Billing for Compliance Professionals

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NHPCO

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Learning Outcomes

- Upon completing this session, participants will be able to:
  1. Identify billing terminology as it relates to hospice such as revenue codes, modifiers, HCPCS, and CPT codes
  2. Understand what to monitor when reviewing billed services
  3. Understand the billing process and connection with physician services
  4. Review resources pertinent to hospice billing

Why We Care About Billing

- The Centers for Medicare and Medicaid Services or CMS is relying more heavily on claims-based submissions to support or reject the quality of care being provided to hospice patients.
- This information will be used to inform and support decisions about hospice care and payment in the future.
- Hospice is seen as a cost-saving activity to the Federal Health programs when administered correctly, while also providing beneficial end of life care.

MedPAC Comments:
CMS's Proposed Rule on Hospice for FY 2025

- CMS proposes an update of 2.6 percent to the FY 2025 hospice payment rates, but MedPAC concluded that current payment rates are sufficient to support high-quality care without an increase to the base payment rates in 2025.
- CMS proposes Hospice Outcomes and Patient Evaluation Assessment Instrument (HOPE) beginning FY 2025. MedPAC urges CMS to
  - Focus on items with high **inter-rater reliability** that are less subject to differential coding practices and monitor inter-rater reliability periodically after the tool is implemented.
  - Implement a strong audit plan to ensure sufficient and continual monitoring of the data as it is collected.

MedPAC Comments:
CMS's Proposed Rule on Hospice for FY 2025

CMS seeks comment on several issues related to payment mechanism for high-intensity palliative care services for hospice enrollees.

- MedPAC has identified hospice use among decedents with end-stage renal disease (ESRD) is an issue. They plan to conduct research about access to hospice and end-of-life care for beneficiaries with ESRD, interviewing clinicians; hospice providers; ESRD facilities, including programs that provide palliative kidney care; and other groups to provide comments to CMS.

Cyberattack

- Change Healthcare/Clearinghouse
  - If this was your clearinghouse payments delayed, NOEs were late, playing catch up
- CrowdStrike –
  - This was smaller scale, but occurred because of programming update to Microsoft.

Provider Enrollment Chain and Ownership System (PECOS)

- Effective June 3, 2024
- Hospice claims deny if the certifying physician entered in the Attending field on the claim is not found in the PECOS as an enrolled or opted-out physician.
  - Steps to Take to Prevent Denials
    - Develop a process to check MD listed on CMS Order & Referring Dataset (will not be listed if MD is not in PECOS)

Provider Enrollment Chain and Ownership System (PECOS)

- Steps to Take to Prevent Denials
  - For initial benefit periods, complete the Attending Physician and Other fields (with the hospice certifying physician listed in the latter field) unless the patient's designated attending physician is the same as the hospice physician certifying the terminal illness
  - For subsequent benefit periods prior to dates of service (DOS) on or after October 1, 2024, the hospice certifying physician should be listed in the claim's Attending Physician field to avoid this denial. Leave the Other field blank.

Provider Enrollment Chain and Ownership System (PECOS)

- Steps to Take to Prevent Denials
  - Is the physician's National Provider Identifier (NPI) correct on the claim?
  - Are any of the digits transposed?
  - Do the first four characters of their last name exactly match the CMS dataset on the claim?
  - A nurse practitioner (NP) or physician assistant (PA) is not entered in the claim's Attending Physician field.

Compliance Professionals Need To Make Plans When Preparing to Audit or Review Claims

- ❑ Will this be an internal audit or external review?
- ❑ Are you performing an audit or a review for education and training?
- ❑ If internal, do you have an audit or review tool?
- ❑ If internal, do you have qualified staff to conduct the review?
- ❑ How frequently are you going to do this?
- ❑ Is this pre-pay review or post-pay review?

What Does a Compliance Officer Need to Know About Billing?

- ❑ **How to locate information related to coding and billing.**
- ❑ Who is your Biller? And Who is your Back up Biller?
- ❑ Who is your Hospice's MAC? Medicaid Program?
- ❑ How does the biller keep up with Hospice Medicare / Medicaid billing instructions?
- ❑ Do you have an overpayment/repayment process if necessary?
- ❑ Do you have checks and balances to ensure claims are billed correctly?
- ❑ Who is your Clearinghouse provider?

Planning Your Audit or Review

- What are you auditing? Length Of Stay, Routine Care, GIP, CHC, and Claims pending due to Cyberattack
- What is the sample size? 5, 10, 15 claims...
- What are you going to do if you find an error?
- Do you need legal counsel?
- Whatever the outcome- document, document document...
  - **Even if you end up not billing the claim or days of services you still document how you handled the issue**.

What does a Compliance Officer Review in Billing?

- Consent Form – signed, dated, attending documented if applicable? Prior to Billing
- Notice of Election (NOE) – submitted timely
- CTI/POC - created and signed
- Verbal Certifications – signed prior to billing
- Visit billed versus visits made and by discipline

What does a Compliance Officer Review in Billing?

- Recertification CTI/POC - created and signed
- Verbal Recertifications – signed prior to billing
- Face to Face completed for 3rd and subsequent recertifications
  - ✓ How many (if any) also have a billable physician visit?

Changes for 2025

- Changes for Fiscal Year 2025
  - Rate increase of 2.9% (final 07.30.2024)
  - Cap Amount - $34,465.34 (final 07.30.2024)
  - Hospice Outcomes & Patient Evaluation (HOPE) will replace Hospice Item Set (HIS) – data collection October 1, 2025
  - Two new quality process measures based on HOPE data, “Timely Follow-Up for Pain Impact” and “Timely Follow-Up for Non-Pain Symptom Impact,” expected to begin no sooner than FY 2028
  - Finalizes several changes to the CAHPS Hospice Survey, including the addition of a web-mail mode survey option to begin April 2025

Changes for 2025

- Changes for Fiscal Year 2025
  - Finalizes the adoption of new OMB labor market delineations based on data collected from the 2020 Decennial Census which will result in changes to the wage index rate for some hospices
  - Finalizes clarifying regulation text changes, with no changes to current policy; includes reorganizing the regulations to clearly identify the distinction between the “election statement” and the “notice of election,” as well as including clarifying text changes that align payment regulations and Conditions of Participation (CoPs) regarding who may certify terminal illness and determine admission to hospice care

Reviews and Audits

- **Review** - a formal assessment or examination of something with the possibility or intention of instituting change if necessary.
- **Audit** - a formal examination of an organization's or individual's accounts or financial situation. Usually followed up with a formal plan of correction and monitoring.

How Do I Do This?

- Keep it simple
- Create a yes/no check sheet...
- Count yeses and noes
- Correct noes if possible
- Decide if you need to dig deeper (expand your review)
- Decide if you need a corrective action plan

Sample Review Tool

Q.	Audit Question	yes, met	no, not met	comment
1	Claim billed matches the level of care? (i.e., Routine, GIP, CHC, IRC)	x		
2	Certification of Illness signed by MD(s) prior to billing claim?	x		
3	Physician Narrative contains sufficient clinical information and other documentation to support the medical prognosis of a life expectancy of 6 months?	x		
4	The claim contains a primary diagnosis and applicable secondary diagnoses to support hospice services?	x		
5	If diagnoses are covered by an LCD, is the criteria for the LCD addressed in the medical documentation?	x		
6	If GIP or CHC is billed, the medical record documentation supports level of service?	x		
7	If IRC is billed, does the medical record documentation support the reason for respite?	x		
8	Face to Face encounter completed within 30 days on or before 3rd Benefit Period ?	x		
9	Are the visits listed on the claim supported by the documentation that the visits were made?	x		
10	Recertifications occur on or before the end of each benefit period?	x		
	Total	**10**	**0**	
	Percentage	100.00%	Compliance	

Conditions of Participation / Hospice Conditions of Payment

eCFR Title 42: Public Health PART 418—HOSPICE CARE /Subpart G—Payment for Hospice Care

- §418.301 Basic rules.
- §418.302 Payment procedures for hospice care.
- §418.304 Payment for physician, and nurse practitioner, and physician assistant services.
- §418.306 Annual update of the payment rates and adjustment for area wage differences.
- §418.307 Periodic interim payments.
- §418.308 Limitation on the amount of hospice payments.
- §418.309 Hospice aggregate cap.
- §418.310 Reporting and recordkeeping requirements.
- §418.311 Administrative appeals.
- §418.312 Data submission requirements under the hospice quality reporting program.

Definitions

- **Revenue Codes** are descriptions of services used in health care billing to define a procedure or process.
- Revenue Codes are assigned dollar amounts leading to payment levels.

Definitions

- **HCPCS -** Healthcare Common Procedure Coding System or Health Care Procedural Coding System;
  - Standardized coding system for describing the specific items and services provided in the delivery of health care.
  - **Coding is necessary for Medicare, Medicaid, and other health insurance programs** to ensure that insurance claims are processed in an orderly and consistent manner.
  - **Reviewed quarterly.**

Definitions

- Current Procedural Terminology **(CPT)** is a medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations.
- CPT codes are used in conjunction with ICD-10-CM numerical diagnostic coding during the electronic medical billing process.

Definitions

- There are three types of CPT codes: Category 1, Category 2, and Category 3. **Reviewed annually**.
- CPT is a registered trademark of the American Medical Association.
- There were 349 editorial changes in the 2024 CPT code set, including 230 new codes, 49 deletions, and 70 revisions.

ICD-10-CM Official Guidelines for Coding and Reporting FY2025

ICD-10-CM Official Guidelines for Coding and Reporting

- FY 2025 (October 1, 2024 - September 30, 2025)
- Uniform Hospital Discharge Data Set (UHDDS)
- The UHDDS definitions also apply to hospice services (all levels of care).
- The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task.

ICD-10-CM Official Guidelines for Coding and Reporting FY2025

Definitions

- **Modifiers** can be two-digit numbers, two-character modifiers, or alpha-numeric indicators.
- Modifiers provide additional information to payers to make sure your provider gets paid correctly for services rendered.
- GV- Attending physician not employed or paid under arrangement by the patient's hospice provider, or
  - GV- Hospice-employed nurse practitioner elected as the patient's attending physician
- GW- Service not related to the hospice patient's terminal condition.

Notice of Election (NOE) is a Must

- The NOE is submitted to notify the Medicare contractor, and the Common Working File (CWF), of the start date of the beneficiary's election to the hospice benefit.
- The NOE is submitted after the beneficiary has signed the election statement and is only submitted once.
- Hospices must submit the NOE **within 5 calendar days after the hospice admission.**
- Refer to the CMS Change Request 8877

Notice of Election (NOE) is a Must Do

- If the NOE is not received timely, those days from admission to the day before the NOE was received, are considered **noncovered**, and the provider is financially liable for those days.
- **Example:**

  Admit Date = 11/10/YY
  NOE receipt date (REC DT) = 11/16/YY (submission to MAC)
  Noncovered days = 11/10/YY – 11/15/YY
- 5 days lost revenue simply for failing to get the information submitted timely

Claim Submission Issues

- Hospices have **12 months** from the date of service to file their claims timely.
- A patient cannot be discharged and re-admitted to the **same hospice on the same day**.

Big Red Flags

- Untimely Face-to-Face Encounters and Discharge
  - If the required face-to-face encounter is not timely, the hospice would be unable to recertify the patient as being terminally ill, and the patient would cease to be eligible for the Medicare hospice benefit.
- If the patient continues to be terminal you must discharge, continue to care for patient, complete face-to-face visit and readmit.
- When this occurs, the hospice must discharge the patient from the Medicare hospice benefit because he or she is not considered terminally ill for Medicare purposes.

Compliance Quick Checks

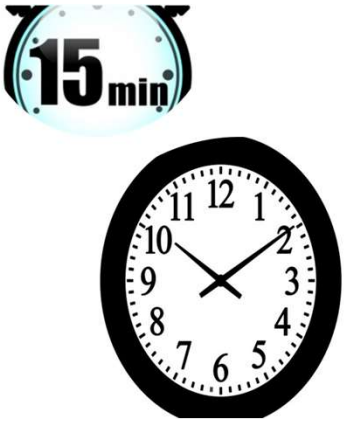
- Service lines on Hospice claims with **Revenue Codes**
  - 651 (Routine Home Care),
  - 652 (CHC),
  - 655 (Inpatient Respite Care) or
  - 656 (General Inpatient Care)
- **Should also contain HCPCS codes** in the range Q5001 – Q5009.
- Failure to include the HCPCS code will cause the MAC to return the claim to the provider (RTP).

Compliance Quick Checks

- The number of **service units** reported on a Hospice claim with Revenue Code 652 (CHC) does not exceed 96.
  - **Claims with service units above 96 will be returned.**
  - **Claim will not process until corrected.** (Known as an RTP)

Compliance Quick Checks

- Payment on Hospice claims will be calculated by interpreting the number of units reported with Revenue Code 652 (CHC) as 15-minute increments and multiplying the hourly CHC rate using the number of increments.
- (1 hour = 4 units) (24-hour x 4 units = 96)



Compliance Quick Checks

- Did the visits reported on the claim occur?
- Are the time increments correct?
- Does documentation support the care provided and billed?

Physician / NP / PA Billing in Hospice

- The face-to-face encounter is not billable
- Hospice physicians may bill for direct patient care provided during such a visit;
- NPs may bill for such visits if they provide physician services and are the designated attending physician.
- This job aid is approved by all HHH MACs

Physician / NP / PA Billing in Hospice

- When billing physician-level services you must use:
  - CPT and or HCPCS codes
  - Modifiers
- Where the service is related to the hospice patient's terminal illness but was furnished by someone other than the designated "attending physician" [or a physician substituting for the attending physician]) the physician or other provider must look to the hospice for payment.

References

- CGS: Hospice Medicare Billing Codes Sheet – by CGS
- CMS National Coverage Policy Article: Billing and Coding: Hospice: Determining Terminal Status
- CMS Online Manuals – Medicare Claims Processing Manual – Chapter 11
- Fact Sheet
- Federal Register
- Medicare Administrative Contractors – NGS, CGS, and Palmetto
- MedPAC comment on CMS's proposed rule on hospice for FY 2025

References – Hospice Billing Tip Sheets

- NGS: Hospice Billing
- New Hospice Certifying Enrollment Questions and Answers - PECOS
- New Hospice Certifying Physician Claim Edit – PECOS
- Palmetto GBA: Hospice Billing Codes
- Supporting Files

Team Discussion Questions

- What did the faculty share that you found thought provoking?
- Did you identify a billing issue or question that you should investigate?
- Did you identify a process that was discussed that you can take back and implement at your organization?
- Who else on your team would benefit from this information?

Thank You!

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