Tackling the Beasts

Hospice & Part D
CR 8358 – Additional Claim Elements

Subscriber Webinar
March 2014

HOSPICE FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

Plan for the Day

Beast #1: CR 8358 **Additional Data Reporting Requirements for Hospice Claims**

- Brief review
- Short discussion re medication pricing

Beast #2: **Part D Payment for Drugs for Beneficiaries Enrolled in Hospice—Final 2014 Guidance**

- A look at the high points
- Start of the discussion about what will need to be in place to comply

Beast #1: CR 8358

- Originally issued July 2013; reissued January 31, 2014
- Need attributed to obtaining information to support hospice payment reform
- Multiple new reporting requirements
  - Visit reporting for hospice staff for GIP in SNFs or hospitals
  - Inclusion of NPI where service was performed if not performed at the same location as hospice's billing location (all levels of care)
  - Inclusion of visit time for post mortem visits on date of death
  - Reporting of infusion pumps & prescription drugs
- Voluntary reporting began January 1, 2014
- Mandatory reporting begins April 1, 2014 for claims with dates of service on or after April 1, 2014
- Claims will RTP if the NPI is missing - will process otherwise

The Most Beastly Part: Medication Reporting

The Major Problems

- Obtaining necessary information in a timely fashion
- Inserting pricing information when medications are
  - Provided on a per diem basis or
  - Part of a per diem payment to other providers
- When asked, CMS refers providers to existing language in the Medicare Claims Processing manual and the Provider Reimbursement manuals – all of which makes absolutely no sense in the hospice world

Beast #2: Medicare Part D & Hospice

Pre-2006	Medicaid programs were paying for medications that were the responsibility of hospices
2006	Medicare Part D commenced – problem continued but now with Medicare paying
2006 forward	OIG includes the issue in almost every annual work plan
2009	OIG starts visiting hospices to start to learn more about provision of medications
2012	OIG issues report **Medicare Could Be Paying Twice for Prescription Drugs for Beneficiaries in Hospice**
2013	Part D plans instructed to recoup money from hospices for 2011 & 2012 prescriptions analgesics paid for by Part D
	Encouraged Part D sponsors to put PA process in place for 4 classes of medications

The Final Guidance

First memo issued December 2013

- Combination of policy review, policy clarification and establishment of procedure
- Comments solicited; was to have a March 1st implementation date
- "From" included individuals with these titles
  - Director, Medicare Drug Benefit and C & D Data Group
  - Director, Chronic Care Policy Group
  - Director, Medicare Program Integrity Group

Final memo March 10, 2014

- Now with May 1 implementation date
- Only first two positions on the "from" list
- Written to Part D sponsors – includes some languaging new to hospices
- Applies to 2014 only – expect rulemaking on a number of areas
- At first glance, provides hope of the possibility of a manageable process

Key Areas: The Hospice & Part D Final Guidance

1. Determination of Payment Responsibility
2. Communication of Determination of Coverage & Hospice Arrival and Departure
3. Flow of Data
4. Implications for Beneficiaries

Payment Responsibility

Assuming that the beneficiary is enrolled in Part D, once a hospice election is made, payment responsibly for any prescription medication will belong to one of three parties

Who Pays?		
Hospice	Part D	Beneficiary

The Assumptive Answer

Drugs Covered under Part D for a Beneficiary Who Has Elected Hospice

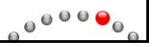
For prescription drugs to be covered under Part D when the enrollee has elected hospice, the drug must be for treatment of a condition that is completely unrelated to the terminal illness or related conditions; in other words, the drug is unrelated to the terminal prognosis of the individual. We expect drugs covered under Part D for hospice beneficiaries will be unusual and exceptional circumstances…

CMS Final 2014 Guidance

Page 2

Federal Register July 27, 2012

"*…We are clarifying that all of a patient's coexisting or additional diagnoses should be reported on the hospice claim*. We note that doing so will bring hospices into compliance with existing, longstanding policy, and will provide data needed for hospice payment reform. *Hospices should not report diagnoses which are unrelated to the terminal illness on their claims.* Hospice claims currently include a field for the patient's principal diagnosis, but allow for up to 17 additional diagnoses to be included on a paper UB–04 claim, or up to 24 additional diagnoses on the 837I 5010 electronic claim." 77 FR 44247



Federal Register August 7, 2013

"We are clarifying that this principal diagnosis, along with the other related diagnoses, would be included on the hospice claim"

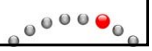
FY 2014 Wage Index Final Rule
78 FR 48247 August 2013

"…rather, [coding clarifications] are to ensure that all principal and diagnoses related to the terminal prognosis are captured on the Medicare hospice claims to more accurately describe hospice beneficiaries receiving the services, drugs, supplies, and DME hospices are required to cover under the regulations at § 418.200, § 418.202, and § 418.204.

FY 2014 Wage Index Final Rule
78 FR 48247 August 2013

The Question

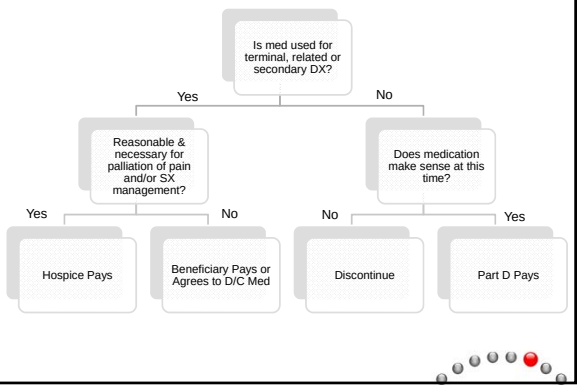
Are CMS expectations of coverage expanding from coverage built around the "condition established after study to be chiefly responsible for the patient's admission" to anything related to the patient's prognosis?



Until there is greater clarity, which path will your hospice follow?

Determination Sequence

Step 1	Determine terminal diagnosis
Step 2	Categorize additional diagnoses and conditions into related, secondary and unrelated
Step 3	Make coverage determinations



What CMS Has to Say

"We expect drugs covered under Part D for hospice beneficiaries will be unusual and exceptional circumstances. **Therefore, the sponsor should place beneficiary-level prior authorization (PA) requirements on all drugs for beneficiaries who have elected hospice to determine whether the drugs are coverable under Part D."**

(Page 3, CMS bolding)

Communication of the Determination of Coverage

Guidance identifies three times that a communication could take place – likely that a hospice could expect a combination of the three

1. At the beginning of care
2. While care is underway
3. After the fact

Prior Authorization Form

- Every sponsor's is a little bit different – if only visually
- At this time, CMS does not have the authority to mandate that the same form be used by all sponsors / plans
- Look for rule making on this in the future
- Final guidance includes a list of suggested elements and asks for comment
  - First portion of list contains standard elements
  - Hospice specific questions at the end
  - See your handouts

Beginning of Care

- Hospices would initiate the PA process at time of election (or very soon thereafter) and hopefully prior to submission of a claim to Part D in order to avoid or work around
  - Avoid holding up prescriptions
  - Data lags in CMS systems
  - Need for retrospective recoveries
- Would also be able to communicate discharges and revocations via this method to immediately re-open Part D to beneficiaries

Beginning of Care

" When hospice providers provide this documentation, sponsors should accept it and use it to satisfy the PA requirements. This is comparable to the process for best available evidence for low-income cost-sharing, and sponsors may use this information until the official notice is received from CMS. Providing this information at the time of the hospice election will facilitate the most timely access to drugs unrelated to a beneficiary's terminal illness or related conditions." (Page 3)

During Care

- Any prescription that comes in will immediately reject with a message the "product may be covered under hospice"
- Nothing can happen until one of following three parties contacts the sponsor to "initiate the PA fulfillment process"
  - Beneficiary
  - Beneficiary's appointed representative
  - Prescriber
- The guidance lays out some different scenarios that might happen at this point

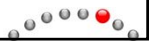
During Care

- Discusses role of "prescribers unaffiliated with the hospice provider"
- Notes that the individual may be unwilling or unable to coordinate with the hospice to provide the PA explanation – at which point hospice would be brought in
- Then, somewhat out of the blue, guidance says

  To ensure care coordination, we believe prescribers who are unaffiliated with the hospice provider, in addition to providing the explanation regarding why the drug is unrelated to the terminal illness or related conditions, should also attest that they have coordinated with the hospice provider and the hospice provider confirmed the unrelatedness of the drug.

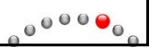
Retrospective Determination

- In situations where the Part D sponsor pays for drug claims prior to knowing about the hospice election, sponsor must perform subsequent review and contact hospice
- Hospice would be expected to
  - Provide documentation to support why medication was
    - Unrelated to terminal illness or related conditions
    - A beneficiary liability
  - Pay for medication if it was its responsibility
- CMS expects all parties to play nicely



Independent Review Function

- December memo discussed the establishment of an independent review process – would require rulemaking
- Commenters suggested that stakeholders work with CMS to
  - Establish standards and criteria for reviewer to use in making coverage determinations
  - Reviewer qualifications
  - Timeframes for each phase of the process
- CMS concurs and "will consider the process for future rulemaking"



In Lieu of Independent Reviewer

CMS expects the following in 2014

- The hospice provider and Part D sponsor to coordinate their benefits;
- The hospice provider or the prescriber to promptly provide verbal communication or written documentation from the hospice provider or prescriber in order to satisfy the beneficiary-level hospice PA. That is, information explaining why the drug is unrelated to the terminal illness or related conditions, or is related to the terminal illness or related conditions and, therefore, is a responsibility of the hospice provider or beneficiary;
- The Part D sponsor to accept and maintain the documentation that the drug is unrelated to the terminal illness or related conditions and is, therefore, reimbursable under Part D and process the claim; and
- The sponsor and hospice to negotiate the retrospective recovery of the amounts paid, if the sponsor has paid for drugs after the effective date of the hospice election, but prior to receipt of notification from CMS. (Page 9)

Flow of Data

- Great deal of discussion regarding the flow of data
- Of much more interest to the Part D sponsors
- The messages to hospices
  - Get your elections and discharges revocations in immediately
  - Make sure that your information is correct in the PECOS system

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html

Implications for Beneficiaries

- One positive for hospices is the clarity that this discussion has brought regarding situations in which the beneficiary may have financial liability
- Examples
  - Beneficiary wants to continue or start a medication that a hospice determines is not reasonable or necessary for the palliation and management of the terminal illness and related conditions
  - Beneficiary wants a non-formulary drug and refused to try a formulary equivalent first
- With this clarity as well as the increase in discussions on Part D will come some challenges for hospices

Communication with Patients & Families

1. We need to increase the frequency of conversations about discontinuing medications that no longer make sense – related and unrelated
2. We need to do so without using jargon, particularly in conversations that involve telling a patient or family that something will not be covered
3. We must recognize that those conversations are about much more than medications

Where Are We Now?

- Some plans are rejecting claims right now, others are not
- All sponsors must have the process underway by May 1 but CMS has given the blessing to any that want to start sooner – as in now
- The guidance seems to back away from the automatic denials of the 4 classes of medications – but that needs to be confirmed
- Expect a steady flow of information for the next few months

Some Larger Considerations

Don't expect this year to let us off the hook - data mining will become a more rewarding endeavor as the picture is becoming much more complete

1. ICD – CM Coding
2. Medications – Provided by Hospice
3. Medications – Provided under Part D

Assume that at some time in the future someone from the outside will be looking at every piece of documentation created to support Part D covering a medication. Document well.

Areas to Evaluate

1. Initial process of establishing terminal DX, sorting out the others and sorting out the medications
2. External and internal communication of above
3. Documentation of above – needs to be consistent and easily retrievable
4. Current competencies in having conversations with patients and families
5. Knowledge level of patient's encounters with other non-attendings
6. Day-to-day communications with part D sponsors: who, how, when, record keeping, etc.

Going Forward

These variables will come into play

- Pharmacy arrangements
- Attending model
- NH Census
- Short stay patients
- What else?

Some Closing Thoughts

1. Assume that at some time in the future someone from the outside will be looking at every piece of documentation created to support your position that Part D should cover a med. Document well.
2. Surprises at the pharmacy make everyone unhappy. Do all that you can to minimize them.
3. Don't get too comfortable with this free-pass system – consider it a short term situation

To Contact Us

Info@HospiceFundamentals.com

Susan Balfour
919-491-0699
Susan@HospiceFundamentals.com

Roseanne Berry
480-650-5604
Roseanne@HospiceFundamentals.com

Charlene Ross
602-740-0783
Charlene@HospiceFundmentals.com

HOSPICE ASSOCIATION OF AMERICA
AN AFFILIATE OF THE NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE

Q&A
Additional Data Reporting Requirements for Hospice Claims

Voluntary Reporting	
***Will the edits for CR 8358 be turned on during the voluntary reporting period?	No, edits will not be turned on until April 1, 2014. CR 8358 provides instructions to MACs to return to provider (RTP) any hospice claims with dates of service on or after April 1, 2014 that do not have an NPI if the claim is reporting a place of service HCPCS of Q5003, Q5004, Q5005, Q5007, Q5008. Providers will receive the same "front end edits" CMS already has in place when the provider attempts to submit a claim that does not have all the required items complete on the claim. For instance, a revenue code of 0250 must have a charge associated with it. The claim will not process unless the charge field is filled in.
Will the additional data required on claims be reflected on the Medicare Summary Notice (MSN) received by the beneficiary?	Yes, it will be processed as covered services with no additional reimbursement in the same way that hospice visits have been appearing on the MSN.
What will happen if we hit the 450 line claim limit?	CMS cannot accept more than 450 lines per claim. If a hospice has charges that exceed this line limit, those charges should be billed on a new claim. With the sequential billing rules, the hospice needs to wait until the following month to submit the claim.
What if my electronic software vendor is not able to include the necessary information on the claim?	The hospice is responsible for ensuring all required data is on the claim.
NPI Reporting	

Is the NPI to be reported for all levels of care or just the GIP level of care?	Hospices shall report the NPI of any nursing facility, hospital, or hospice inpatient facility where the patient is receiving hospice services, regardless of the level of care provided when the site of service is not the billing hospice.
*Do we report the NPI of a hospice inpatient unit that we contract with for GIP care?	Yes, hospices report the NPI of a hospice inpatient facility if the facility is not the billing hospice's facility. The HCPCS Q5006 indicates "hospice care provided in inpatient hospice facility", which could be the billing hospice's facility. Therefore, claims will not be returned if the NPI is not reported with the HCPCS Q5006.
Do we report the NPI of contracted hospitals when those hospitals are part of our healthcare system?	Yes, hospices report the NPI of hospitals when the billing hospital does not have the same NPI as the billing hospice.
Hospice Staff Provided GIP Visit Reporting/Post Mortem Visit Reporting	
The discipline "therapist" is included in the CR as one of the disciplines whose time is to be accounted for in any post mortem visit. Does this include any type of therapist conducting visits?	Visits are to be recorded on the claim for the following disciplines: Nurses Aides Social workers Physical therapists Occupational therapists Speech-language pathologists
Are visits to be reported for all levels of care or only GIP levels of care?	Hospices have been reporting discipline visits by all levels of care since 2008. The requirement in CR 8358 is for the visits at the GIP level of care to be broken down into 15 minute increments instead of the total number of visits for the week.
*Are the visits to be reported only for hospice staff or does it include facility staff visits as well?	Only visits by hospice-employed (including contracted or volunteer) staff are to be reported.
Regarding rounding of minutes for use of the PM modifier, how would the visit be reported for the following scenario? RN arrives at patient's home at 9:25 AM and leaves at 10:45 AM. Patient died at 10:06 AM. The total number of minutes for the visit is 80. Eighty minutes is 5 units if reported as a single visit. If the visit is split to reflect the post mortem visit the total units is 6 based on the Time Reporting	Anytime a patient dies during a visit, the visit is to be split between the time prior to death and the time post mortem. In this example, the total number of units would be 6.

rounding rules. Which is correct – 5 units or 6 units?	
If the patient dies shortly before midnight but is not pronounced until the following day, what is the date of death and how does this impact visit reporting?	The Medicare billing day begins and ends at midnight. A patient's date of death is the date listed on the death certificate which is the date the death is pronounced. Consider the following example: Nurse arrives at 10 PM for a patient visit on April 1, patient passes at 11:45 PM and nurse leaves at 2 AM the following morning. The patient is pronounced on April 2. Any visit time between midnight and 2 AM is considered post mortem visit time. Consider the same scenario but the patient is pronounced on April 1. In this case, none of the time between midnight and 2 AM on April 2 is put on the claim. CMS systems cannot accept dates of service beyond the patient's date of death.
Sometimes we are not notified of the patient's death until after the patient dies so any visit time we have is post mortem. Are we able to include this visit time on the claim?	Hospices should include the visit time on the claim as post mortem visit time (with the PM modifier). The hospice staff does not need to be present at the patient's time of death in order for post-mortem visit time to be allowed on the claim.
*Does the patient's body need to be present in order for the visit to be considered a post mortem visit?	No, the patient's body does not need to be present for a PM visit. As stated elsewhere no visits beyond the patient's date of death should be on the hospice claim.
Drug and Infusion Pump Reporting	
What should we put on the claim as the charge for the drug?	CMS' policy is for providers to bill Medicare the same that they charge other payers. There are four manual references listed below that support this position. *Medicare Claims Processing Manual (CMS Pub. 100-04) Ch. 25, §75.5* states "The CMS policy is for providers to bill Medicare on the same basis that they bill other payers. This policy provides consistency of bill data with the cost report so that bill data may be used to substantiate the cost report. Medicare and non-Medicare charges for the same department must be reported consistently on the cost report." *Provider Reimbursement Manual, Part 1, Ch. 22* ***Section 2202*** defines "charges" as "the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and

	discounts deductions." ***Section 2203*** states "To assure that Medicare's share of the provider's costs equitably reflects the costs of services received by Medicare beneficiaries, the intermediary, in determining reasonable cost reimbursement, evaluates the charging practice of the provider to ascertain whether it results in an equitable basis for apportioning costs. So that its charges may be allowable for use in apportioning costs under the program, each facility should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing the services. While the Medicare program cannot dictate to a provider what its charges or charge structure may be, the program may determine whether or not the charges are allowable for use in apportioning costs under the program." ***Section 2204*** states "The Medicare charge for a specific service must be the same as the charge made to non-Medicare patients (including Medicaid, CHAMPUS, private, etc.), must be recorded in the respective income accounts of the facility, and must be related to the cost of the service."
What do we do if we aren't able to get a timely invoice from the pharmacy showing all the prescription drugs used for the month?	The hospice is responsible for including the necessary information on the claim so the hospice will either have to wait to submit its claim to Medicare until after the pharmacy invoice is received or develop an alternative data collection method for prescription drugs used per patient.
We have a per diem contract with our pharmacy and aren't billed by drugs utilized per patient? How should we enter the drug information on the claim?	The hospice is responsible for including the required drug information per patient on the claim so the hospice will need to find an alternative data collection method for the required information.
How are we to bill for compounded drugs?	Hospices should use revenue code 0250 for compounded (non-injectable) drugs with the same prescription number for each ingredient of the compound drug. In addition, the hospice is to provide the NDC for each ingredient in the compound.
Do we include each drug in a Comfort Kit on the claim or is the Comfort Kit considered one "drug"?	The NDC of each prescription drug in the Comfort Kit is to be reported.
Our pharmacy doesn't include the NDC number on the drug label or on the invoice. How do we get this number?	Hospices can find NDC numbers at http://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm
Do we report all drugs or only those related to the patient's terminal illness?	Report only those drugs related to the patient's principal diagnosis and all related diagnoses.

We use a Pyxis system on our inpatient unit. Is the "fill" counted each time we administer a drug from the Pyxis (i.e. only a portion of what is prescribed – one pill at a time)?	When a facility uses a medication management system where each administration of a hospice medications is considered a fill for hospice patients receiving care, the hospice shall report a monthly total for each drug (i.e., report a total for the period covered by the claim), along with the total dispensed.
Do we report all drugs for the patient even if the patient is receiving GIP in a contracted facility?	All prescription injectable and non-injectable drugs related to the palliation and management of the terminal illness and related conditions is to be included on the claim regardless of the site of service and level of care. See question above regarding facilities using a medication management system.
Do we have to report drugs obtained from our own pharmacy or only those through contracted pharmacies?	The ownership/arrangement with the pharmacy supplier does not matter - all prescription injectable and non-injectable drugs related to the palliation and management of the terminal illness and related conditions is to be included on the claim.
How do we bill for infusion pumps?	Report infusion pumps on a line-item basis for each pump and for each medication fill and refill. Use revenue code 029X for the equipment and 0294 for the drugs along with the appropriate HCPCS.
Where do we find the appropriate HCPCS code?	Hospices can find HCPCS codes at: http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html?redirect=/medhcpcsgeninfo
We have a contract for infusion pumps that includes a weekly pump rental fee. How do we reflect this on the claim?	Hospices are to reflect the total charge for the infusion pump for the period covered by the claim, whether the hospice is billed for it daily, weekly, biweekly, with each medication refill, or in some other fashion. The hospice shall include on the claim the infusion pump charges on whatever basis is easiest for its billing systems, so long as in total, the claim reflects the charges for the pump for the time period of that claim.
We own all of our infusion pumps so don't receive an invoice for these. Do we enter "$0.00" in the charge column of the claim?	Hospices are to enter a charge on the claim for the infusion pump and the charge is to be based on the hospice's cost for the pump. A hospice has overhead and administrative costs associated with all pump use whether the pump is owned or rented. Please see the question above, "What should we put on the claim as the charge for the drug?", for information about charges.

02/03/2014
Updated 03/03/2014

***Either this question or answer was revised for clarity.**

Part D Payment for Drugs for Beneficiaries Enrolled in Hospice—Final 2014 Guidance
March 10, 2014

Attachment 2- Medicare Part D Hospice Prior Authorization Information

Part D Sponsor/PBM Information for faxing/mailing
Name / Address / Fax # /Phone #

Today's Date

PATIENT and INSURANCE INFORMATION
Patient Name / DOB / Patient Phone# / Insurance ID Number

PRESCRIBER INFORMATION
Prescribing Physician's Name / Physician NPI# / Clinic Name / Clinic Address /City, State, Zip
Clinic Contact Person's Name / Clinic Phone # / Clinic Secure Fax #

PRESCRIPTION INFORMATION
Medication Requested / Strength / Dosing Schedule / Quantity per Month

---

PRIOR AUTHORIZATION INFORMATION

1. Is the patient currently enrolled in Hospice?

   If No, date of disenrollment
   Hospice name and contact information / Name / Phone # / Secure Fax #

2. Is the medication related to the terminal illness or related conditions and covered under the hospice benefit?

3. If no, is the medication not covered by Hospice because:

   a. It is being used for a condition unrelated to the terminal illness or related conditions?
   If so, please provide an explanation of why the condition being treated is unrelated to the terminal illness or related conditions and therefore is not covered under hospice benefit and may be covered under Medicare Part D.

   b. It is being used for a condition related to the terminal illness or related conditions, but the medication is not included on the hospice formulary, is not medically necessary or is waived through the hospice election? Medicare Part D will not cover this medication.

4. If the prescriber of the medication is unaffiliated with the hospice provider, has the hospice provider confirmed that the medication is unrelated to the terminal illness or related conditions?