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Enhancements to Processing of Hospice Routine Home Care Payments

MLN Matters Number: MM10573
Related Change Request (CR) Number: 10573
Related CR Release Date: April 27, 2018
Effective Date: October 1, 2018
Related CR Transmittal Number: R4035CP
Implementation Date: October 1, 2018

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for providers billing Medicare Administrative Contractors (MACs) for hospice services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10573 creates new fields on the hospice Pricer output to display the number of days paid at the high, and at the low, Routine Home Care rates. It also instructs the maintainer of the Fiscal Intermediary Shared System (FISS) to create an output record to match the updates to the hospice Pricer output, and for the Common Working File (CWF), to store with FISS the number of prior days retained for the life of the claim. A separate field is added on the claim record that will store any days from a prior period that were used in determining the count of days. This data is currently used in processing but is not stored for future reference.

In addition, the Centers for Medicare & Medicare Services (CMS) has determined that there is no longer a need to collect detailed drug data on the hospice claim, thereby reducing provider reporting burden. Instead, hospices must report total durable medical equipment (DME) and medication charges on the claim.

BACKGROUND

Medicare pays a higher rate for hospice services at the RHC level of care for the first 60 days of service. These 60 days are counted, at the beneficiary level, across any hospice benefit periods that are not separated by a 60-day gap.

At present, FISS cannot, in all cases, identify the number of prior service days from the face of the claim. Rather, the CWF must read data from services provided at other hospices and return to FISS additional days that apply to the payment calculation.

Hospice providers have told the Centers for Medicare & Medicare Services (CMS) of the

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difficulties of determining which RHC days were paid at the high or low rate; and are looking for ways to make high versus low RHC payments more transparent. Through discussions with the MACs, CMS believes that one way to accomplish this transparency is to add value codes to the claim that display the number of days paid at both the high and low RHC payment rates.

Specifically, CR10573 instructs MACs to:

1. Modify the input/output record to the Hospice Pricer to reflect the revised layout in the Medicare Claims Processing Manual, Chapter 11 (Processing Hospice Claims), Sections 30.3 (Data Required on the Institutional Claim to A/B MAC (HHH)) and 130.1 (Input/Output Record Layout);
2. Create fields that display the number of days paid at the high RHC rate, and the number of days paid at the low RHC rate;
3. Put the high days returned by Pricer on the claim as a value code 62 amount, and the low days returned by Pricer on the claim as a value code 63 amount;

   Table 1 displays the value codes, their titles, and their definitions;

Table 1*

Code	Title	Definition
62	Number of High Routine Home Care Days	Days that fall within the first 60 days of a routine home care hospice claim. The Medicare system puts the high days returned by Pricer on the claim as a value code 62 amount.
63	Number of Low Routine Home Care Days	Days that come after the first 60 days of a routine home care hospice claim. The Medicare system puts the low days returned by Pricer on the claim as a value code 63 amount.

***These codes are not submitted by the hospice, but are applied by Medicare during processing and may be visible in their MAC's online claim history.**

With regard to DME and medication, hospices must report a monthly charge total for all drugs (that is, report a total charge amount for the period covered by the claim) using revenue code 0250. Hospices shall report a monthly charge total for DME (report a total charge amount for the period covered by the claim), including DME infusion drugs, using revenue center 029X for the item of DME and 0294 for DME infusion drugs. CMS no longer requires hospices to report a charge total and amount dispensed per drug, CMS no longer requires hospices to report injectable drugs using revenue code 0636, and CMS no longer requires hospices to report HCPCS codes for DME infusion pumps or DME drugs.

ADDITIONAL INFORMATION

The official instruction, CR10573, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4035CP.pdf. The revised Medicare Claims Processing Manual, Chapter 11, is a part of that CR.

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

DOCUMENT HISTORY

Date of Change	Description
April 30, 2018	Initial article released.