MEDICARE REIMBURSEMENT REFERENCE GUIDE
HOSPICE

EFFECTIVE OCTOBER 1, 2020

Overview

This guide provides an overview of Medicare reimbursement methodologies and potential coding options for hospice care and FY21 Medicare payment rates. Reimbursement opportunities may exist under individual state Medicaid programs and commercial payer policies. Providers should consult with their appropriate payer contacts to ensure alignment on coverage, coding, and payment expectations for the utilization of these technologies and/or the associated services.

Hospice

Hospice care is provided to terminally ill patients with a life expectancy of under six months. Patients may be under hospice care in an inpatient facility, a skilled nursing facility, or in their home. The patient's attending physician creates a written care plan to outline the items and services that will be needed.

Patient Benefits[1]

Hospice care is a benefit under the Medicare Part A hospital insurance program. In order to access Medicare-certified hospice care, a patient must elect the hospice benefit and be certified by a physician as being terminally ill with a life expectancy of less than six months. The benefit election begins when the patient files a Notice of Election (NOE) statement with a chosen hospice. At that point, the individual must also waive their rights to Medicare payment for hospice care at any location other than their chosen hospice, as well as any Medicare services related to treatment of the condition for which hospice was elected.

The initial benefit election period is 90 days. The patient may receive Medicare coverage for two 90-day periods, and then a subsequent unlimited number of 60-day periods. The initial certification of terminal illness for hospice care may be completed up to 15 days before benefit election and must also be recertified 15 days before each subsequent benefit period.

Hospice care under the Medicare program includes the following:[2]

- Nursing care provided by or under the supervision of a registered professional nurse
- Physical or occupational therapy, or speech-language pathology services
- Medical social services under the direction of a physician
- Services of a home health aide who has successfully completed a training program approved by the Secretary of HHS
- Homemaker services
- Medical supplies (including drugs and biologicals) and the use of medical appliances while under a hospice care plan
- Physician services
- Short-term inpatient care in an inpatient facility meeting such conditions as the Secretary of HHS determines to be appropriate to provide such care. Such respite care may be provided only on an intermittent, non-routine, and occasional basis. Short-term care may not be provided consecutively over longer than five days.
- Counseling with respect to care of the terminally ill individual and adjustment up until death
- Any other item or service that is specified in the plan and for which payment may otherwise be made under this title

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Coverage

For Medicare coverage, hospice services must meet *all* the following requirements:[1]

- Hospice service must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions
- The individual must elect hospice care
- A plan of care must be established and periodically reviewed by the attending physician, the medical director, and the Interdisciplinary group of the hospice program
- That plan of care must be established before hospice care is provided
- The services provided must be consistent with the plan of care
- A certification that the individual is terminally ill must be completed

Durable medical equipment (DME) and supplies provided by the hospice and related to the care of a terminal patient are also covered under the Part A hospice benefit. Covered supplies are those that are part of the written care plan and are for palliation and management of the patient's terminal illness or related conditions. Any DME and supplies that are used for the treatment of a condition unrelated to the terminal illness may be eligible for coverage under Part B.[2]

Coding

Coding for hospice per diem services are reported using revenue codes 0651, 0652, 0655, and 0656, and the ICD-10-CM codes. The selection of the principal diagnosis for admission of a patient into hospice should be the diagnosis that most contributed to the terminal diagnosis of the patient. Any additional diagnoses that affect patient care are also required to be reported.

Hospices may use revenue code 0657 to report charges for services provided to patients by attending physicians, or nurse practitioners acting as attending physicians, who are employees or who receive compensation from the hospice. Appropriate Current Procedural Terminology™* (CPT™*)[3] codes are required in order to determine the appropriate payment for these services. Using the combination of revenue codes and Healthcare Common Procedural Coding System (HCPCS) codes, hospices are required to report the total number of visits provided to a patient in 15-minute increments. The visits are reported by the type of care provided. Table 1 outlines the revenue codes and associated HCPCS codes for each type of service.[4]

Modifiers

The following modifiers are available for reporting on hospice claims:

- GV: Used when services are provided by Doctor of Medicine, Doctor of Osteopathy, Nurse Practitioner, or Physician Assistant.
- PM: Reported on visits that occurred on the date of death.
- KX: Used when a hospice has filed a late Notice of Election (NOE) under exceptional circumstances.

HCPCS and Revenue Codes[4]

Table 1: Revenue Codes
Hospice must enter the following visit revenue codes, when applicable:

HCPCS CODE	REVENUE CODE	PROCEDURE DESCRIPTION
G0151	042x	Physical Therapist
G0152	043x	Occupational Therapist
G0153	044x	Speech Therapy: Language Pathologist
G0299	055x	Skilled Nursing: Registered Nurse
G0300	055x	Skilled Nursing: Licensed Practical Nurse
G0155	056x	Medical Social Services
G0155	059	Medical Social Services
G0156	057x	Home Health/Hospice Aide
N/A	0250	Non-Injectable Prescription Drugs
Applicable HCPCS	029X	Infusion Pump
Applicable HCPCS	0636	Injectable Drugs

Visits by registered nurses, licensed vocational nurses, and nurse practitioners (unless the nurse practitioner is acting as the beneficiary's attending physician) are reported under revenue code 055x.

Payment
Once a patient elects hospice care they waive their rights to Medicare payment for any additional services related to the treatment of their terminal illness outside of hospice. Under the hospice benefit, facilities are paid a per diem rate based on the number of days and level of care provided. Levels of care include routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIC). Attending physician services, and those of a nurse practitioner serving as an attending physician, are paid under Part A in addition to the daily hospice rates as long as the aggregate cap is not exceeded (see below).

Routine Home Care (RHC)
Under RHC patients receive hospice care in their home. These services are paid on a per diem basis regardless of the volume or intensity of the services provided. CMS finalized two RHC rates, to provide separate payment rates for the first 60 days of care, and care beyond 60 days. Table 2 below outlines the RHC rates for FY21.

Table 2: FY21 Hospice Routine Home Care Rates

REVENUE CODE	LEVEL OF CARE (DAYS)	FY21 PAYMENT RATES
651	Routine Home Care (days 1-60)	$199.25
651	Routine Home Care (days 61+)	$157.49

Continuous Home Care (CHC)

During a crisis period, a patient in hospice may receive continuous care in their home provided by a nurse, hospice aide, or homemaker. CHC is provided only as necessary to maintain the terminally ill patient at home. CHC is provided at a minimum of eight aggregate hours (not necessarily continuous) of primary nursing care within a 24-hour period. If skilled nursing care is provided for less than eight aggregate hours during a 24-hour period, then the care is covered as a RHC day.[6]

In addition to the two RHC rates, CMS finalized a service intensity add-on (SIA) payment that will help to compensate for the intensity of skilled visits provided in the last seven days of life. The SIA payment is equal to the CHC hourly rate multiplied by the hours of nursing or social work provided (up to four hours total) that occurred on the last day of service.[4] Refer to Table 3 for the SIA payment rate.

Inpatient Respite Care and General Inpatient Care[5]

Short-term inpatient hospital stays may be provided as long as they follow the hospice written care plan. In this case, Medicare then covers two levels of inpatient care: respite care to relieve the patient's caregivers for a maximum of five consecutive days at a time including the date of admission, but not counting the date of discharge; and general inpatient care for pain control and symptom management, which cannot be managed in any other setting.

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Table 3: FY21 Hospice CHC, IRC, and GIP Payment Rates[5]

REVENUE CODE	PROCEDURE DESCRIPTION	FY21
652	Continuous Home Care (CHC) Full Rate = 24 hours of care	$1,432.41 ($59.68/hourly rate)
655	Inpatient Respite Care	$461.09
656	General Inpatient Care	$1,045.66

*Based on a full CHC per day payment (which is 24 hours).

Capped Payment

To ensure that hospice remains a home base benefit, the inpatient and respite care cap limits the number of days to no more than 20 percent of a hospice's total Medicare hospice days for that year.[1] The inpatient cap for FY21 is $30,683.93[5] CMS finalized aligning the cap period for both the inpatient and hospice aggregate cap with federal fiscal year FY17 and later. Therefore, the cap year begins October 1 and ends September 30.[6]

Quality Reporting[6]

Under the Hospice Quality Reporting Program (HQRP), hospices were required to begin collecting quality data in October 2012, submitting it in 2013. For fiscal year 2014, and each subsequent year, failure to submit required quality data will result in a two-percentage point reduction to the market basket percentage increase for that fiscal year.[5]

The HQRP requires hospices to report quality data for both HIS and the Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS™) survey data, which are used to calculate performance on quality measures. HIS data can be used to calculate eight National Quality Forum (NQF)-endorsed measures and one non-NQF-endorsed measure. Descriptions of the nine HIS-based measure can be found here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.

The CAHPS Hospice Survey was considered a single measure by NQF and endorsed as NQF #2651. CAHPS data can be used to calculate eight patient experience measures. Additional details about CAHPS quality measures can be found on the CAHPS survey webpage at: https://www.hospicecahpssurvey.org/globalassets/hospice-cahps/scoring-and-analysis/5-30-19-updates/steps-for-scoring-cahps-hospice-survey-measures--for-website-2018q3-final.pdf.

Therapy-Specific Coding and Reimbursement Information

All equipment and supplies provided by the hospice and related to the care of a terminal patient are covered under the Part A hospice benefit. Covered supplies are those that are part of the written care plan and are for palliation and management of the patient's terminal illness or related conditions. Any DME and supplies that are used for the treatment of a condition unrelated to the terminal illness may be eligible for coverage under Part B.

For more information, contact the Medtronic MITG Reimbursement Hotline: 877-278-7482 or Rs.MedtronicMITGReimbursement@Medtronic.com

REFERENCES:

[1]Medicare Regulations and Guidance. Medicare Benefit Policy Manual. Chapter 9 – Coverage of Hospice Service Under Hospital Insurance. Rev. 246, 09-14-2018. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf
[2]Social Security Act. Title 18. Part E. Section 1861 (dd). https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
[3]CPT copyright 2020 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.
[4]Medciare Regulations and Guidance. Medicare Claims Processing Manual. Chapter 11 – Processing Hospice Claims. Rev. 4280, 04-19-19. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html
[5]Medicare Program; FY 2021 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements. Final Rule, Federal Register (Fed. Reg. Vol. 85 No. 150 47070-47098) 42 CFR Part 418. Published August 4, 2020.
[6]Medicare Program; FY 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements. Final Rule, Federal Register (83 Fed. Reg. Vol. 84 No. 151 38484 – 38544) 42 CFR Part 418. Published August 6, 2019.
[7]Centers for Medicare & Medicaid Services. Hospice Quality Reporting Program. Current Measures. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html

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