# Eli's Hospice Insider

## In other news...

• **Say goodbye to consult codes.**CMS has eliminated this series of CPT codes for docs, and that means hospices can't bill with them anymore either.

"Does the policy of no longer recognizing CPT consultation codes for the purposes of Medicare billing apply to billing for physicians' services in hospices, where the hospice bills Part A for the services of physicians on staff or working under arrangement with the hospice?" says a new question and answer set in MLN Matters article SE1010.

"Yes, when hospices bill Part A for the services of physicians, they must use CPT codes that are paid under the MPFS," CMS explains in the Q&A.

Why? "Since the CPT consultation codes are no longer recognized for payment under the MPFS, hospices must follow the same guidelines for reporting E/M services as physicians billing Part B,"CMS continues."Hospices should use the most appropriate E/M codes to bill for E/M services furnished by physicians that could be described by CPT consultation codes."

The article is at www.cms.hhs.gov/MLNMattersArticles/downloads/SE1010.pdf.

• **Remember to include a manifest** when submitting documentation for medical review. So advises a new question-and-answer from regional home health intermediary Palmetto GBA.

A hospice complained to Palmetto because it submitted records for multiple ADR'd claims in one envelope,according to the latest set of Hospice Coalition Q&As posted on the RHHI's Web site.

When Palmetto received the envelope, one chart was lost and the hospice was notified it didn't submit documentation by the deadline. Thus,the denial went into the provider's denial rate.

"Providers are encouraged to include a manifest when submitting multiple records together," Palmetto says in the Q&A. Also, "each record should be bound individually."

In this scenario, Palmetto's medical review staff will work with the provider to try to find the lost record and resolve the issue, the intermediary adds in the Q&A.

• **If your agency often takes a hit** when a Medicare Advantage patient elects hospice care, you'll welcome this news. Starting soon, the Medicare fee for service program will pick up some of the slack.

Problem: "Problems arise regarding payment responsibility when services are provided on the date of election," CMS acknowledges in Feb. 5 Transmittal No. 121 (CR 6778). "As a result, services provided on the date of election are often rejected by both the MA plan and traditional Medicare, leaving the provider uncertain as to which entity should be responsible for the claim payment."

Solution: Now CMS makes clear who should pay. Starting July 6, the Medicare claims system won't reject claims for FFS Medicare on the date benes elect hospice. Currently, FFS claims are rejected as an MA plan responsibility.

That means Medicare will pay for ambulance transport under FFS, CMS explains. An ambulance ride is not the MA plan's responsibility once the patient elects hospice, but it's not the hospice's responsibility until it has admitted the patient and completed an initial assessment and plan of care, CMS clarifies.

Tip: Hospices will have to resubmit affected claims after July 6."Contractors will not be required to provide automated

adjustments," the transmittal notes.

The transmittal is at www.cms.hhs.gov/transmittals/downloads/R121BP.pdf.

• **Prepare to report a separate line item** for each level of care change starting soon.

As of April 29, CMS is requiring hospices to make this change in billing practices to better link the visits reported with the appropriate level of care being billed.

Currently, when a hospice patient has different levels of care within a given month, it is sometimes not clear from the claim which visits or calls are associated with each level of care reported on the claim, CMS said.

When the change goes into effect,claims should report separate line items for the level of care each time the level of care changes. For example,if a patient begins the month receiving routine home care followed by a period of general inpatient care and then later returns to routine home care all in the same month, in addition to the one line reporting the general inpatient care days, there should be two separate line items for routine home care.

CMS hopes that the change will ensure visits and calls are associated with the level of care being billed, with minimal administrative demands on providers. However, CMS warns,should providers not adhere to this policy it may consider implementing a line item date of service billing requirement for hospice level of care revenue codes, resulting in separate line for the level of care for each day billed on the hospice claim.

Read the transmittal here: www.cms.hhs.gov/transmittals/downloads/R1897CP.pdf.