Eli's Hospice Insider

Reimbursement: Prepare For Hospice Payment Reform Billing Now With These 7 Steps

Get friendly with HETS.

You may feel you are ready for hospice payment reform taking effect Jan. 1, but are your billing and supporting systems ready too?

Many clients of **Astrid Medical Services** billing company in Corpus Christi, Texas, think that payment reform is "long overdue," relates owner **Lynn Olson**. They welcome the policy changes. But they "are concerned about the implementation," Olson acknowledges.

Some implementation issues are out of hospices' hands namely, system glitches on Medicare's side. Many hospices are keeping their fingers crossed that claims processing won't stall like it did with ICD-10, Olson tells **Eli**.

But on the eve of payment reform, hospices can take steps to make sure they transition to new billing rules smoothly and without costly delays. Consider this advice from the experts to make your reform transition as pain-free as possible:

1. Focus on software. Hospices' number-one priority in these last weeks should be making sure their billing software is ready to go. The clients of **Rose Kimball** of **Med-Care Administrative Services** in Dallas have checked their software and are "optimistic" the software will perform accurately under the two-tier system, Kimball says.

If you haven't yet done so, billing expert **M. Aaron Little** with **BKD** advises that you assess your software now to make sure it will:

- discontinue using skilled nursing G-code G0154 for claims dated Jan. 1 and later. "If visits continue to be incorrectly billed with this code, it will cause cash flow delays and require claims corrections," Little warns.
- separately code all SN visits made by RNs (G0299) versus LPNs (G0300) for claims dated Jan. 1 and later. In addition to cash flow delays and claims corrections, mistakes with these codes could cost you your Service Intensity Add-on payments in the last seven days of life (see story, p. 5).

2. Ensure visits make it onto claims. Coding claims correctly isn't the only concern when it comes to obtaining your rightful SIA payments. You have to make sure the relevant RN and Medical Social Work visits get onto the claim at all. This will require a multi-step process that ranges from capturing the visits when they occur to making sure those visits appear on the claim accurately, Little notes.

3. Reconsider your staffing strategy. Under reform, hospices with larger proportions of long-stay patients will see a reimbursement hit. The SIA helps to offset that reduction, but only when visits in the last seven days are made by RNs or MSWs, not LPNs. After day 60, an RN visit lasting four hours in the last seven days of life plus the RHC rate will pay $304.81 compared to the RHC rate alone of $146.83 if an LPN makes the visit.

When deciding whether to send an RN or LPN, "the pay scale between RNs and LPNs is a major consideration," Kimball notes.

Remember, the RN visit must be medically necessary. But the **Centers for Medicare & Medicaid Services** rebuffed

suggestions to make SIA visits harder to claim by requiring special review. "No additional documentation will be required in order to receive the SIA payment," the agency said in the 2016 final payment rule for hospices.

Beware: CMS will be keeping an eye on SIA utilization, though. "We appreciate the concern that some hospices may attempt to capitalize on extra payments made possible through the SIA policy," the agency said in the rule. "CMS will certainly continue to monitor hospice behavior for any concerning patterns as well as any impact to future payment updates. However ... providing payment for increased services at the end of life is consistent with the goal of responding to and providing for intensified patient needs."

Uncertainty: Hospices hoping to improve their finances by utilizing RNs more also may find the effort wasted if their patient lives longer than expected, and the visits are made outside the seven-day SIA window. "It is not always easy to project the last seven days of life," Kimball points out. Usually predictions are more accurate in the 24-to-48 hour timeframe, she notes.

4. Obtain accurate LOS information. Knowing whether you'll receive Tier 1 (Days 1-60) or Tier 2 (Days 61+) RHC rates will be key to predicting your financial status for patients and managing budgets accordingly. But obtaining hospice LOS information may not be as easy as it sounds.

LOS data is vital, because the "episode" that determines your patient's payment tier follows the patient from one hospice to another if there is not a 60-day gap between discharge and admission. Thus, a patient you think is new to the benefit and entitled to the Tier 1 $186.84 RHC rate may really receive the Tier 2 $146.83 rate because they spent 60 days or more on another hospice's service before coming to you. Or the switchover from Tier 1 to Tier 2 may occur mid-course.

Patients and their referral sources may not accurately report previous hospice benefit periods. And when you look up the patient in the HETS system or the Common Working File, previous benefit period information will not appear if the previous provider hasn't billed for that patient yet.

Hindrance: CMS requires hospices to file the Notice of Election and Notice of Termination/Revocation within five days. However, unlike with the NOE, there's no financial penalty for late filing of the NOTR.

Some of these problems are out of providers' hands, but you can make sure you do a thorough HETS/CWF search when admitting a patient. "Typically, checking CWF/HETS once is sufficient unless something comes to the attention of the agency later that may require a recheck," Little judges.

Resource: Learn more about the HETS system with the HETS UI User Guide at www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/HETS-UI-User-Guide.pdf.

5. Monitor claims. "Implement a process to closely monitor claims in the early months of 2016," Little urges.

In particular: Checking for correct RHC payments is important. But "I think it would be to the advantage of hospices to monitor claims that are billed for deceased patients to verify that, when applicable, the SIA was correctly paid and accounted for in the receivables," Little stresses.

6. Be prepared for glitches. Plan for a cash flow slowdown early in the year as potential system glitches are worked out, both on your side and CMS's.

7. Resist live discharge temptations under new system. CMS, Medicare Administrative Contractors, the **HHS Office of Inspector General, the Medicare Payment Advisory Commission**, the mainstream press, and others already have their eye on the issue of live discharges in hospice. MACs are reviewing claims from hospices with high live

discharge rates, and such rates are factoring into whistleblower lawsuits, **Department of Justice** investigations, and more.

Hospices with a large proportion of patients with long LOS are seeing higher medical review and will be facing lower payments under reform, Kimball notes. Some may be tempted to discharge patients back to their home health agencies to avoid both problems.

"That could raise red flags, even though their intent is to not be subjected to medical reviews for 'exceptionally' long lengths of stay," Kimball warns. "CMS plans on monitoring live discharge trends."

CMS did note in the rule that its policy for episode days to follow the patient, unless there's a 60-day or longer gap in care, aims "to mitigate potential high rates of discharge and readmissions ('churning')."

One possibility: One commenter on the 2016 proposed rule for hospice payment suggested "that for live discharges prior to 60 days, the lower tiered RHC rate be applied to all claims where a patient is in their initial 60 days," CMS noted in the final rule. "We will take this suggestion under advisement for future rulemaking after analyzing any trends in discharges and revocations," the agency replied.