HOSPICE CARE NEWS
InContext

DIXON HUGHES PLLC
Certified Public Accountants and Advisors

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HOSPICE BILLING UPDATE

Hospice claims with dates of service January 1, 2007, and forward require providers to bill continuous care hours on separately dated line items in 15-minute increments, and to report the appropriate Healthcare Common Procedure Coding System (HCPCS) code which identifies the service location of all levels of care.

Over the past decade, Medicare has instituted progressively more complex payment methods. These changes have required claims to include more line item dated detail, modifiers, HCPCS codes, and reporting of non-covered charges. Hospice claims have not undergone the changes that have been implemented for other institutional-provider types. With the reporting of such detail, the quality and richness of Medicare analytical data files has improved.

Hospice claims have only been required to include a small number of service lines to report the dates and/or hours of the four levels of care. HCPCS codes were only required when reporting physician billing for procedures provided by hospice employed/contracted physicians. The limit of claims data has restricted Medicare's ability to ensure payment accuracy and to prudently analyze services provided under this benefit.

Hospice providers will need to indicate the following on their claims:

- Continuous Care – claims must reflect a minimum 8 hours of continuous care in 15-minute increments. Rounding of hours is no longer allowed. Only direct patient care during a period of crisis is billable. For example: 8 hours would be entered as 32 units. Nine hours, 45 minutes would be billed as 39 units. (0652 Revenue Code)
- HCPCS Codes – reflect the location of services rendered for all levels of hospice care. Multiple locations of care may occur within a billing month and should be reported as separate and distinct line items.

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WINTER 2007

SEGREGATING AND REPORTING TELE-MONITORING COSTS

Many home health agencies are utilizing telemonitoring as part of the plan for monitoring patient information throughout the episode of care. For home health agencies, these expenses are to be segregated and reported as non-reimbursable services provided by the Agency. These requirements are not applicable to hospices; however, as hospices explore the use of telemonitoring as part of the plan of care and oversight, we recommend the following:

(1) Telemonitoring costs should be segregated in the accounting records of the hospice.

(2) These telemonitoring costs should be reported as other hospice services on the Hospice Cost & Data Report, but not as non-reimbursable activities.

This separate reporting has many advantages in the continuous assessment of these activities by the hospice. Telemonitoring costs would include not only the costs associated with the equipment used, but also the personnel costs incurred to provide the oversight of these activities.

If your hospice is interested in exploring telemonitoring you may find it valuable to contact NHPCO or NAHC to determine which vendors will be exhibiting at the upcoming NHPCO program in Washington, D.C. and the NAHC programs in Washington, D.C., Boston, MA, and Denver, CO.

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Report care provided in:

- Q5001 – Beneficiary's home/residence
- Q5002 – Assisted Living Facility (ALF)
- Q5003 – Nursing Long Term Care Facility (LTC) or Non-Skilled Nursing Facility (NF)
- Q5004 – Skilled Nursing Facility (SNF)
- Q5005 – Inpatient Hospital
- Q5006 – Inpatient Hospice Facility
- Q5007 – Long Term Care Hospital (LTCH)
- Q5008 – Inpatient Psychiatric Facility
- Q5009 – Place not Otherwise Specified (NOS)

Examples of multiple location billing:

Rev Code	HCPCS	Code	Units	Date
0651	Q5004	11	0107	(Routine Care 11 days at SNF)
0651	Q5001	20	011207	(Routine Care 20 days at home)

SETTING HOSPICE CHARGES FOR SERVICE

The vast majority of hospices in the country use the Medicare reimbursement rate for hospice services as the standard charge to be applied to all payor sources. Any payment that differs from the Medicare rate (contractually agreed-to rate or other acceptable payment, e.g. charity discount) is reconciled through the use of a contra-revenue account for contractual adjustment or charity. The question is how hospices should establish charges for service.

The existing practice is the result of simplicity. In most hospices Medicare patients and, accordingly, Medicare program revenues constitute the vast majority of the revenues earned. Additionally, most state-administered Medicaid programs use the Medicare payment rates as the Medicaid program payment rate. These circumstances explain why this methodology is currently employed by most hospices.

In fact, almost all healthcare providers other than hospices establish charge structures based on competitive rates and costs incurred to provide the services. Hospitals have a charge structure based on a combined per-day rate for inpatient residential services and other charges based on the various services and supplies furnished. These charges

are generally paid by few, if any, patients or payors. Likewise, home health agencies have generally created a per-visit charge although the Medicare program reimburses generally on a per-episode basis.

Charge Alternatives

(1) Use the Medicare reimbursement rate, as generally applied today, as the standard charge on a per-day basis depending on the four levels of care defined by the Medicare program. The difference between any acceptable payment and the established rate is recorded as a contractual adjustment or charity care depending on the facts and circumstances relating to the payor and the payment.

(2) Set per-day rates at amounts in excess of the Medicare payment rates based on the costs incurred to provide the services and competitive rates, if such are applicable. It is not generally recommended that the per-day rates be set at amount less than the Medicare payment rate. Differences between the established rates and the acceptable payments, including those from the Medicare program, would be recorded as contractual adjustment or charity care depending on the facts and circumstances relating to the payor and the payment.

(3) Set service payment rates based on the quantity and type of service rendered, e.g. rates per-hour for nursing services and other personal services, rates for supplies used in the provision care, and per-day rates for inpatient and respite care services provided in institutional settings. Generally, under this type of charge structure, a daily administrative charge would also be made for development, maintenance and oversight of the plan of care. Differences between the computed charges and the acceptable payments, including those from the Medicare program, would be recorded as contractual adjustment or charity care depending on the facts and cir cumstances relating to the payor and the payment. This alternative requires substantial maintenance and effort in comparison to the other two alternatives. For this reason, this method is extremely rare in the industry although it gets significant conversation because of the information that could be produced and providing a charge structure truly based on the services rendered on behalf of the patient. Additionally, considerations in the charge structure would have to be given to those services provided post-death when no payment is generally available.

While it is expected that the vast majority of hospices will continue to use alternative 1 or 2 presented above the informational value of alternative 3 should be subject to consideration in anticipation of the continued future growth of hospice services and the increasing volumes of activity relating to non-Medicare populations.

HOSPICE CARE NEWS: IN CONTEXT

Hospice Care News: In Context **is intended for Administrators, CEOs, CFOs, accounting personnel, compliance officers and clinical management personnel at hospice providers. The publication is intended to:**

- **Highlight current developments relating to financial and compliance matters for hospice providers**
- **Address cost reporting issues for providers**
- **Notify providers of educational offerings for hospice personnel**
- **Provide informative, although limited, discussion of topics of interest in the management of hospice providers**

The newsletter is intended to benefit all types of hospice providers, whether they be free-standing, hospital based, home health agency based, tax-exempt, proprietary or governmental.

Other providers that deal continuously with hospice providers, such as nursing homes, home health agencies, physicians or hospitals may also find the newsletter of benefit to them. It may also be of benefit to Board members or others responsible for oversight of the activities of a hospice. If you desire others to receive a copy of this newsletter, do not hesitate to contact us.

Your comments regarding this newsletter, including ideas for future topics, are also appreciated.

HOSPICE AND THE STARK LAWS

It has been generally determined that Stark does not apply to the Medicare hospice benefit. Stark prohibits claims for designated health services if referrals for such services come from a physician with whom the healthcare provider has a prohibited financial relationship. Bundled hospice services are not included in the listing of designated services; however, many of the designated services are part of the bundled hospice services. Even though the bundled hospice services, which include physical therapy, durable medical equipment, radiology and clinical laboratory services, have been determined to be exempt from Stark, hospices providing or planning to provide unbundled services on the designated list should consult with legal counsel relating to the potential applicability of Stark.

Designated health services covered by the Stark law include:

- Clinical laboratory services
- Physical therapy, occupational therapy and speech pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

Even if Stark is not an issue for most hospice providers, hospices must be keenly aware of anti-kickback arrangements. Key issues regarding any arrangement with physicians include:

- Does the arrangement or practice have a potential to interfere with, or skew, clinical decision-making?
- Does the arrangement or practice have a potential to increase costs to federal healthcare programs, beneficiaries or enrollees?
- Does the arrangement or practice have a potential to increase the risk of over-utilization or inappropriate utilization?

In summary, regardless of the potential inapplicability of Stark laws to hospices, legal counsel should be consulted relating to any financial relationships by hospices with physicians. These relationships may include ownership or compensation of various forms.

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To ensure compliance with requirements imposed by the IRS, we inform you that any tax advice contained in this communication (including any attachments) is not intended or written to be used, and cannot be used, for the purpose of avoiding penalties under the Internal Revenue Code.

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Tell Us How We Can Help

We would welcome the opportunity to answer your questions and discuss your needs. Just fill in and fax this response form to **Margie Pringle** at **304.368.0406** or e-mail **mpringle@dixon-hughes.com.**

Express Response Form

Please call me at (   ) ____________________________ to arrange an appointment.

I would like more information about your services for hospice programs:

- ☐ Cost Reporting
- ☐ HIPAA
- ☐ Strategic Business Planning
- ☐ Financial Feasibility Studies
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- ☐ Corporate Compliance
- ☐ Mergers and Acquisitions
- ☐ Board Issues
- ☐ Educational Programs

I would like more information about the other services you offer, especially those relating to:

- ☐ Audit Services
- ☐ Tax Services
- ☐ Management Consulting
- ☐ Financial Planning
- ☐ Technology Solutions

Has this issue of our newsletter been helpful to you? We would love to have your input:

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