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Eli's Hospice Insider

PAYMENT NOTES :

Good news: One big headache caused by Medicare's new requirement for hospice visit charges may soon get better. Last year, the Centers for Medicare & Medicaid Services began requiring hospices to list visit charges on their claims, the agency notes in April 24 Transmittal No. 471 (CR 6386). The claims system processes these visit charges as noncovered and they show up on the remittance advice and beneficiary Medicare Summary Notice (MSN).

The misleading RAs and MSNs have caused some secondary payors to make inappropriate payments for the charges and some beneficiaries to believe they owe for the charges and appeal them, the transmittal notes.

Change: "To minimize confusion ... Medicare will change the outcome of processing these charges to reflect as covered on the remittance advice notice and the MSN," CMS says. The change takes effect Oct. 1. The National Association for Home Care & Hospice is pleased that CMS is alleviating the problem, the trade group's **Janet Neigh** tells **Eli**.

Do you know your hospice transfer rules? Hospices scratching their heads over their Medicare reimbursement for transfer patients are getting a helping hand from regional home health intermediary Cahaba GBA. Patients receive payment for only one level of hospice care a day: routine home care (RHC), continuous home care (CHC), respite, or general inpatient care (GIP).

In a transfer situation, Medicare uses the level to which the patient was transferred to determine payment for that day, Cahaba explains in its June provider newsletter.

For example, a patient under RHC is transferred to GIP on April 1. April 1 is billed as a GIP day, Cahaba illustrates in the article. What if a hospice patient dies in GIP or respite care? That day is paid at the GIP or respite care level, Cahaba adds.

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