Eli's Hospice Insider

Diagnosis Coding: Get Ready To Shoulder More Hospital Costs

Your diagnosis coding will determine whether you pay for hospital care.

CMS is taking the next step to turn up the heat on hospices that it views as shirking their bundling responsibilities under the benefit.

Under a new Change Request, in April Medicare will "deny an inpatient hospital claim when the principal diagnosis on the inpatient claim matches one of the hospice diagnosis codes," the Centers for Medicare & Medicaid Services says in Nov. 7 CR 8273. "Services related to a hospice terminal diagnosis provided during a hospice period are included in the hospice payment and are not paid separately. An inpatient hospital claim will be denied when providers bill with a condition code 07 on an inpatient claim and the principal diagnosis on the inpatient claim is found to match one of the hospice diagnosis codes."

Hospices can say thanks to Recovery Audit Contractors for the new edit. RAC data "identified inpatient hospital claims where the principal diagnosis listed was one of the patient's listed hospice terminal diagnoses during the hospice period, yet providers were billing the principal diagnosis with a condition code 07," CMS notes in the CR. "The payments associated with these claims are considered overpayments because [CMS] does not pay separately for an inpatient hospital stay when a hospice terminal diagnosis is listed as a principal diagnosis."

CMS does acknowledge that services won't always be related to terminal illness in these cases, however. "In the limited instances (e.g., as the result of an appeal or reopening) where payment is appropriate, the A/B MAC shall have the capability to override the edit," the agency instructs its MACs in the CR.

Watch out: The CR's implementation date is April 7, 2014, but "we believe the CR instructs MACs to retroactively review hospital claims with dates of service within 3 years of the implementation date," warns the National Association for Home Care & Hospice. "Therefore, MACs are expected to recoup the overpayments from the billing hospital for any hospital claims that match the edit criteria."

That could lead hospitals to come knocking on your door for reimbursement from three years ago, observers say.

The CR is at www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1312OTN.pdf.