Hospice: The Future Unfolding

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NOE Changes October 1, 2014

• If an NOE is not filed timely, the hospice will be ineligible for payment from the effective date of election until the day the NOE is received by the MAC.
• A timely-filed NOE is one that is submitted to, and accepted by, the MAC within 5 calendar days after the effective date of election. A timely-filed NOTR is one that is submitted to, and accepted by, the MAC within 5 calendar days after the effective date of discharge or revocation.
• MACs will provide hospices with information about exceptions process/policies.
• NO consequences for late filing of NOTR will be imposed at this time.
• CMS will explore potential to batch file NOEs.
NOE Changes October 1, 2014

Example of timely/untimely NOE calculation

- Admission date = 10/10/14
- Day 1 = 10/11/14
- Day 2 = 10/12/14
- Day 3 = 10/13/14
- Day 4 = 10/14/14
- Day 5 = 10/15/14  This is the NOE “due date”

If NOE received and accepted before 10/15/14, it is timely
If NOE received and accepted on 10/15/14, it is timely
If NOE received and accepted on/after 10/16/14, it is untimely

NOE Exceptions

- CMS finalizes an exceptions policy for failure to meet timely filing of the NOE; a hospice may be eligible for an exception to the consequences of late filing of the NOE if it documents and requests an exception based on 4 circumstances listed below and the MAC grants the exception:
  - Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice’s ability to operate;
  - An event that produces a data filing problem due to a CMS or MAC systems issue beyond the control of the hospice;
  - A newly Medicare-certified hospice that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its MAC; or
  - Other circumstances determined by CMS to be beyond the control of the hospice.
NOE Exceptions

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  - Fires, floods, earthquakes, or other unusual events that inflict extensive damage to the hospice’s ability to operate;
  - An event that produces a data filing problem due to a CMS or MAC systems issue beyond the control of the hospice;
  - A newly Medicare-certified hospice that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its MAC; or
  - Other circumstances determined by CMS to be beyond the control of the hospice.
To confirm the NOE was received by the FISS system and verify the status of your NOE:

Step 1: Choose FISS Main Menu Option 01 (Inquiries)
Step 2: Choose Inquiry Menu Option 12 (Claim Summary)
Step 3: Enter your hospice’s NPI, the patient’s HIC number, and TOB (81A or 82A) and press ENTER. NOEs which are received will appear.
Step 4: Monitor your NOEs daily in FISS.
   If the NOE appears in a status/location (S/LOC) beginning with an “S,” it has been accepted.
   If the NOE appears in a S/LOC beginning with a “T” (RTP), it requires correction before being considered “accepted.”

The REC DT reflects the date Medicare received your NOE.
Note: This date will update when you correct an NOE that was RTP'd.

Submitting Claim with Untimely NOE

If the NOE is untimely, provider must submit claim with:
- An occurrence span code 77 with noncovered dates
- Noncovered dates = admission date to day before NOE received

Example of untimely NOE: ADM DT=0102YY REC DT 0110YY

Admit date = 01/02/YY
NOE submitted/accepted on 01/10/YY
Submitting Claim with Untimely NOE

If the NOE is untimely, provider must submit claim with:

- Noncovered level of care days on separate revenue code line from covered days

<table>
<thead>
<tr>
<th>CL</th>
<th>REV</th>
<th>HCPC MODS</th>
<th>DATE</th>
<th>UNIT</th>
<th>TOT</th>
<th>COV</th>
<th>TOT CHARGE</th>
<th>NOC CHG</th>
<th>SERV DATE</th>
<th>RED DATE</th>
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<tbody>
<tr>
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<td>50.00</td>
<td>0102YY</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Discipline visits and drugs associated with noncovered days must be submitted with
  - Noncovered units; and
  - Noncovered charges

- KX modifier if requesting an exception

Errors on Claims with Untimely NOE

<table>
<thead>
<tr>
<th>Reason Code</th>
<th>Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>U5194</td>
<td>OSC 77 is missing; OR OSC 77 dates are incorrect</td>
</tr>
<tr>
<td>34923</td>
<td>Date on revenue code line is within OSC 77 dates, but units or charges are covered; OR Revenue code line has noncovered units/charges, but service date is outside of OSC 77 dates; OR Total noncovered units do not equal noncovered days indicated by OSC 77</td>
</tr>
</tbody>
</table>

Known Issue: When submitting claims with noncovered charges via 5010, FISS autoplugs covered units, causing claims to hit reason code. To avoid error:
1. Key claim direct data entry (DDE) to show units as noncovered
2. When claim RTPs, correct claim by deleting noncovered revenue code line(s), and re-entering with noncovered units
Untimely NOEs & Subsequent Claims

For subsequent hospice claims, where untimely NOE spans into next billing month, hospice must submit subsequent claim with:

- OSC 77
  - Dates = FROM DATE of claim, and TO DATE = day before NOE received
- KX modifier if requesting an exception
- Noncovered days/services

Example:
- Hospice admission = 1027YY
- NOE submitted untimely = 1118YY
- Initial claim = DOS 1027YY-1031YY with OSC 77 1027YY-1031YY
- Subsequent claim = DOS 1101YY-1130YY with OSC 77 1101YY-1117YY

*Attending Physician Update*

- CMS will amend the regulations at §418.24(b)(1) and require the election statement to include the patient’s choice of attending physician

- Information identifying the attending physician should be recorded on the election statement in enough detail so that it is clear which physician or NP was designated as the attending physician. Hospices have the flexibility to include this information on their election statement in whatever format works best for them, provided the content requirements in §418.24(b) are met.

- Language on the election form should include an acknowledgement by the patient (or representative) that the designated attending physician was the patient’s (or representative’s) choice.
If a patient (or representative) wants to change his or her designated attending physician, he or she must follow a procedure similar to that which currently exists for changing the designated hospice. Specifically, the patient (or representative) must file a signed statement, with the hospice, that identifies the new attending physician in enough detail so that it is clear which physician or NP was designated as the new attending physician.

The statement needs to include the date the change is to be effective, the date that the statement is signed, and the patient's (or representative's) signature, along with an acknowledgement that this change in the attending physician is the patient's (or representative's) choice. The effective date of the change in attending physician cannot be earlier than the date the statement is signed.

CMS provides clarification that attending physician status need not change when a patient enters GIP. If attending physician is not available, hospice physician fills in.

Hospice should document in medical record situations where attending is no longer willing or available to follow patient. Hospice should inform patient or representative that new attending may be chosen.

CMS will issue educational materials to alert hospices and treating physicians about inappropriate use of attending physician modifier on claim and update beneficiary materials.
Beneficiaries are allowed to transfer hospices once per benefit period. You can verify any prior transfers in the benefit period by:

- Asking the beneficiary
- Contacting the transferring hospice
- Review HIQH/ELGH Page 9 for the provider number on the most recent hospice period to ensure it matches the transferring hospice.
- The hospice the patient is transferring from submits their final claim as usual except:
  - The type of bill must be an 8X1 or 8X4
  - The patient status code must be a '50' if the patient is transferring to another hospice under routine or continuous care, or a '51' if the patient is transferring under respite or GIP.
  - Include remarks on FISS Claim Page 04 indicating the name and address of the hospice the patient is transferring to.

Important reminder when submitting a final claim indicating transfer:
- Do not use occurrence code ‘42’
Transfer Billing

It is critical that the transferring hospice submit their final claim before the receiving hospice submits any billing transactions. The transferring and receiving hospice must communicate to verify sequential billing is followed in transfer situations. After the transferring hospice’s final claim has processed, the receiving hospice must submit a Notice of Transfer (also known as a Notice of Change).

The information required on a Notice of Transfer is the same as an NOE except:

- The Type of bill must end in “C” (81C or 82C)
- The ‘From’ date and ‘Admit Date’ must be the date the transfer was effective
- FISS Claim Page 04 must include the transferring hospice’s name and address

Once the Notice of Transfer has processed (P B9997), the receiving hospice can begin submitting their hospice claims as usual.

Discharge/Revocation

When a beneficiary is discharged from hospice or revokes the hospice benefit, the hospice agency must reflect the discharge/revocation on their final hospice claim.

Important reminders when submitting a discharge or revocation claim:

- Ensure the TOB ends with a “1” (if it is the only claim) or a “4” (if prior hospice claims have been billed) Example: 811 or 814
- Ensure the ‘To’ date is the day of discharge/revocation
- Ensure the patient status (STAT) code is a ‘01’
- It is critical that occurrence code ‘42’ is included with the date of the discharge/revocation. (or 52 condition code where applicable – 07/01/12 and later) This code results in a revocation indicator posting to the beneficiary’s eligibility record (ELGH).
- Include remarks on FISS claim page 4 to indicate the reason for discharge/revocation;
- If occurrence code 42 or condition code 52 is omitted from the final claim, the hospice must submit an adjustment claim to add one of the two and the date.
Discharge/Revocation

Effective for dates of service on or after July 1, 2012, Medicare is requiring hospices to discontinue use of occurrence code 42 for situations when a provider initiates the termination of hospice care and only use occurrence code 42 to indicate a discharge due to a patient revocation, in accordance with the existing NUBC instructions. Additionally, the Centers for Medicare & Medicaid Services (CMS) is requiring hospices to use new NUBC condition code 52 to indicate a discharge due to the patient’s unavailability or inability to receive hospice services from the hospice that has been responsible for the patient. In such a circumstance, the patient is considered to have moved out of the hospice’s service area.

Discharge/Revocation

Examples of when such a code could be used include, but are not limited to, when a hospice patient moves to another part of the country or when a hospice patient leaves the area for a vacation. This code would also be appropriate when a hospice patient is receiving treatment for a condition unrelated to the terminal illness or related conditions in a facility with which the hospice does not have a contract, and thus is unable to provide hospice services to that patient. Medicare’s expectation is that the hospice provider would consider the amount of time the patient is in that facility before making a determination that discharging the patient from the hospice is appropriate.
A Notice of Termination/Revocation (NOTR), also known by its type of bill - 8XB. Per Change Request 8877, effective October 1, 2014, the NOTR must be submitted to, and accepted by, CGS within 5 calendar days after the hospice discharge or revocation, unless a final hospice claim has already been submitted. To be accepted by CGS, the NOTR must be free of billing or keying errors that would cause the NOTR to be returned or rejected.

An NOTR must be submitted to CGS direct data entry (DDE), meaning it must be keyed directly into the Fiscal Intermediary Standard System (FISS). To submit a NOTR, providers must use FISS Option 28 (Hospice Claims), and complete information on Claim Page 01 and Claim Page 03.

The screenprints and tables below indicate what fields are required, and what data is required in each field. If information is not entered correctly, your NOTR will be returned to you for correction (RTP).

<table>
<thead>
<tr>
<th>Field Name/Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIC Required</td>
<td>Enter the beneficiary’s Health Insurance Claim Number (HICN)</td>
</tr>
<tr>
<td>TOB Required</td>
<td>818 (non-hospital based) or 828 (Hospital-based)</td>
</tr>
<tr>
<td>NPI Required</td>
<td>Enter your National Provider Identifier (NPI)</td>
</tr>
<tr>
<td>PAT, CONT# Optional*</td>
<td>Up to 20 digits are available for you to enter your internal account number for tracking purposes.</td>
</tr>
<tr>
<td>START DATES FROM/TO Required</td>
<td>Enter the start date of the hospice benefit period in which the termination/revocation is effective in the “FROM” field. Example: The benefit period in which the discharge/revocation occurred is 04/16/YY to 06/14/YY. The revocation was effective 05/31/YY. The admit date reported would be 04/16/YY. Enter the date the termination/revocation is effective in the “TO” field.</td>
</tr>
<tr>
<td>LAST Required</td>
<td>Enter the beneficiary’s last name exactly as it appears on the Medicare card or the beneficiary’s eligibility file.</td>
</tr>
</tbody>
</table>
Notice of Termination/Revocation

<table>
<thead>
<tr>
<th>Field Name/Requirement</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>FIRST</td>
<td>Required</td>
</tr>
<tr>
<td>DOB</td>
<td>Required</td>
</tr>
<tr>
<td>ADDR</td>
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<tr>
<td>ZIP</td>
<td>Required</td>
</tr>
<tr>
<td>SEX</td>
<td>Required</td>
</tr>
<tr>
<td>ADMIT DATE</td>
<td>Required</td>
</tr>
<tr>
<td>FAC ZIP</td>
<td>Required</td>
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</tbody>
</table>

Hospice ADR Denials

Tips for Dealing With ADRs and Probe Edits

- **Routinely monitor the Fiscal Intermediary Standard System (FISS) claims inquiry system to determine ADR requests and track ADR responses.**
  - To ensure timely notification of ADR requests, hospices should regularly check the FISS system because the timeframe for response is only 45 days.
  - The FI/MAC may not communicate the outcome of the ADR by standard mail, so the provider will need to continue monitoring the claims status specific to the patient.
Check the system for ADR claims to confirm receipt of your medical records in response to the ADR. This confirmation step is also available for appeals sent to the QIC.

Track your appeals. If you have not received a response to an appeal within 60 days of submission, begin calling the FI/MAC and/or QIC bodies. You may be told that 1) “Claim is not in the system,” even though you have the mailing tracking information and know it was delivered. (Knowing this allows time to resubmit.) or 2) No claim found. Many appeals can be salvaged by closely tracking status “at the back end” as well as at the “front end.” If a hospice has a reconsideration appeal with MAXIMUS Federal Services, it can track the appeal at http://www.q2a.com/q2a/q2a.nsf/

Ask to reduce the number of claims in the requested sample, if applicable. In provider-specific probes, the Fiscal Intermediary generally requests to review a set number of claims, often between 20 and 40. For hospices with a small census, it might take the Intermediary several months to be able to gather enough claims to complete the probe, and the hospice would be faced with severe cash flow issues while the claims are caught in the probe. A hospice in this situation should ask the Intermediary to reduce the number of claims pulled in the probe to a more reasonable number based on the hospice’s census.

### Hospice ADR Denials

#### Hospice Top Medical Review Denial Reason Codes: October - December 2015

The following information provides hospice medical review denial data related to the most recent calendar quarter. Please review this information and the educational resources to assist with preventing these types of denials.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Denial Code</th>
<th>Denial Description</th>
<th># of Claims Denied</th>
<th>% of Claims Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SPTDR</td>
<td>Six-month terminal prognosis not supported</td>
<td>623</td>
<td>42.3%</td>
</tr>
<tr>
<td>2</td>
<td>SFM001</td>
<td>According to Medicare hospice requirements, the information provided does not support a terminal prognosis of six months or less.</td>
<td>240</td>
<td>16.6%</td>
</tr>
<tr>
<td>3</td>
<td>56000</td>
<td>Requested documentation not received/received timely</td>
<td>129</td>
<td>8.7%</td>
</tr>
<tr>
<td>4</td>
<td>SPCE2</td>
<td>Missing/incomplete/untimely certification/recertification</td>
<td>97</td>
<td>6.5%</td>
</tr>
<tr>
<td>5</td>
<td>SF2FF</td>
<td>Missing/incomplete/untimely face-to-face encounter</td>
<td>49</td>
<td>3.3%</td>
</tr>
</tbody>
</table>
**HIS – Hospice Item Set**

**Summary of Timeliness Compliance Threshold for HIS Submission**

In Sections E.6.d and E.6.e of the FY 2016 Final Rule, CMS finalized a timeliness compliance threshold for HIS submissions. These policies go into effect for the FY 2018 reporting year, which begins January 1, 2016.

- Section E.6.d of the Final Rule states that hospices are required to submit all HIS records (HIS-Admission and HIS-Discharge records) by the submission deadline. The submission deadline for HIS records is 30 days from the event date (the patient's admission to or discharge from the hospice).

- Section E.6.e of the Final Rule states that beginning with the FY 2018 reporting year, in order to avoid the 2 percentage point reduction in their Annual Payment Update (APU), hospices will be required to submit a minimum percentage of their HIS records by the 30 day submission deadline. CMS will incrementally increase this compliance threshold over a 3 year period. For the FY 2018 APU determination, at least 70% of all required HIS records must be submitted within the 30 day submission deadline to avoid the 2 percentage point reduction in the FY 2018 APU. For the FY 2019 APU determination, providers must submit 80% of all required HIS records by the 30 day deadline. Finally, for the FY 2020 APU determination and all subsequent years, providers must submit 90% of all required HIS records according to the 30 day deadline. See Table 1, below.

- Please note that this compliance threshold is related to the submission deadline for HIS records only; completion deadlines will not be considered in the timeliness compliance threshold calculations.

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**Table 1. Timeliness Compliance Threshold Requirements by Reporting Year**

<table>
<thead>
<tr>
<th>Reporting Year ( &amp; Affected APU)</th>
<th>Dates</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2018</td>
<td>1/1/16 – 12/31/16</td>
<td>70% of all required HIS records submitted meet 30 day deadline</td>
</tr>
<tr>
<td>FY 2019</td>
<td>1/1/17 – 12/31/17</td>
<td>80% of all required HIS records submitted meet 30 day deadline</td>
</tr>
<tr>
<td>FY 2020 &amp; Beyond</td>
<td>1/1/18 – 12/31/18 &amp; beyond</td>
<td>90% of all required HIS records submitted meet 30 day deadline</td>
</tr>
</tbody>
</table>
HIS – Hospice Item Set

Preliminary Algorithm for Compliance Threshold Calculation

In the FY 2016 Final Rule, CMS released a preliminary algorithm for how the 70/80/90 timeliness compliance thresholds would be calculated. In general, HIS records submitted for patient admissions and/or discharges occurring during the reporting period (January 1st – December 31st of the reporting year involved) will be included in the denominator of the compliance threshold calculation. The numerator of the compliance threshold calculation would include any records from the denominator that were submitted within the 30 day submission deadline. In the FY 2016 Final Rule, CMS also stated they would make allowances in the calculation methodology for two circumstances. First, the calculation methodology will be adjusted for records for which a hospice was granted an extension or exemption by CMS. Second, adjustments will be made for instances of modification/inactivation requests (Item A0050. Type of Record = 2 or 3).
2016 Hospice Payment Reform

- **Changes in County Designations:** CMS reports that the use of the new delineations will result in new CBSAs, 37 counties that were urban and are now rural, 105 counties that were rural and are now urban, and existing CBSAs that have been split apart.
- **Transition Period:** CMS proposes that there will be a one year transition period to the new delineations, at 50% at the old CBSA or rural value and 50% at the new value.
- **Rural Floor:** The 0.8 rural floor has been maintained and applies to counties designated as rural. For rural counties with a wage index value under 0.8, the hospice’s wage index receives a 15% increase up to 0.8

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**Effective for hospice services with dates of service on or after January 1, 2016, a hospice day billed at the RHC level of care will be paid one of two RHC rates based upon the following:**

1. The day is billed as an RHC level of care day.
2. If the day occurs during the first 60 days of an episode, the RHC rate will be equal to the RHC ‘High’ Rate.
3. If the day occurs during days 61 and beyond, the RHC rate will be equal to the RHC ‘Low’ Rate.
4. For a hospice patient who is discharged and readmitted to hospice within 60 days of that discharge, his/her prior hospice days will continue to follow the patient and count toward his/her patient days for the receiving hospice in the determination of whether the receiving hospice may bill at the high or low RHC rate, upon hospice election.
5. For a hospice patient who has been discharged from hospice care for more than 60 days, a new election to hospice will initiate a reset of the patient’s 60-day window, paid at the RHC ‘High’ Rate upon the new hospice election.
2016 Hospice Payment Reform

Routine Home Care (RHC) Per Diem Rates

Example:
- Patient elected hospice for the first time on 01/10/16.
- The patient revoked hospice on 01/30/16.
- The patient re-elected hospice on 02/16/16.
- The patient discharged deceased from hospice care on 03/28/16.

✓ Since the break in hospice care from 01/30 to 02/16 was less than 60 days the patient day count continues on the second admission.
✓ RHC provided during first election from 01/10/16 to 01/30/16 accounts for 21 days that the high RHC rate would apply. The 60 day count continues with second admission on 2/16/16 and the high RHC rate would apply for an additional 39 days. Day 61 begins the low RHC rate on 3/27/16.
✓ Multiple RHC days are reported on a single line item on the claim. The line item date of service represents the first date at the level of care and the units represent the number of days. As a result, both high and low RHC rates may apply to a single line item.

2016 Hospice Payment Rates

<table>
<thead>
<tr>
<th>Code/Description</th>
<th>Labor portion</th>
<th>Non-labor portion</th>
<th>Final FY2016 Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>651 -- Routine Home Care (10/1 - 12/31/16)</td>
<td>68.71%</td>
<td>31.29%</td>
<td>$161.89</td>
</tr>
<tr>
<td>651 -- Routine Home Care days 1 - 60 (eff. 1/1/2016)</td>
<td>68.71%</td>
<td>31.29%</td>
<td>$186.84</td>
</tr>
<tr>
<td>651 -- Routine Home Care days 61+ (eff. 1/1/2016)</td>
<td>68.71%</td>
<td>31.29%</td>
<td>$146.83</td>
</tr>
<tr>
<td>652 -- Continuous Home Care</td>
<td>68.71%</td>
<td>31.29%</td>
<td>$944.79</td>
</tr>
<tr>
<td>654 -- Inpatient Respite</td>
<td>54.43%</td>
<td>45.87%</td>
<td>$167.45</td>
</tr>
<tr>
<td>656 -- General Inpatient Care</td>
<td>64.01%</td>
<td>35.99%</td>
<td>$720.11</td>
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</table>
2016 Hospice Payment Reform

Service Intensity Add-On Payment (SIA)
Effective for hospice services with “ dates of service on and after January 1, 2016, a hospice claim will be eligible for an end of life (EOL) Service Intensity Add-On (SIA) payment if the following criteria are met:
1. The day is an RHC level of care day.
2. The day occurs during the last seven days of life (and the beneficiary is discharged dead).
3. Service is provided by a Registered Nurse (RN) or social worker that day for at least 15 minutes and up to 4 hours total.
4. The service is not provided by a social worker via telephone.

The SIA Payment amount shall equal:
• The number of hours (in 15 minute increments) of service provided by an RN or social worker during the last seven days of life for a minimum of 15 minutes and up to 4 hours total per day;
• Multiplied by the current hospice Continuous Home Care (CHC) hourly rate per 15 minutes x visit units (not greater than 16).
• Adjusted for wage index.

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2016 Hospice Payment Reform

The SIA policy necessitates the creation of two new G codes for nursing that distinguish between nursing care provided by a RN and nursing care provided by a Licensed Practical Nurse (LPN). During periods of crisis such as the precipitous decline before death, patient needs typically surge and more intensive services are warranted. The Medicare Conditions of Participation (CoPs) at 42 CFR 418.56(a) state that an RN is responsible for ensuring that the needs of the patient and family are continually assessed. CMS would expect that at end of life the needs of the patient and family would need to be frequently assessed and thus the skills of an RN are required. RNs are more highly trained clinicians with commensurately higher wage rates.

Since the existing codes do not distinguish between services provided by an RN and a LPN, CMS will obtain new codes to distinguish between RN services and LPN services by January 1, 2016.

The SIA daily payment calculated by the Hospice PRICER will be entered on the first applicable visit line item for each date of service payable.
2016 Hospice Payment Reform

Service Intensity Add-On Payment (SIA)

Example:
Billing Period: 12/01/XX – 12/09/XX
Patient Status: 40 RHC in home, discharged deceased.

<table>
<thead>
<tr>
<th>Line Item</th>
<th>Revenue Code</th>
<th>HCPCS</th>
<th>Date of Service</th>
<th>Units</th>
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<tbody>
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<td>0651</td>
<td>Q5001</td>
<td>12/01/XX</td>
<td>9</td>
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<td>0551</td>
<td>G0154</td>
<td>12/01/XX</td>
<td>4</td>
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<tr>
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<td>0571</td>
<td>G0156</td>
<td>12/02/XX</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>0561</td>
<td>G0155</td>
<td>12/05/XX</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>0571</td>
<td>G0156</td>
<td>12/05/XX</td>
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<td>G0154</td>
<td>12/06/XX</td>
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</table>

Day 1 of 7, 12/03/XX, no qualifying units reported for the EOL SIA.
Day 2 of 7, 12/04/XX, no qualifying units reported for the EOL SIA.
Day 3 of 7, 12/05/XX, qualifying units are 4. Day 3 of the EOL SIA payment is stored on the first applicable visit line for that date: 0561 G0155 12/05/XX UNITS 4
Day 4 of 7, 12/06/XX, qualifying units are 3. Day 4 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551 G0154 12/06/XX UNITS 3
Day 5 of 7, 12/07/XX, no qualifying units reported for the EOL SIA.
Day 6 of 7, 12/08/XX, no qualifying units reported for the EOL SIA.
Day 7 of 7, 12/09/XX, qualifying units are 10. Day 7 of the EOL SIA payment is stored on the first applicable visit line for that date: 0551 G0154 12/09/XX UNITS 4.
Key Tips For Surviving Hospice Billing

- Ensure Medicare Verifications at happening at the point of referral
  - Verify content in your patient setup to the Medicare system
- Collect the data for the NOE and make sure it is keyed a couple of days before due to ensure that it processes without errors
- Check the system on a daily basis for Returned to Provider situations
- Ensure that your pharmacy fully understands the detail needed for billing drugs on claims.
- Ensure G codes for nursing are setup in system appropriately
- Ensure followup if the RHC and SIA are not paid correctly
- Work to fully understand the process of filing claims with late NOE, that have validated exception reason.

Questions
Thank You For Coming!

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