MLN Matters
Information for Medicare Fee-for-Service Health Care Professionals

News Flash - Understanding the Remittance Advice: *A Guide for Medicare Providers, Physicians, Suppliers, and Billers* serves as a resource on how to read and understand a Remittance Advice (RA). Inside the guide, you will find useful information on topics such as the types of RAs, the purpose of the RA, and the types of codes that appear on the RA. To order your copy today, go to the Medicare Learning Network Product Ordering page at *http://www.cms.hhs.gov/MLNProducts* on the CMS website.

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Billing Instructions Regarding Payment for Hospice Care Based on Location Where Care is Furnished

Note: This article was revised on January 24, 2008, to add references to related Change Requests (CRs) 5567 (Reporting of Additional Data to Describe Services on Hospice Claims) and CR5245 (Instructions for Reporting Hospice Services in Greater Line Item Detail) in the Additional Information section below. All other information remains the same.

Provider Types Affected

Providers who bill Regional Home Health Intermediaries (RHHI) for inpatient hospice care for Medicare beneficiaries.

What You Need to Know

CR 5745, from which this article is taken, instructs hospices how to document where you provide inpatient levels of care. It announces for Routine Home Care (RHC) and Continuous Home Care (CHC) levels of care (revenue code 651 and 652): 1) National Uniform Billing Committee (NUBC) approval (effective January 1, 2008) of a new value code (value code G8) to identify a facility core based statistical area (CBSA); and 2) the redefinition of value code 61 to apply to residence locations only.

The development of these codes allows you to continue the current practice of billing all hospice services on a single monthly claim, while allowing Medicare to wage adjust the services on that claim accurately under the new the FY 2008 Hospice Wage Index regulation.

You should make sure that your billing staffs are aware of these value code changes for inpatient hospice care.

Background

CR 5745 instructs hospices how to bill for the location where you provide inpatient levels of hospice care.

Currently, not all Medicare payments for hospice services are wage adjusted based on the location where the service is furnished. For example, Medicare now uses the core based statistical area (CBSA) on the hospice facility's provider file as the basis for the wage adjustment of inpatient hospice levels of care. This assumes that any inpatient levels of care are provided at an inpatient facility (either at the hospice itself or under arrangements with a facility within the same CBSA). Alternatively, Medicare uses the beneficiary's residence CBSA as the basis for wage adjustment of Routine Home Care (RHC) and Continuous Home Care (CHC) levels of care (revenue code 651 and 652).

Further, the beneficiary's residence CBSA (whether or not it is an inpatient setting) is currently reported on the claim using value code 61(defined by the NUBC as "Location Where Service is Furnished (HHA and Hospice))." However, while this definition of value code 61 is broad enough to include both home and facility settings, the code itself does not distinguish between the two locations; and there may be circumstances where RHC and CHC are provided in inpatient settings, as these settings may serve as the beneficiary's place of residence.

Therefore, since hospice providers frequently bill both home and inpatient levels of care on the same claim; if multiple instances of value code 61 were reported, the claim would not distinguish which CBSA code corresponded to which level of care.

While requiring hospices to bill separately for home vs. inpatient levels of care, would meet Medicare's need in terms of making accurate payment without making a value code change; this could create unnecessary administrative burden on hospices. Moreover, by artificially increasing the number of hospice claims, it would increase Medicare's administrative costs.

To avoid these impacts, the Centers for Medicare & Medicaid Services (CMS) asked the NUBC to approve a new value code to distinguish a facility CBSA from the currently reported residence CBSA. This code allows you to continue the current practice of billing all hospice services on a single monthly claim while enabling Medicare to wage adjust the services on that claim accurately under the new regulation. The NUBC approved this new code (value code G8) effective January 1, 2008, and also redefined value code 61 to apply to residence locations only. These codes and their definitions are displayed in Table 1, below.

Table 1

NUBC Approved Value Codes for Hospice Care

Code	Title	Definition
61	Place of Residence where Service is Furnished (Routine Home Care and Continuous Home Care)	Metropolitan Statistical Area (MSA) or Core Based Statistical Area (CBSA) number (or rural state code) of the place of residence where hospice service is delivered. A residence can be an inpatient facility if an individual uses that facility as a place of residence. It is the level of care that is required and not the location where hospice services are provided that determines payment. In other words, if an individual resides in a freestanding hospice facility and requires routine home care, then claims are submitted for routine home care. Hospices must report value code 61 when billing revenue codes 0651 and 0652.
G8	Facility where Inpatient Hospice Service is Delivered (General Inpatient and Inpatient Respite Care).	MSA or CBSA number (or rural state code) of the facility where inpatient hospice services are delivered. Hospices must report value code G8 when billing revenue codes 0655 and 0656.

Important Notes:

If hospice services are provided to the beneficiary in more than one CBSA area during the billing period, you should report the CBSA that applies at the end of the billing period. This applies for either RHC and CHC (e.g., the beneficiary's residence changes between locations in different CBSAs); or for general inpatient and inpatient respite care (e.g., the beneficiary is served in inpatient facilities in different CBSAs.)

On your claims, enter the five digit CBSA, with two trailing zeroes, in the "amount" field (i.e., if the CBSA is 10180, enter 1018000).

Additional Information

You can find more information about billing Instructions for payment for hospice care based on where the care is furnished by going to CR 5745, located at *http://www.cms.hhs.gov/Transmittals/downloads/R1352CP.pdf* on the CMS website. You will find updated *Claims Processing Manual*, Chapter 11 (Processing Hospice Claims), Section 30.3 (Data Required on Claim to FI) as an attachment to that CR.

Providers may also want to read the following related CRs and their related MLN Matters article:

- CR5567 (Reporting of Additional Data to Describe Services on Hospice Claims) at *http://www.cms.hhs.gov/Transmittals/downloads/R1397CP.pdf* and related MM5567 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5567.pdf* and
- CR5245 (Instructions for Reporting Hospice Services in Greater Line Item Detail) at *http://www.cms.hhs.gov/Transmittals/downloads/R1011CP.pdf* and related MM5245 at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5245.pdf* on the CMS website.

If you have any questions, please contact your RHHI at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.