

Basic Hospice Billing Session Eight

April 22, 2022



Today's Presenters



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Objectives

- Discuss hospice benefit background
- Review different transactions hospice providers may submit to Medicare

Agenda

- Hospice benefit background
- Transactional billings
 - 8XA –NOE
 - 8XB –NOTR
 - 8XC – NOC
 - 8XD – notice of cancel
 - 8XE – notice of change of ownership

Hospice Benefit Background



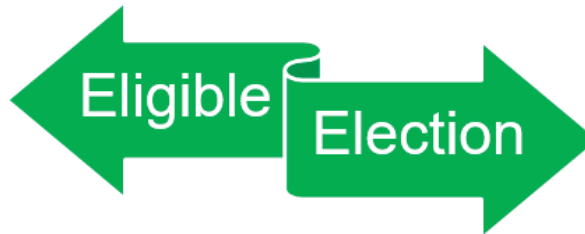
Hospice Benefit

- Hospice benefit began in 1983
 - Under the Part A Hospital Insurance Program
- Medicare beneficiary must:
 - Be entitled to Part A
 - Have a terminal illness with a life expectancy of 6 months or less
 - Receive care from a Medicare-certified hospice agency



Hospice Coverage

- Entitled to Part A
- Certification of terminal illness



Beneficiary election statement

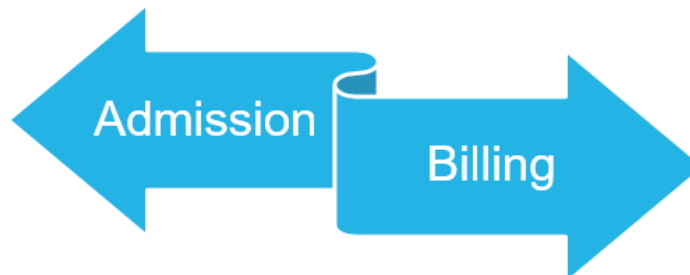


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Admitting to Hospice

Beneficiary Election Statement
PCTI
Plan of Care

**Initial Assessment
Comprehensive Assessment**



Notice of Election (TOB 8XA)

Filing Claims



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Hospice Benefit

- Two 90-day periods (followed by)
- Unlimited 60-day periods
- Beneficiary may voluntarily terminate hospice care at any time during any benefit period
- Beneficiary may change their hospice provider once per benefit period

Hospice Election

- Beneficiary or authorized representative must elect the hospice benefit
 - Election statement filed with the hospice will be maintained in CWF
- All traditional Medicare Part A and Part B benefits waived for services related to treatment and management of terminal illness
 - Exception: services provided by the individual's attending physician, who may be a NP or a PA, if that physician, NP or PA is not an employee of the designated hospice or receiving compensation from the hospice for those services

Note: Medicare services for a condition unrelated to the terminal condition for which hospice was elected can be paid by Medicare, if the patient is eligible for such care.

Hospice Care

- Services can be covered by hospice if:
 - They are reasonable and necessary for the palliation or management of the terminal illness and related conditions
 - The beneficiary (or authorized representative) elects the hospice benefit
 - There is a CTI completed by the patient's attending physician (if they have chosen one), and the Medical Director or a physician member of the IDG
 - Nurse Practitioners or physician assistants serving as the attending physician **may not** certify or recertify the terminal illness
 - There is a plan of care established before any services are provided

Hospice Care

- Combination of home and inpatient care of the terminally ill that combines medical, spiritual bereavement and psychosocial services
- Designed to help both the patient and the family
- “Whole person care” (physical, emotional, social, spiritual) with emphasis on pain control, symptom management, and emotional support rather than life-sustaining measures

Hospice Services

- Depending on the terminal illness and related conditions, the plan of care created by the hospice team can include any (or all) of the following services:
 - Doctor services
 - Nursing care
 - Medical equipment, like wheelchairs or walkers
 - Medical supplies, like bandages or catheters
 - Prescription drugs for symptom control or pain relief
 - Hospice aide and homemaker services
 - Physical therapy services
 - Occupational therapy services
 - Speech-language pathology services



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Hospice Services (cont.)

- Social work services
- Dietary counseling
- Grief and loss counseling for the patient and family
- Short-term inpatient care for pain and symptom management
- Short term respite care – if the usual caregiver (e.g., family member) needs a rest, patient can receive inpatient respite care in a Medicare-approved facility (like a hospice inpatient facility, hospital, or nursing home)
 - Arranged by hospice provider
 - Stay can last up to five days each time the patient is in respite care
 - Respite care can be provided more than once; however, it can only be provided on an occasional basis
- Any other Medicare-covered services needed to manage pain and other symptoms related to the terminal illness and related conditions, as recommended by the patient's hospice team



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Noncovered Services

- Medicare will not cover any of the following once a beneficiary elects the Medicare hospice benefit:
 - Treatment intended to cure the terminal illness (the beneficiary always has the right to stop hospice care at any time by revoking the benefit)
 - Prescription drugs to cure the terminal illness (rather than for symptom control or pain relief)
 - Care from any hospice provider that wasn't set up by the hospice medical team
 - Room and board (Medicare does not cover room and board. However, if the hospice team determines that the beneficiary needs short-term inpatient or respite care services that they arrange, Medicare will cover the stay in the facility. Beneficiaries may have to pay a small copayment for the respite stay.)
 - Care in an emergency room, inpatient facility care, or ambulance transportation, unless it's either arranged by the hospice team or is unrelated to your terminal illness

Certifications/Recertifications

- In order to receive reimbursement, a hospice **must** obtain written certification of terminal illness
 - If written CTI cannot be obtained timely, verbal certification can be used; however the written certification must be on file prior to claim submission
- Certifications and Recertifications:
 - Required at the start of every hospice benefit period
 - Must be obtained no later than two calendar days after the first day of each period, i.e., the certification must be obtained by the end of the third calendar day

Face-to-face Encounter

- A hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient prior to the beginning of the patient's third benefit period, and prior to each subsequent benefit period
 - Must occur no more than 30 calendar days before the third benefit period recertification and each subsequent recertification
 - May occur on the first day of the benefit period and still be considered timely

FTF

- When a required FTF encounter does not occur timely, the recertification is considered incomplete and therefore Medicare will not cover and pay for hospice services
- If failure to meet the FTF requirements is the only reason the patient ceases to be eligible for the Medicare hospice benefit, Medicare would expect the hospice to discharge the patient from the hospice benefit but continue to care for the patient (at its own expense) until the FTF occurs
 - This will reestablish Medicare eligibility
 - Hospice will readmit the patient once the FTF is complete and the patient (or their representative) files an election statement

The Billing Process



Billing Overview

- In order to successfully bill Medicare, there are transactions/claims that may have to be submitted
- Medicare requires providers submit two types of billing transactions under the hospice benefit: the NOE and the claim
- Providers are also required to submit a NOTR within five calendar days after the date of discharge or revocation IF the final claim cannot be submitted within this timeframe
- There are also other billing transactions that are used to report situations to Medicare such as transfers, corrections to the CWF, and change of ownership



Terms used in Hospice

- **Benefit period**
 - Two 90 day periods
 - Unlimited 60 day periods
 - Starts with an election of the benefit and ends with completion of the benefit period, a discharge or revocation
- **Election period**
 - Encompasses one or more benefit periods in which the beneficiary has not revoked or discharged
- **Episode of hospice care**
 - Encompasses one or more benefit periods that are not separated by more than 60 days



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Election Period Information

- **Period number**
 - A sequential number assigned to each election period
- **Elect date**
 - The date of the election reported in the "from" date of the NOE
- **Receipt Date**
 - The receipt date of the NOE that created the election period
- **Revoc Date**
 - The revocation date reported in the Through date of the NOTR or of a discharge claim
- **Revoc Ind**
 - A revocation indicator assigned when the revocation date is recorded
- **Provider**
 - The CMS Certification Number (CCN) of the hospice that submitted the NOE
- **NPI**
 - The National Provider Identifier of the hospices that submitted the NOE



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Benefit Period Information

- **Start Date 1**
 - The start date of the benefit period
- **Term Date 1**
 - The end date of the benefit period
- **Prov 1**
 - The CCN of the hospice whose claims created the benefit period
- **Inter 1**
 - A number identifying the Medicare Administrative Contractor service Prov 1
- **DOEBA**
 - Date of earliest billing activity, the first date billed in the period
- **DOLBA**
 - Date of latest billing activity, the “Through” date of the last claim processed in the period



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Benefit Period Information

- **Days Used**
 - The number of days in the period used to date
- **Start Date 2**
 - The effective dates of a transfer during the period
- **Prov 2**
 - The CCN of the hospice from the 8XC transfer notice
- **Inter 2**
 - A number identifying the Medicare Administrative Contractor serving Prov 2
- **Revocation Ind**
 - No longer used (see the election period screen)



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Hospice Billing Transactions

- Transactions
 - Abbreviated claims to notify or update the Medicare claims processing system of change
- Types of transactions
 - 8XA – notice of election
 - 8XB – notice of termination/revocation
 - 8XC – notice of change of provider/transfer notice
 - 8XD – notice of cancel
 - 8XE – notice of change of ownership



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8XA, 8XB, 8X

- 8XA – Notice of Election
 - When beneficiary elects hospice services, hospice submits claim with specific data elements within 5 calendar days
- 8XB – Notice of Termination/Revocation
 - If beneficiary is discharged alive or if beneficiary revokes election of hospice care, hospice files NOTR



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8XC, 8XD, 8XE

- 8XC – Notice of Change of Provider/Transfer Notice
 - If beneficiary is transferred to another hospice, admitting hospice submits a transfer notice after the transfer has occurred
- 8XD Cancellation of an Election
 - A cancellation notice removes the hospice election period that was created by an NOE
- 8XE – Change of Ownership Notice
 - Beneficiary will remain with the same hospice, but the person or group running the hospice is changing. A change of ownership typically occurs when a Medicare provider has been purchased (or leased) by another organization.



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Hospice Coding



Condition Codes

Code	Title	Description
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.
52	Out of Hospice Service Area	Code indicates the patient is discharged for moving out of the hospice service area. This can include patients who relocate or who go on vacation outside of the hospice's service area, or patients who are admitted to a hospital or SNF that does not have contractual arrangements with the hospice.

Condition Codes

85	Delayed Recertification of Hospice Terminal Illness	Effective for claims received on or after 1/1/2017, and is defined "Delayed recertification of hospice terminal illness. Must use with OSC 77 when the physician recertification is untimely. This code is not used with OSC 77 when used to indicate an untimely NOE.
H2	Discharge by a Hospice Provider for Cause	Used by the provider to indicate the patient meets the hospice's documented policy addressing discharges for cause. Results only in the discharge from the provider's care, not from the hospice benefit.

Occurrence Codes

Code	Title	Description
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. This code is reported on the claim for the billing period in which the certification or re-certification was obtained.
42	Date of Termination of Hospice Benefit	Code indicates the date on which the beneficiary terminated his/her election to receive hospice benefits. This code can be used only when the beneficiary has revoked the benefit.
55	Date of death	Code and date of death is required when the patient discharge status code indicates death (40-expired at home, 41-expired at medical facility, or 42-expired place unknown).



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Occurrence Span Code and Date

Code	Title	Description
77*	Provider Liability – Utilization Charged	Code indicates From/Through dates for a period of non-covered hospice care for which the provider accepts payment liability (other than for medical necessity or custodial care).
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 billing period.



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Value Codes and Core-Based Statistical Area

Code	Title	Description
61	Place of Residence where Service is Furnished (Routine Home Care and Continuous Home Care)	<ul style="list-style-type: none"> •Core-based Statistical Area (CBSA) number of the location where the hospice service is delivered •Hospices must report value code 61 when billing revenue codes 0651 and 0652
G8	Facility where Inpatient Hospice Service is Delivered (General Inpatient and Inpatient Respite Care)	<ul style="list-style-type: none"> •CBSA number of the facility where inpatient hospice services are delivered •Hospices must report value code G8 when billing revenue codes 0655 and 0656



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Level of Care Revenue Codes

Code	Title	Description
0651	Routine Home Care (RHC)	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.
0652	Continuous Home Care (CHC)	Continuous home care is to be provided only during periods of crisis to maintain the beneficiary at home. A period of crisis is a period of time when the beneficiary requires the higher level of "continuous care" for at least 8 hours in a 24-hour period (midnight to midnight) to achieve palliation or management of acute medical symptoms. The care does not have to be "continuous" to qualify, but must total eight hours or more of care within the 24 hour period. The care can be provided by a RN, LPN and home health aide. However, more than 50 percent of the total care provided must be provided by a nurse.



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Level of Care Revenue Codes

0655	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 5 days each) is allowable in a single billing period. If the beneficiary dies under inpatient respite care, the day of death is paid at the inpatient respite care rate.
0656	General Inpatient Care (GIP)	Payment at the inpatient rate is made when general inpatient care is provided. General inpatient care is provided when hospice beneficiaries are in need of pain control or symptom management that cannot be provided in any other setting.

Prescription Drug/Infusion Pump Revenue Codes

Code	Title	Description
0250	Noninjectable Prescription Drug	Report on a line-item basis per fill, along with NDC.
029X	Infusion Pump	Report on the claim on a line-item basis per pump order for the equipment.
0294	Infusion Pump Drug	Report on the claim on a line-item basis per medication fill for the drugs along with the appropriate HCPCS code.
0636	Injectable Prescription Drug	Report on a line item basis per fill along with the appropriate HCPCS code.

Hospice References and Resources



References and Resources

- [CMS Website](#)
 - [Internet Only Manuals](#)
 - [Medicare Benefit Policy Manual, Chapter 9](#)
 - Coverage of Hospice Services Under Hospital Insurance
 - [Medicare Claims Processing Manual, Chapter 11](#)
 - Processing Hospice Claims
 - [Hospice Educational Resources](#)



References and Resources

- CMS Resources
 - [Hospice Educational Resources](#)
 - Creating an Effective Hospice Plan of Care
 - Enhancing RN Supervision of Hospice Aide Services
 - Safeguards for Medicare Patients in Hospice Care
 - Provider Compliance Tips for Hospital Based Hospice
 - Hospice Payment System



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References & Resources

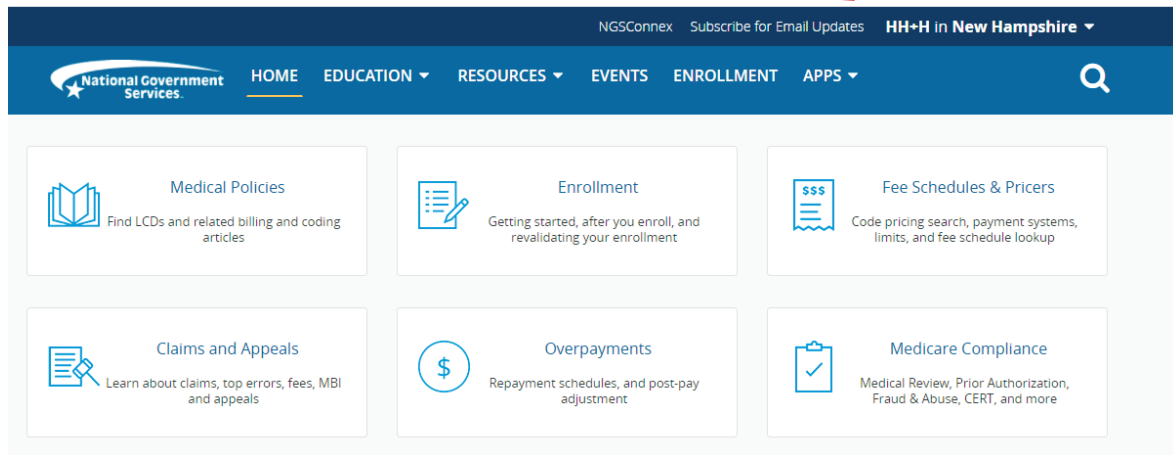
- [NGS Website](#)
 - Education > Medicare Topics > Hospice Billing
 - Resources > Medicare Compliance > Targeted Probe and Educate
 - Resources > Medicare Compliance > Fraud and Abuse



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NGS Email Updates

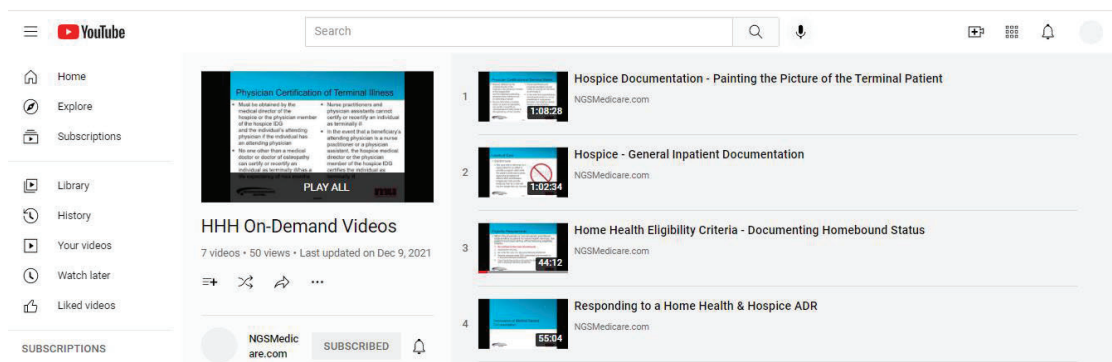
- Subscribe to receive the latest Medicare information



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NGS HHH On-Demand Videos



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- Educational opportunities available
 - Computer-based training courses
 - Teleconferences, webinars, live seminars/face-to-face training
- Self-report attendance
- [Medicare University website](#)



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- If you are accredited with a professional organization other than AAPC, and you plan to request continuing education credit, please contact your organization not National Government Services with your questions concerning CEUs



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Provider Contact Center Procedures

- The Provider Contact Center should always be your first option when contacting National Government Services
 - Required to log and track all incoming inquiries
- Tiered system to respond accurately to all provider inquiries



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Provider Contact Center

State/Region	Toll-Free Number	Interactive Voice Response (IVR)	Hours of Service
Alaska, Arizona, California , Hawaii, Idaho, Nevada, Oregon, Washington, American Samoa, Guam, Northern Mariana Island	866-590-6724 TTY: 888-897-7523	866-277-7287	Monday–Friday 8:00 a.m.–4:00 p.m. PT Thursday, closed for training 12:00–2:00 p.m. PT



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Thank You!

- Questions?

