RAC Alert: How to Bill Medicare for Hospice Patients When You Are Not the Hospice Provider

What is Hospice?

Hospice care focuses on improving the quality of life for persons and their families faced with a life-limiting illness. The primary goals of hospice care are to provide comfort, relieve physical, emotional, and spiritual suffering, and promote the dignity of terminally ill persons. Hospice care neither prolongs nor hastens the dying process. As such, it is palliative not curative. Hospice care is a philosophy or approach to care rather than a place. Care may be provided in a person's home, nursing home, hospital, or independent facility devoted to end-of-life care.

How is Medicare Hospice Care Paid?

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an attending physician, which may include a nurse practitioner. If the attending physician, who may be a nurse practitioner, is an employee of the designated hospice, he or she may not receive compensation from the hospice for those services under Part B.

These physician professional services are billed to Medicare Part A by the hospice.

What is the RAC Issue?

Recovery Auditors recently reported a billing issue for physicians providing services unrelated to a Hospice terminal diagnosis provided during a Hospice period. Hospice claims are filed under Part A, while services not related to a Hospice diagnosis are filed under Part B. In these cases, unrelated care was billed **without** the accompanying GW modifier. **All services related to a Hospice terminal diagnosis are included in the Hospice payment and are not paid separately.**

For beneficiaries enrolled in Hospice, Medicare Administrative Contractors (MACs) and/or Medicare Carriers must deny any service furnished on or after January 1, 2002, that are submitted without either GV or GW modifier.

GV Modifier = Attending physician treating a patient with a **Hospice related** terminal diagnosis, but not employed or paid under arrangement by the patient's hospice provider

GW Modifier = Service **not related** to the Hospice patient's terminal condition

Recovery Auditor Finding

In this audit, the recovery auditors conducted an automated review of claims for physician services. A significant number were deemed to contain improper billing resulting in **overpayment.**

> ***Claim Example 1****: A patient is enrolled in Hospice and goes to a physician's office for open treatment of a femoral fracture, with internal fixation or prosthetic replacement, CPT code 27236.*

Finding: *If the procedure is unrelated to the terminal diagnosis (Non-Hospice related), the physician's bill should contain modifier GW. If this modifier is not appended, the procedure is related to the terminal diagnosis and should not be reimbursed under the part B benefit, instead paid under the hospice benefit.*

Claim Example 2: *The patient is shown as being on hospice starting August 1, 2010, through August 31, 2010. A provider billed CPT code 45378, Colonoscopy, with no modifiers to Part B on August 3, 2010.*

Finding: *The billing of code 45378 would be incorrect since the beneficiary was enrolled in hospice. There can be no separate reimbursement unless the service was unrelated to the terminal diagnosis, which has to be reflected by the proper modifier.*

How to Capture Medicare Hospice Information

- Identify patients enrolled in Hospice, and document in your system the Hospice in which they are enrolled.
- If you have referred a patient to Hospice, flag their account in the computer so anyone performing coding or billing can investigate the of use appropriate modifiers.
- If you have received correspondence notifying you of a patient's enrollment in Hospice, notify staff and make sure the billing record is flagged for appropriate coding.
- If you become aware during the patient's care that the patient you are treating is in Hospice, document the name of the Hospice and notify staff, making sure the billing record is flagged.
- Patients sometimes dis-enroll or are discharged from

Hospice, so do not assume a patient is continuing care under Hospice. When in doubt, contact the patient's Hospice to clarify if the patient is or is not enrolled.

- A little extra leg work will not only cause your claim to be paid on time and properly, it will also keep you from having to pay back any money if improperly paid to you.

CMS Roundup of 17 Announcements: More Information Than You Can Shake a Stick At!

Hospital Wage Index Reform Call

Special Open Door Forum: Presentation and Listening Session on Hospital Wage Index Reform

Tuesday, April 12, 2011, 1:30 PM – 3:00 PM ET.

Section 3137(b) of the Affordable Care Act requires CMS to submit to Congress, by December 31, 2011, a report that includes a plan to reform the wage index under the Medicare hospital inpatient prospective payment system (IPPS). CMS acquired the services of Acumen, LLC to assist in its study of the wage index. During the first part of this special open

door forum, Acumen will present its concept of an alternative methodology for the wage index. The second part will be a listening session, during which CMS would like to hear from you regarding your opinions about Acumen's concept, as well as any suggestions on alternative methods for computing the wage index. If you wish to participate via conference call, dial **1-800-837-1935** Conference ID 50101623. Please see the full participation announcement in the Downloads section **here**.

Electronic Health Record Incentive Program Attestation Begins This Week

Attestation for the Medicare Electronic Health Record (EHR) Incentive Program begins on Monday, April 18, 2011. In order to receive your Medicare EHR incentive payment, you must attest through CMS's web-based Medicare and Medicaid EHR Incentive Programs Registration and Attestation System.

You can **preview selected screenshots** of the Attestation System to help you understand what the attestation process will involve. Please note that these screenshots are only examples – the final appearance and language may incorporate additional changes. CMS will release additional information about the Medicare attestation process soon, including User Guides that provide step-by-step instructions for completing attestation and educational webinars that describe the attestation process in depth.

You need to understand the required meaningful use criteria to successfully attest. Meaningful use requirements for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) participating in the Medicare EHR Incentive Program are different:

- EP Meaningful Use Criteria – Must report on 15 core

measures, 5 of 10 menu measures, and 6 clinical quality measures, consisting of 3 required core measures and 3 additional measures.

- Visit the **Stage 1 EHR Meaningful Use Specification Sheets for EPs** for information on core and menu measures for EPs.
- Visit the **Clinical Quality Measures page** for information on the required clinical quality measures for EPs.

- Eligible Hospital and CAH Meaningful Use Criteria – Must report on 14 core measures, 5 of 10 menu measures, and 15 clinical quality measures.

  - Visit the **Stage 1 EHR Meaningful Use Specification Sheets for Eligible Hospitals and CAHs** for information on core and menu measures for eligible hospitals and CAHs.
  - Visit the **Clinical Quality Measures page** for information on the required clinical quality measures for eligible hospitals and CAHs.

You should also make sure that you begin your 90-day reporting period in time to attest and receive a Medicare payment in 2011. The last days to begin 90-day reporting periods for 2011 incentive payments are:

- Sunday, July 3, 2011, for eligible hospitals and CAHs; and
- Saturday, October 1, 2011, for EPs.

Under the Medicaid EHR Incentive Programs, the date when participants can begin attestation for adopting, implementing, upgrading, or demonstrating meaningful use of certified EHR technology varies by state. Visit the **Medicaid State EHR Incentive Program web-tool** for more information about your state's participation in the Medicaid EHR Incentive Program.

Want more information about the EHR Incentive Programs? Make sure to visit the **CMS EHR Incentive Programs website** for the latest news and updates on the EHR Incentive Programs; also read the new EHR Incentive Program **FAQs from CMS.**

Preventive Services, Preventive Physical Examinations and Annual Wellness Visits Quick Reference Charts

The ABCs of Providing the Initial Preventive Physical Examination Quick Reference Chart provides Medicare Fee-For-Service providers a list of the elements of the IPPE, as well as coverage and coding information. View the chart **here.**

The ABCs of Providing the Annual Wellness Visit Quick Reference Chart provides Medicare Fee-For-Service providers a list of the elements of the AWV, as well as coverage and coding information. View the chart **here.**

The *Medicare Preventive Services* Quick Reference Chart provides Medicare Fee-For-Service providers coverage, coding, and payment information on the variety of preventive services covered by Medicare. View the chart **here.**

A hardcopy booklet containing all three charts, as well as the *Quick Reference Information: Medicare Immunization Billing* chart, will be available at a later date.

Latest HCPCS Code Set Changes

The Centers for Medicare & Medicaid Services is pleased to announce the scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set.

These changes have been posted to the HCPCS web page **here**. Changes are effective on the date indicated on the update.

Revisions to ASP Pricing Files

The Centers for Medicare and Medicaid Services (CMS) has posted revised October 2010 and January 2011 ASP (average sales price) files, which are available for download **here** (see left menu for year-specific links).

Physician or NPP Signatures on Lab Requisitions

In the Monday, November 29, 2010, Medicare Physician Fee Schedule final rule, the Centers for Medicare & Medicaid Services (CMS) finalized its proposed policy to require a physician's or qualified non-physician practitioner's (NPP) signature on requisitions for clinical diagnostic laboratory tests paid under the clinical laboratory fee schedule effective Saturday, January 1, 2011. (A requisition is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient.)

On Monday, December 20, 2010, CMS informed its contractors of concerns that some physicians, NPPs, and clinical diagnostic laboratories are not aware of or do not understand this policy. As such, CMS indicated that it will focus in the first quarter of 2011 on developing educational and outreach materials to educate those affected by this policy. CMS indicated that once the first quarter educational campaign is fully underway, it will expect requisitions to be signed.

After further input from community, CMS has decided to focus for the remainder of 2011 on changing the regulation that

requires signatures on laboratory requisitions because of concerns that physicians, NPPs, and clinical diagnostic laboratories are having difficulty complying with this policy.

Face-to-Face Encounter Requirements for Home Health and Hospice

Effective April 1, 2011, the Centers for Medicare & Medicaid Services (CMS) expects home health agencies and hospices have fully established internal processes to comply with the face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services.

Section 6407 of the ACA established a face-to-face encounter requirement for certification of eligibility for Medicare home health services, by requiring the certifying physician to document that he or she, or a non-physician practitioner working with the physician, has seen the patient. **The encounter must occur within the 90 days prior to the start of care, or within the 30 days after the start of care.** Documentation of such an encounter must be present on certifications for patients with starts of care on or after January 1, 2011.

Similarly, section 3131(b) of the ACA requires a hospice physician or nurse practitioner to have a face-to-face encounter with a hospice patient prior to the patient's 180th-day recertification, and each subsequent recertification. The encounter must occur no more than 30 calendar days prior to the start of the hospice patient's third benefit period. The provision applies to recertifications on and after January 1, 2011.

On December 23, 2010, due to concerns that some providers needed additional time to establish operational protocols

necessary to comply with face-to-face encounter requirements mandated by the Affordable Care Act (ACA) for purposes of certification of a patient's eligibility for Medicare home health services and of recertification for Medicare hospice services, CMS announced that it will expect full compliance with the requirements, beginning with the second quarter of CY2011.

Throughout the first quarter of 2011, CMS has continued outreach efforts to educate providers, physicians, and other stakeholders affected by these new requirements. CMS has posted guidance materials including a MLN Matters article, questions and answers documents, training slides, and manual instructions which are available via CMS' Home Health Agency Center and Hospice webpages. CMS' Office of External Affairs and Regional Offices contacted state and local associations for physicians and home health agencies and advocacy groups to ensure awareness about the face-to-face encounter laws, and to distribute the educational materials.

CMS will continue to address industry questions concerning the new requirements, and will update information on the Web site here for **home health** and here for **hospice**.

Federally Qualified Health Center Fact Sheet Revised

The revised publication titled *Federally Qualified Health Center* (revised March 2011) is now available in downloadable format from the Medicare Learning Network® **here**. This fact sheet is designed to provide education about Federally Qualified Health Centers (FQHC), including background; FQHC designation; covered FQHC services; FQHC preventive primary services that are not covered; FQHC Prospective Payment System; FQHC payments; and *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* provisions that

impact FQHCs.

Avoiding the Adjustment 2012 Medicare Payment Adjustment for Not ePrescribing in 2011

In November 2010, the Centers for Medicare & Medicaid Services announced that, beginning in calendar year 2012, eligible professionals who are not successful electronic prescribers based on claims submitted between Sat Jan 1 and Thu June 30, 2011, may be subject to a payment adjustment on their Medicare Part-B Physician Fee Schedule-covered professional services. Section 132 of the *Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)* authorizes CMS to apply this payment adjustment whether or not the eligible professional is planning to participate in the eRx Incentive Program.

From 2012 through 2014, the payment adjustment will increase each calendar year. In 2012, the payment adjustment for not being a successful electronic prescriber will result in an eligible professional or group practice receiving 99% of their Medicare Part-B PFS amount that would otherwise apply to such services. In 2013, an eligible professional or group practice will receive 98.5% of their Medicare Part-B PFS-covered professional services for not being a successful electronic prescriber in 2011 or as defined in a future regulation. In 2014, the payment adjustment for not being a successful electronic prescriber is 2%, resulting in an eligible professional or group practice receiving 98% of their Medicare Part-B PFS-covered professional services. (The payment adjustment does not apply if less than 10% of an eligible professional's or group practice's allowed charges for the Sat Jan 1, 2011 through Thu June 30, 2011, reporting period are comprised of codes in the denominator of the 2011 eRx

measure.) Also note that earning an eRx incentive for 2011 will NOT necessarily exempt an eligible professional or group practice from the payment adjustment in 2012.

How to Avoid the 2012 eRx Payment Adjustment:

- Eligible professionals – An eligible professional can avoid the 2012 eRx Payment adjustment if (s)he:
  - Is not a physician (MD, DO, or podiatrist), nurse practitioner, or physician assistant as of Thu June 30, 2011, based on primary taxonomy code in NPPES;
  - Does not have prescribing privileges. Note that (s)he must report **G8644** at least one time on an eligible claim prior to Thu June 30, 2011;
  - Does not have at least 100 cases containing an encounter code in the measure denominator;
  - Becomes a successful e-prescriber; and reports the eRx measure for at least 10 unique eRx events for patients in the denominator of the measure.

NOTE: Group Practices – For group practices that are participating in eRx GPRO-I or GPRO-II during 2011, the group practice MUST become a successful e-prescriber. Depending on the group's size, the group practice must report the eRx measure for 75-2500 unique eRx events for patients in the denominator of the measure. For additional information, please visit the "Getting Started" webpage **here** or download the "Medicare's Practical Guide to the Electronic Prescribing (eRx) Incentive Program" under "Educational Resources" on the same website.

Implementation of Errata for

Version 5010 of HIPAA Transactions

BTW, **errata** is a list or lists of errors and their corrections. Errata is plural and the singular is erratum.

CMS does not have a version 4010A1 direct data entry and a separate version 5010 direct data entry. The Priority (Type) of Admission or Visit code is now required on all version 4010A1 institutional claims submitted or corrected via direct data entry, as well as on version 5010 institutional claims, regardless of how they are submitted. Providers that are unsure which code to use are to use code 9 (Information not Available). Additional Priority (Type) of Admission or Visit code values and descriptions are available from the **National Uniform Billing Committee** or from your servicing MAC. The Priority (Type) of Admission or Visit code is not required on 4010A1 institutional claims submitted or corrected via an 837. More information on Version 5010 **here.**

IMPORTANT 5010/D.0 IMPLEMENTATION ITEMS

REMINDER – 5010/D.0 Errata requirements and testing schedule can be found here

REMINDER – Contact your MAC for their testing schedule

READINESS ASSESSMENT – Have you done the following to be ready for 5010/D.0?

READINESS ASSESSMENT – What do you need to have in place to test with your MAC?

READINESS ASSESSMENT – Do you know the implications of not being ready?

New Mental Health Services Booklet

A new publication titled “Mental Health Services” is now

available in downloadable format from the Medicare Learning Network® **here**. This booklet is designed to provide education on mental health services, including covered mental health services, mental health services that are not covered, mental health professionals, outpatient psychiatric hospital services, and inpatient psychiatric hospital services.

Ambulance Fee Schedule Fact Sheet Revised

The revised publication titled "Ambulance Fee Schedule" (revised March 2011) is now available in downloadable format from the Medicare Learning Network® **here**. This fact sheet is designed to provide education about the Ambulance Fee Schedule including background, ambulance providers and suppliers, ambulance services payments, and how payment rates are set.

Health Professional Shortage Area Fact Sheet Revised

The revised publication titled "Health Professional Shortage Area" (revised March 2011) is now available in downloadable format from the Medicare Learning Network® **here**. This fact sheet is designed to provide education on the Health Professional Shortage Area (HPSA) payment system and includes an overview of the program and general requirements.

Medicare Disproportionate Share Hospital Fact Sheet Revised

The revised publication titled “Medicare Disproportionate Share Hospital” (revised March 2011) is now available in downloadable format **here**. This fact sheet is designed to provide education on Medicare Disproportionate Share Hospitals (DSH) including background; methods to qualify for the Medicare DSH adjustment; *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* and *Deficit Reduction Act of 2005* provisions that impact Medicare DSHs; number of beds in hospital determination; and Medicare DSH hospital payment adjustment formulas.

G0431QW is Deleted and G0434QW is Added to CLIA Waived Test Schedule

The Centers for Medicare & Medicaid Services (CMS) is updating the status of two codes on the Clinical Laboratory Fee Schedule (CLFS).

- Effective April 1, 2011, code G0431QW is deleted from the CLFS. Code G0431 describes a high complexity test, and should not be reported with a QW modifier; the QW modifier indicates a CLIA waived test.
- Effective April 1, 2011, code G0434QW is added to the CLFS. Code G0434 can describe a CLIA waived test. The use of the QW modifier to indicate a CLIA waived test is necessary for accurate claims processing.

Codes G0431 and G0434 will remain on the CLFS.

CMS Launches a Dedicated Web Page for the Medicare Shared Savings Program/Requirements for ACOs

On March 31, 2011, The Centers for Medicare & Medicaid Services (CMS) published in the Federal Register proposed rule ***CMS-1345-P, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations*** that implements the Medicare Shared Savings Program (Shared Savings Program) and establishes the requirements for Accountable Care Organizations. CMS has launched a dedicated web page **here** for Medicare FFS providers and other providers of services and suppliers. Bookmark the web page and check back often, as CMS continues to add information on the program.

Program for Evaluating Payment Patterns Electronic Report (PEPPER) for CAHs

Beginning in April 2011, the Centers for Medicare & Medicaid Services (CMS) will make available free hospital-specific comparative data reports for critical access hospitals (CAHs) nationwide. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) provides hospital-specific data statistics for Medicare discharges at risk for improper payments. Hospitals can use the data to support internal auditing and monitoring activities. PEPPER is the only free report comparing a CAH's Medicare billing practices with other CAHs by state, Medicare Administrative Contractor (MAC) or Fiscal Intermediary (FI) jurisdiction and the nation. CMS has contracted with TMF Health Quality Institute to develop and distribute the reports.

PEPPER will be distributed electronically to CAH QualityNet Administrators and those who have basic user accounts with the PEPPER Recipient role on or about Monday, April 25, via a My QualityNet secure file exchange. In preparation for receiving and downloading PEPPER from My QualityNet, these individuals should verify that their computer systems are equipped with the software and configuration required to use My QualityNet by following the steps at **www.qualitynet.org** (see "Getting Started With QualityNet" and "Test Your System.") Additional information about downloading PEPPER from My QualityNet can be found **here** (includes System Setup and Test Guide, Troubleshooting Tips and a guide for Configuration Changes for Compatibility with QualityNet).

CAHs may work with their Quality Improvement Organization (QIO) to obtain a QualityNet administrator account by visiting **www.qualitynet.org** and clicking on the Hospitals – Inpatient link. Obtaining a My QualityNet account may take several weeks; CAHs should plan accordingly.

TMF will conduct a web-based training session for CAH staff providing information on PEPPER and how to use it on Thursday, April 28, at 1 p.m. central time. To register for the training, CAH staff should visit https://tmfevents.webex.com. The training will be recorded and posted on http://www.pepperresources.org.

For more information, including the PEPPER distribution schedule, a sample PEPPER for CAHs and information about QualityNet accounts, visit the PEPPER website. CAH staff are encouraged to join the e-mail list on this website to receive important notifications about upcoming PEPPER distribution and training opportunities.

Image by The Library of Congress via Flickr