier. In the final rule CMS states:

Given that CMS intends to promote direct patient care in the 7 days prior to death, visits for the pronouncement of death will not be included as eligible visits for SIA payments.

Q: If a patient revokes or is discharged from a hospice and then admitted to another hospice on the same day will both hospices be paid at the applicable RHC rate for that day?
A: No. Medicare will not pay for two hospices in cases of a discharge or revocation. Medicare will pay both hospices in cases of a transfer ONLY. When the patient is discharged or revokes the patient will need to wait at least until the next day to again elect the Medicare hospice benefit, if eligible.

Q: If a hospice accepts a transfer patient from another hospice, will both hospices be paid for the day of care at the applicable RHC rate?

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A: Yes, in cases of a transfer Medicare will pay both hospices.

Q: Is a hospice required to provide an RN or SW visit each of the last seven days of a patient’s life?
A: No. Hospices should continue to include RN and SW visits in the plan of care as necessary to meet the patient and family needs identified on assessment and in the plan of care.