Hospice: The Future Unfolding

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Healthcare Provider Solutions, Inc.

SESSION EVALUATIONS

Available 5 minutes before close of session
Access Session Evaluations using your CONFERENCE MOBILE APP

STEPS TO COMPLETE YOUR EVALUATION WILL BE SHOWN AT THE CLOSE OF THIS SESSION
2017 Hospice Quality Update

CMS expects Hospice Compare website to go live in the spring or summer of 2017. Agencies are urged to prepare by updating to Hospice Item Set (HIS) V2.00.0 as soon as possible. Medicare’s Certification and Survey Provider Enhanced Reports (CASPER) will allow hospice providers to preview HIS-measure scores prior to them appearing on Hospice Compare.

Two new quality measures take the HIS a step closer toward becoming a clinical assessment tool. **These new quality measures become effective on April 1, 2017 will affect FY 2019 and subsequent payment determinations:**

1. Hospice Visits When Death is Imminent
2. Hospice & Palliative Care Composite Process Measure

New HIS Measures

**Measure 1** Hospice Visits When Death is Imminent- focuses on imminent death and addresses case management and clinical care

**Measure 2** Hospice & Palliative Care Composite Process Measure - gives providers the flexibility to provide individualized care aligned with the patient’s, family’s and caregivers’ preferences and goals for care including contributing to the overall well-being of the individual and others who are important in his/her life
New HIS Measures

Hospice Care Visits When Death is Imminent
Two subsets, each of which will be reported separately

Measure 1 – the percentage of patients with at least one nursing, physician, NP, or PA visit in the last three days of life that addresses clinical care management

Measure 2 – the percentage of patients receiving at least two MSW, chaplain, spiritual counselor, LPN or Aide visits in the last seven days of life

- Measures will be submitted through the HIS
- Within 30 days of the Event Date (Admission or Discharge)
- Individual components are assessed separately for each patient and then aggregated into one score for the hospice
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.

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>
Diagnosis Clarification

“Unless there is clear evidence that a condition is unrelated to the terminal prognosis all conditions are considered to be related to the terminal prognosis and the responsibility of the hospice to address and treat.”

Hospice Discharge

In most situations, discharge from a hospice will occur as a result of one the following:

- The beneficiary decides to revoke the hospice benefit;
- The beneficiary moves away from the geographic area that the hospice defines in its policies as its service area;
- The beneficiary transfers to another hospice;
- The beneficiary’s condition improves and he/she is no longer considered terminally ill. In this situation, the hospice will be unable to recertify the patient;
- The beneficiary dies;
- Discharge for CAUSE.
Discharge for Cause

Discharge for cause: There may be extraordinary circumstances in which a hospice would be unable to continue to provide hospice care to a patient. These situations would include issues where patient safety or hospice staff safety is compromised. When a hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause, that the patient’s (or other persons in the patient’s home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired, the hospice can consider discharge for cause.

The hospice must do the following before it seeks to discharge a patient for cause:

✓ Advise the patient that a discharge for cause is being considered;

✓ Make a serious effort to resolve the problem(s) presented by the patient’s behavior or situation;

✓ Ascertain that the patient’s proposed discharge is not due to the patient’s use of necessary hospice services; and

✓ Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into the patient’s medical records.

✓ The hospice must notify the Medicare contractor and State Survey Agency of the circumstances surrounding the impending discharge. The hospice may also need to make referrals to other relevant state/community agencies (i.e., Adult Protective Services) as appropriate.
Discharge Order

Discharge order: Prior to discharging a patient for any reason other than a patient revocation, transfer, or death, the hospice must obtain a written physician's discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.

Discharge Planning

- Discharge planning: The hospice must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.
- The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.
- Once a patient is no longer considered terminally ill with a life expectancy of 6 months or less if the disease runs its normal course, Medicare coverage and payment for hospice care should cease. Medicare does not expect that a discharge would be the result of a single moment that does not allow time for some post-discharge planning.
Discharge Planning

• *Rather, it would be expected that the hospice’s interdisciplinary group is following the patient, and if there are indications of improvement in the individual’s condition such that hospice may soon no longer be appropriate, then planning should begin.* If the patient seems to be stabilizing, and the disease progression has halted, then it could be the time to begin preparing the patient for alternative care. Discharge planning should be a process, and planning should begin before the date of discharge.

• *In some cases, the hospice must provide Advanced Beneficiary Notification (ABN) or a Notice of Medicare Non-Coverage (NOMNC) to patients who are being discharged.* See Pub. 100-04, Medicare Claims Processing Manual, Chapter 30 “Financial Liability Protections”, Section 50.15.3.1, for information on these requirements.

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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.

**NO consequences for late filing of NOTR** will be imposed at this time.
Timely 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.

Relief has now been granted in some circumstances, but this requires TIMELY correction on the hospice's part. In MLN Matters SE1633 the following has been stated:

- Medicare has determined that timely-filed NOEs with inadvertent errors that cannot be immediately corrected due to Medicare system constraints (and thus returned to the provider for correction, causing late system acceptance of NOEs and non-covered days) are outside the control of the hospice and so qualify for an exception to the timely filing requirement in the circumstances described below.
- MACs will grant an exception only for instances where timely-filed NOEs contained errors that could not be immediately corrected due to system constraints.
- MACs will grant an exception for the late NOE if the hospice is able to provide the MAC with documentation showing:
  1. When the original NOE was submitted
  2. When the NOE was returned to the hospice for correction or was accepted and available for correction, and
  3. When the hospice resubmitted the NOE.
Timely NOE Exceptions

- MACs will grant the exception if all documentation is provided and the hospice took appropriate actions **within 2 business days** to make corrections.
- Once the NOE is returned for correction the hospice will have **2 business days** to resubmit. When the NOE was posted to the Common Working File (CWF) and must be cancelled and resubmitted, they will have 2 business days to cancel the NOE and then **2 business days** to submit the new NOE after the date that the cancellation NOE finalizes.
- MACs have previously educated that hospices need not wait until an NOE is returned to correct many errors. In these instances, an exception will not be granted.
- It is not appropriate for hospices to submit a partial NOE to fulfill the timely-filing requirement. MACs will not grant exceptions in cases where it appears that the hospice is engaging in such practices.

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 RTPd.
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

Admit date = 0102YY
NOE receipt date = 0110YY

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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, FISSION autoprocured 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 §418.21(b) 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.

*Attending Physician Update*

- 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.
* Attending Physician Update

- 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.

Notice of Termination/Revocation

- 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 screen prints 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).
### 2016 Hospice Payment Reform

**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.

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### 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.
## 2017 Hospice Payment Rates

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>FY2016 Payment Rates</th>
<th>Proposed Wage Index Standardization Factor (SNF)</th>
<th>FY2017 Proposed Hospice Payment Update Percentage</th>
<th>FY2017 Payment Rates – Final and (proposed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care (days 1-60)</td>
<td>$186.84 X 1.0000 X 0.9989 X 1.021</td>
<td>$190.55 (final)</td>
<td>($190.41)</td>
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<tr>
<td>651</td>
<td>Routine Home Care (days 61+)</td>
<td>$146.83 X 0.9999 X 0.9995 X 1.021</td>
<td>$149.82 (final)</td>
<td>($149.68)</td>
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<tr>
<td>652</td>
<td>Continuous Home Care</td>
<td>$40.19 = FY2017 hourly rate</td>
<td>$944.79 N/A X 1.0000 X 1.021</td>
<td>$964.63 (final)</td>
<td>($963.69)</td>
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<tr>
<td>653</td>
<td>Inpatient Respite Care</td>
<td>$167.45 N/A X 1.0000 X 1.021</td>
<td>$170.97 (final)</td>
<td>($170.80)</td>
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<tr>
<td>654</td>
<td>General Inpatient Care</td>
<td>$720.11 N/A X 0.9996 X 1.021</td>
<td>$734.94 (final)</td>
<td>($734.22)</td>
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## 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.
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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</thead>
<tbody>
<tr>
<td>0651</td>
<td>0551</td>
<td>Q5001</td>
<td>12/01/XX</td>
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<td>G0299</td>
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<td>0571</td>
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<td>12/02/XX</td>
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<td>G0156</td>
<td>12/09/XX</td>
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</tbody>
</table>

2016 Hospice Payment Reform

- 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 G0299 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 G0299 12/09/XX UNITS 4.

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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.
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