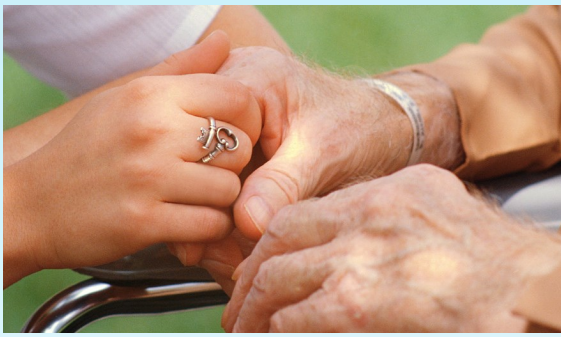
IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201611 MARCH 1, 2016

Changes to hospice reimbursement effective January 1, 2016, affect billing and claims processing



The Centers for Medicare & Medicaid Services (CMS) issued a final rule, *CMS 1629-F*, regarding the reimbursement of routine home care (RHC) hospice services effective January 1, 2016. The rule establishes two rates for RHC hospice services. A higher *per diem* rate applies to RHC services rendered during the first 60 days of hospice care and a reduced *per diem* rate applies to RHC services rendered on days thereafter. These differing rates serve to capture the varying levels of resource intensity necessary during the course of providing RHC hospice services. The rule also establishes a service intensity add-on (SIA) payment for face-to-face services provided by a registered nurse (RN) or social worker during the last seven days of a member's life. These changes as well as the RHC *per diem* rates were announced in *Indiana Health Coverage Programs (IHCP) Bulletin* BT201573. The changes apply to IHCP fee-for-service (FFS) hospice claims with dates of service (DOS) on or after January 1, 2016.

The IHCP is modifying its claims processing system to accommodate the reimbursement changes outlined in the CMS rule. Until system modifications are implemented, RHC claims will adjudicate using the old reimbursement methodology. As system modifications are completed, hospice claims will be mass-adjusted or reprocessed to reimburse using the new methodologies. Providers will receive notice of mass adjustments or reprocessing before they occur. Watch for further details in upcoming IHCP publications.

Adjudication of claims for RHC hospice services

The new reimbursement methodology for RHC hospice services will change the way claims for these services adjudicate; however, requirements for billing RHC services will not change. Providers should continue to use the following revenue codes when billing RHC services for a member:

- 651 – *Routine home care delivered in a private home*
- 653 – *Hospice services/routine home care delivered in a nursing facility*

Claims for revenue code 653 must continue to include occurrence code 51 and the date of death/discharge in form locator 32.

The IHCP will calculate the number of days a member is enrolled in hospice. This calculation will determine the correct *per diem* payment amount to apply to claims for RHC services: the higher rate for RHC services rendered during the first 60 days of hospice services, and the lower rate for RHC services rendered on days 61 and after.

If a member is discharged from hospice and readmitted within 60 days of discharge, the member's prior patient days will follow the member and count toward his or her total hospice patient days to determine the appropriate RHC reimbursement rate (see Example 1). If a member is discharged from hospice for more than 60 days, a new election to hospice will reset the member's patient hospice days to day 1 for RHC reimbursement purposes (see Example 2).

Example 1:
A member is in hospice for 58 days and then discharged. The member is then readmitted to hospice seven days later. Upon readmission, the count of patient hospice days will begin at day 59. RHC services rendered on days 59-60 will be paid at the higher rate; RHC services on days 61 and after will be paid at the lower rate.

Example 2:
A member is in hospice for 45 days and is then discharged. The member is then readmitted to hospice 65 days after discharge. Upon readmission, the count of hospice patient days will begin at day 1. RHC services rendered on days 1-60 will be paid at the higher rate; RHC services on days 61 and after will be paid at the lower rate.

Claims processing system modifications will include a calculator that captures days enrolled in hospice from October 1, 2015 forward. This calculation will be used to properly apply the correct *per diem* rate to claims for RHC services with DOS on or after January 1, 2016. Claims for RHC hospice services will continue to adjudicate in the claims processing system using the current reimbursement methodology until system modifications are implemented. An expected completion date for the modifications to calculate patient days and to apply the higher and lower *per diem* RHC rates has not been established. However, once modifications are made, claims for RHC services for the affected DOS will be mass adjusted to correct payment amounts. Providers will be notified in advance when mass adjustments will occur.

Guidance for billing services associated with the SIA payment

The SIA payment is made for services provided by an RN or social worker during the last seven days of a member's life. The payment amount is calculated using the continuous home care hourly rate adjusted by the regional wage index. The SIA payment is limited to 16 units or 4 hours per day.

The following billing instructions should be followed:

- The following revenue codes must be billed for the SIA payment as appropriate:
  - 551 – *RN service intensity add on payment*
  - 561 – *Social Worker service intensity add on payment*
- The SIA revenue codes must be billed as detail line items on the claim when billing for RHC services for the same dates of service.
- A procedure code is not required in conjunction with revenue codes 551 and 561.

- Claims with revenue codes 551 or 561 must include occurrence code 55 and the date of death in form locator 31.
- The claim must include a patient discharge status of 20 in form locator 17.
- The units billed for revenue codes 551 and/or 561 must reflect the time spent with the member in 15-minute increments with no rounding up. The *entire* 15 minutes must be used rendering services to the member and must be documented in the medical record. See Examples 3 and 4:

  Example 3:
  RN spends 30 minutes with the member; revenue code 551 is billed for a total of two units

  Example 4:
  Social worker spends 40 minutes with the member; revenue code 561 is billed for a total of two units (rounded to the nearest 15-minute increment without rounding up)

Providers are advised to *immediately* begin following the guidelines for billing for applicable SIA payments on claims for RHC hospice services with DOS on or after January 1, 2016. Doing so will prevent the need to adjust or refile claims later. Although detail lines for SIA payments will initially deny under the current claims processing system, after system modifications are made, these claims can be mass-adjusted by the IHCP to pay appropriately without any additional provider action. Providers will be notified in advance when mass adjustments will occur.

Billing for SIA payments on previously adjudicated RHC hospice services claims

Providers must adjust or refile previously adjudicated claims for RHC hospice services with DOS on or after January 1, 2016, in order to bill for any applicable SIA payments. Affected claims for RHC hospice services for the DOS during the last seven days of a member's life can be adjusted or refiled to add line items reflecting RN or social work services for SIA payments. Although detail lines for SIA payments will initially deny in the current claims processing system, after system modifications are made, these claims will be mass-reprocessed by IHCP to allow payment of the SIA detail. An expected completion date for system modifications related to SIA payments has not yet been established. Providers will be notified in advance when reprocessing will occur.

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