DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Information for Medicare Fee-For-Service Health Care Professionals

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MLN Matters® Number: MM7677 Revised | Related Change Request (CR) #: 7677

Related CR Release Date: February 3, 2012 | Effective Date: July 1, 2012

Related CR Transmittal #: R2410CP | Implementation Date: July 2, 2012

New Hospice Condition Code for Out of Service Area Discharges

Note: This article was revised on February, 6, 2012 to reflect the changes issued in a revised CR. That CR inserted language from the "Claims Processing Manual" that was omitted in error (*Untimely Face-to-Face Encounters and Discharge*). The CR release date, transmittal number and web address for the CR also changed. All other information remains the same.

Provider Types Affected

Hospices that bill Medicare contractors (Regional Home Health Intermediaries (RHHIs) or Medicare Administrative Contractors (A/B MACs)) for certain hospice services provided to Medicare beneficiaries are affected.

Provider Action Needed

This article is based on Change Request (CR) 7677, which requires hospices to discontinue use of occurrence code 42 for situations when a provider initiates the termination of hospice care. You are instructed to use occurrence code 42 only to indicate a discharge due to a patient revocation, in accordance with the existing National Uniform Billing Committee (NUBC) instructions.

Additionally, you must begin to use the new NUBC condition code 52 to indicate a discharge due to the patient's unavailability or inability to receive hospice services from the hospice that has been responsible for the patient.

We have included guidance for billing for denials of room and board charges and accurate payment for physician services performed by a nurse practitioner. Please be sure your staff is aware of these changes.

Background

A hospice may discharge a patient if the patient moves out of the hospice's service area or transfers to another hospice; if the hospice determines that the patient is no longer terminally ill; or if the hospice determines that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired (i.e., a discharge for cause). Hospices also record a discharge on claims when a patient initiates the discharge by revoking the hospice benefit. (See 42 Code of Federal Regulations (CFR) 418.26.)

Providers and policymakers are currently unable to distinguish a patient-initiated discharge due to a revocation from some hospice-initiated discharges on hospice claims. Additionally, providers and policymakers are also unable to determine whether a discharge is due to the patient's moving out of the hospice's service area or due to the patient's no longer being terminally ill. Having this information would help in understanding different patterns of hospice care and their associated costs, which is necessary for future payment reform. Additionally, there is concern about a possible program vulnerability when a patient is discharged from the hospice benefit, has an intervening hospital stay, and then is readmitted to the hospice benefit. Knowing the reason for the discharge would help in focusing efforts to strengthen the integrity of the benefit, and in identifying differing care patterns that may be associated with more costly hospice care.

Occurrence code 42 is defined by the NUBC as "date of discharge/hospice term date (hospice only)." The NUBC code instructions related to the use of occurrence code 42 state that, "for final bill for hospice care, enter the date the Medicare beneficiary terminated his election of hospice care." However, this code is not only used to indicate a patient-initiated discharge, but also is currently used to indicate provider-terminated care such as that which occurs when a beneficiary is no longer terminally ill.

Effective for dates of service on or after July 1, 2012, Medicare is requiring hospices to discontinue use of occurrence code 42 for situations when a provider initiates the termination of hospice care and only use occurrence code 42 to indicate a discharge due to a patient revocation, in accordance with the existing NUBC instructions. Additionally, the Centers for Medicare & Medicaid Services (CMS) is requiring hospices to use new NUBC condition code 52 to indicate a discharge due to the patient's unavailability or inability to receive hospice services from the hospice that has been responsible for the patient. In such a circumstance, the patient is considered to have moved out of the hospice's service area. Examples of when such a code could be used include, but are not limited to, when a hospice patient moves to another part of the country or when a hospice patient leaves the area for a vacation. This code would also be appropriate when a hospice patient is receiving treatment for a condition unrelated to the terminal illness or related conditions in a facility with which the hospice does not have a contract, and thus is unable to provide hospice services to that patient. Medicare's expectation is that the hospice provider would consider the amount of time the patient is in that facility before making a determination that discharging the patient from the hospice is appropriate.

The table below summarizes how hospice discharges would be coded on claims based on the changes in this CR and based on no changes to the coding for discharge for cause or for transfers:

Discharge Reason	Coding Required in Addition to Patient Status Code
Beneficiary Revokes	Occurrence Code 42
Beneficiary Transfers Hospices	Patient Status Code 50 or 51; no other indicator
Beneficiary No Longer Terminally Ill	No other indicator
Beneficiary Discharged for Cause	Condition code H2
Beneficiary Moves Out of Service Area	New condition code 52

Billing Reminders

Effective with dates of service on or after July 1, 2012, note that Medicare will return hospice claims where:

- Both condition code 52 and condition code H2 are present;
- Condition code 52 is present and the patient status code is 30;
- Condition code H2 is present and the patient status code is 30;
- Condition code H2 is present with occurrence code 42; or
- Condition code 52 is present with occurrence code 42.

Also, as a result of CR7677, effective with claims **submitted** on or after July 1, 2012:

- Medicare will pay revenue code 0657 when reported with a GV modifier appended to the HCPCS code at the lower of the submitted charge or 85% of the Medicare Physician Fee Schedule.
- Medicare will adjust hospice claims already processed containing revenue code 0657 reported with a GV modifier appended to a HCPCS code if payment was made at 85% of the submitted charges and the claim is brought to the attention of your Medicare contractor within 6 months of the implementation date of CR7677, which is July 2, 2012.

- When Medicare contractors deny hospice room and board charges, they will use claim adjustment reason code 96 for non-covered service and group code PR (Patient responsibility).

Additional Information

The official instruction, CR7677, issued to your RHHI and A/B MAC regarding this change, may be viewed at http://www.cms.gov/Transmittals/downloads/R2410CP.pdf on the CMS website.

If you have any questions, please contact your RHHI or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.