Overview
This guide includes an overview of Medicare reimbursement methodologies and potential coding options for the use of select Medtronic technologies and services related to CY 2017 Medicare payment rates. Similarly, reimbursement opportunities may exist under individual state Medicaid programs and commercial payer policies. Providers should consult with their appropriate payer contacts to ensure alignment on coverage, coding and payment expectations for the utilization of these technologies and/or the associated services.

Hospice
Hospice care is provided to terminally ill patients with a life expectancy of under six months. Patients may be under hospice care in an inpatient facility, a skilled nursing facility or in their home. The patient’s attending physician creates a written care plan to outline the items and services that will be needed.

Patient Benefits
Hospice care is a benefit under the Part A hospital insurance program. In order to access Medicare-certified hospice care, a patient must elect the hospice benefit and be certified by a physician as being terminally ill with a life expectancy of less than six months. The benefit election begins when the patient files a Notice of Election (NOE) statement with a chosen hospice. At that point, the individual must also waive their rights to Medicare payment for hospice care at any location other than their chosen hospice, as well as any Medicare services related to treatment of the condition for which hospice was elected.

The initial benefit election period is 90 days. The patient may receive Medicare coverage for two 90-day periods, and then a subsequent unlimited number of 60-day periods. The initial certification of terminal illness for hospice care may be completed up to 15 days before benefit election, and must also be recertified 15 days before each subsequent benefit period.

Hospice care under the Medicare program includes the following:
- Nursing care provided by or under the supervision of a registered professional nurse
- Physical or occupational therapy, or speech-language pathology services
- Medical social services under the direction of a physician
- Services of a home health aide who has successfully completed a training program approved by the Secretary of HHS
- Homemaker services
- Medical supplies (including drugs and biologicals) and the use of medical appliances while under a hospice care plan
- Physician’s services
- Short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting such conditions as the Secretary of HHS determines to be appropriate to provide such care. Such respite care may be provided only on an intermittent, non-routine and occasional basis and may not be provided consecutively over longer than five days.
Counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment up until his/her death
- Any other item or service which is specified in the plan and for which payment may otherwise be made under this title

**Coverage**

**Hospice Medical Necessity.** To be covered under Medicare, hospice services must meet all of the following requirements:
- Hospice service must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions
- The individual must elect hospice care
- A plan of care must be established and periodically reviewed by the attending physician, the medical director and the interdisciplinary group of the hospice program
- That plan of care must be established before hospice care is provided
- The services provided must be consistent with the plan of care
- A certification that the individual is terminally ill must be completed

Durable medical equipment (DME) and supplies provided by the hospice and related to the care of a terminal patient are also covered under the Part A hospice benefit. Covered supplies are those that are part of the written care plan, and are for palliation and management of the patient’s terminal illness or related conditions. Any DME and supplies which are used for the treatment of a condition unrelated to the terminal illness may be eligible for coverage under Part B.

**Coding**

Coding for hospice per diem services are reported using level of care revenue codes 0651, 0652, 0655, and 0656, and the ICD-10-CM coding nomenclature. Coding guidelines for selection of the principal diagnosis for admission of a patient into hospice is that which most contributed to the terminal diagnosis of the patient. Any additional diagnoses that affect patient care are also required to be reported.

Hospices may use revenue code 0657 to report charges for services provided to patients by attending physicians, or nurse practitioners acting as attending physicians, who are employees or who receive compensation from the hospice. Appropriate CPT codes are required in order to determine the appropriate payment for these services. Nurse practitioners must append the –GV modifier to the procedure code for proper identification.

Using the combination of revenue codes and HCPCS codes, hospices are required to report the total number of visits provided to a patient in 15-minute increments. The visits are reported by the type of care provided. Table 1 below outlines the revenue codes and associated HCPCS codes for each type of service.

**Table 1:**

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>REVENUE CODE</th>
<th>PROCEDURE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0151</td>
<td>042x</td>
<td>Physical Therapist</td>
</tr>
<tr>
<td>G0152</td>
<td>043x</td>
<td>Occupational Therapist</td>
</tr>
<tr>
<td>G0153</td>
<td>044x</td>
<td>Speech-Language Pathologist</td>
</tr>
<tr>
<td>G0154</td>
<td>055x</td>
<td>Skilled Nursing (LPN or RN)</td>
</tr>
<tr>
<td>G0155</td>
<td>056x</td>
<td>Clinical Social Worker</td>
</tr>
<tr>
<td>G0155</td>
<td>0569</td>
<td>Clinical Social Worker – phone calls</td>
</tr>
<tr>
<td>G0156</td>
<td>057x</td>
<td>Home Health Aide</td>
</tr>
</tbody>
</table>
Modifiers
The following modifiers are available for reporting on hospice claims:

- PM (post-mortem visit): Reported on visits that occurred on the date of death
- KX (requirements specified in the medical policy have been met): Used when a hospice has filed a late Notice of Election (NOE) under exceptional circumstances.

Providers may also request coding assistance through the Medtronic Reimbursement Support Line at 877-278-7482.

Payment
Once patients elect hospice care they waive their rights to Medicare payment for any additional services related to the treatment of their terminal illness outside of hospice.

Under the Part A hospice benefit, facilities are paid a per diem rate based on the number of days and level of care provided. Levels of care include routine home care (RHC), continuous home care (CHC), respite care, and inpatient care for pain control and symptom management. Attending physician services, and those of a nurse practitioner serving as an attending physician, are paid under Part A in addition to the daily hospice rates as long as the aggregate cap is not exceeded (see below).

Routine Home Care (RHC)
Under RHC patients receive hospice care in their home. These services are paid on a per diem basis regardless of the volume or intensity of the services provided. CMS finalized two RHC rates, to provide separate payment rates for the first 60 days of care, and care beyond 60 days. This payment distinction begins January 1, 2017. Table 2 below outlines the RHC rates for the remainder of 2016 through FY 2017.

Table 2: FY 2017 Hospice Routine Home Care Rates

<table>
<thead>
<tr>
<th>REVENUE CODE</th>
<th>PROCEDURE DESCRIPTION</th>
<th>FY 2017 PMT (JAN 1, 2017–SEPT 30, 2017)</th>
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</thead>
<tbody>
<tr>
<td>651</td>
<td>Routine Home Care (days 1-60)</td>
<td>$190.55</td>
</tr>
<tr>
<td>651</td>
<td>Routine Home Care (days 61+)</td>
<td>$149.82</td>
</tr>
</tbody>
</table>

Continuous Home Care (CHC)
During a crisis period, a patient in hospice may receive continuous care in their home provided by a nurse, hospice aide or homemaker. CHC is provided only as necessary to maintain the terminally ill patient at home. CHC is provided at a minimum of 8 aggregate hours (not necessarily continuous) of primary nursing care within a 24-hour period. If skilled nursing care is provided for less than 8 aggregate hours during a 24-hour period, then the care is covered as a RCH day.

In addition to the two RHC rates, CMS finalized a service intensity add-on (SIA) payment that will help to compensate for the intensity of skilled visits provided in the last 7 days of life. The SIA payment is equal to the continuous home care (CHC) hourly rated multiplied by the hours of nursing or social work provided (up to 4 hours total) that occurred on the last day of service. Refer to Table 3 for the SIA payment rate (CHC hourly rate), which also begins January 1, 2017.

Respite Care and Inpatient Care
Once a patient elects hospice care they waive their rights to Medicare payment for any additional services related to the treatment of their terminal illness outside of hospice. However, short-term inpatient hospital stays may be provided as long as they follow the hospice written care plan. In this case, Medicare then covers two levels of inpatient care; respite care to relieve the patient’s caregivers for up to 5 days, and inpatient care for pain control and symptom management which cannot be
managed in any other setting. Table 3 below outlines the CHC, respite care and inpatient care rates for FY 2017.

Table 3: FY 2017 Hospice CHC, Respite Care and Inpatient Care Rates

<table>
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<tbody>
<tr>
<td>652</td>
<td>Continuous Home Care Full Rate = 24 hours of care</td>
<td>$964.63</td>
<td>$39.41</td>
</tr>
<tr>
<td>655</td>
<td>Inpatient Respite Care</td>
<td>$170.97</td>
<td>$170.97</td>
</tr>
<tr>
<td>656</td>
<td>General Inpatient Care</td>
<td>$734.94</td>
<td>$734.94</td>
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</table>

Capped Payment
Hospice claims are subject to two payment caps during the CMS fiscal year of November 1 to October 31: an inpatient cap and an aggregate cap. To ensure that hospice remains a home based benefit, the inpatient and respite care cap limits the number of days to no more than 20% of a hospice’s total Medicare hospice days for that year. The inpatient cap for FY 2017 is $28,404.99.

The hospice aggregate cap limits the total aggregate payment a hospice can receive in a year. The aggregate cap for FY 2016 is $27,382.63.

Medicare intends to shift the cap accounting year to match the federal fiscal year by the end of FY 2018. Details on how payment caps will be calculated can be found in the FY 2016 Hospice Final Rule.

Quality Reporting
Under the Hospice Quality Reporting Program (HQR), hospices were required to begin collecting quality data in October 2012, submitting it in 2013. For fiscal year 2014, and each subsequent year, failure to submit required quality data will result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year.

The HQR requires hospices to submit data to CMS via the Hospice Item Set (HIS). This data can be used to calculate six National Quality Forum (NQF)-endorsed measures and one modified NQF measure. Descriptions of the seven measures can be found here: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/Current-Measures.html

Therapy-Specific Coding and Reimbursement Information
All equipment and supplies provided by the hospice and related to the care of a terminal patient are covered under the Part A hospice benefit. Covered supplies are those that are part of the written care plan, and are for palliation and management of the patient’s terminal illness or related conditions. Any DME and supplies which are used for the treatment of a condition unrelated to the terminal illness may be eligible for coverage under Part B.
REFERENCES:
1 Social Security Act, Title 18, Section 1861 (dd) www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html Last accessed August, 2015.
2 Medicare Benefit Policy Manual, Chapter 9: Coverage of Hospice Services Under Hospital Insurance
4 FY 2017 Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements; Final Rule, Federal Register (81 Fed Reg, No. 152) August 5, 2016, 42 CFR Part 418.
6 FY 2017 Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements; Final Rule, Federal Register (81 Fed Reg, No. 152) August 5, 2016, 42 CFR Part 418.

DISCLAIMER:
The information contained in this guide is for educational purposes only and is not intended to serve as reimbursement advice. The information herein is taken from the materials published by the Centers for Medicare and Medicaid Services and the American Medical Association and may be helpful to providers in staying up to date on coding and billing of services. This information is subject to change, cannot guarantee coverage or reimbursement. Medtronic makes no other representations as to selecting codes for procedures or compliance with any other billing protocols or prerequisites. As with all claims, providers are responsible for exercising their independent clinical judgment in selecting the codes that most accurately reflect the patient’s condition and procedures performed for a patient and to consult with each patient’s health plan for appropriate reporting of each procedure. Providers should refer to current, complete, and authoritative publications such as AMA HCPCS Level II, CPT, ICD-10, Revenue Code publications, or insurer policies for selecting codes based on the care rendered to an individual patient, and may wish to contact individual carriers, fiscal intermediaries, or other third-party payers as needed.

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