SECTION: **PATIENT ACCOUNTS**

SUBSECTION: **BILLING PROCEDURES**

SUBJECT: **MEDICARE HOSPICE ELECTION**

APPROVED BY: _____
Patient Accounts Manager

POLICY:

The purpose of this policy is to ensure compliance with Centers for Medicare and Medicaid Services (CMS) regulations and the requirements for Medicare Hospice Election accounts.

I. **HOSPICE ELECTION DEFINITION & COVERAGE:**

A. Medicare Hospice Election exists when a Medicare beneficiary who is enrolled in a Health Maintenance Organization (HMO) Managed Care plan has elected their hospice benefit during an inpatient or outpatient hospital stay.

II. **GUIDELINES:**

A. Once a managed care enrollee has elected hospice, all his or her Medicare benefits revert to fee-for-service, though the enrollee remains on managed care for any additional benefits provided by his or her managed care plan, such as dental or vision coverage.

B. The Medicare hospice benefit, through fee-for-service Medicare, covers all hospice care from the effective date of election to the date of discharge or revocation. During the election, fee-for-service Medicare also covers attending physician services and all care unrelated to the terminal illness.

C. Upon discharge or revocation, fee-for-service Medicare continues to cover the beneficiary through the end of the month when the beneficiary revokes or is discharged from hospice alive. At the start of the month following revocation or discharge, all billing and coverage revert to the managed care plan.

1. Example #1: Patient elects hospice on 7/15/20 and has an Inpatient Stay from 7/18/20-8/7/20. Hospice is then revoked on 8/7/20. Medicare FFS would cover any visits between 7/15/20 and 8/31/20. Medicare HMO would then be responsible for any visits in September and on.

2. Example #2: Patient has an Inpatient stay from 7/18/20-8/7/20 but elects hospice only from 8/26/20-8/28/20. MCR HMO would be responsible for IP stay but Medicare FFS would be responsible for any visits between 8/26/20 and 8/31/20. Medicare HMO would then be responsible for any visits in September and on.

REFERENCES: Pub 100-04, Medicare Claims Processing Manual, Chapter 9, And Coverage of Hospice Services under Hospital Insurance: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
11/23/2022	**Patient Safety and Quality Committee** Applicable Administrator, Hospital or Medical Committee
12/8/2022	**Quality Management Committee** Applicable Administrator, Hospital or Medical Committee
1/26/2023	**Medical Executive Committee** Applicable Administrator, Hospital or Medical Committee
	Board of Supervisors Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **7/1/2020**

REVISED: **N/A**

REVIEWED: **11/23/2022**

SECTION: **PATIENT ACCOUNTS**

SUBSECTION: **BILLING PROCEDURES**

SUBJECT: **MEDICARE DIALYSIS END-STAGE RENAL DISEASE (ESRD) PROSPECTIVE PAYMENT SYSTEM (PPS) CONSOLIDATED BILLING**

APPROVED BY: _____
Patient Accounts Manager

POLICY

The purpose of this policy is to ensure compliance with Centers for Medicare and Medicaid Services (CMS) regulations and the requirements for Medicare Dialysis End-Stage Renal Disease (ESRD) billing.

I. MEDICARE ESRD PPS CONSOLIDATED BILLING GUIDELINES:

A. The ESRD Prospective Payment System (PPS) implemented consolidated billing requirements for limited Part B items and services included in the ESRD facility's bundled payment. Certain laboratory services, drugs and biologicals, equipment, and supplies are subject to consolidated billing and are no longer separately payable when provided to ESRD beneficiaries by providers other than the ESRD facility. Under consolidated billing, ESRD facilities are expected to furnish services, either directly, or under an arrangement with an outside supplier.

B. Patient must be eligible for Medicare Part B (Outpatient) Services to bill.

C. Only one month of service can be billed per claim, you cannot bill charges from two different months on one claim.
   1. If charges from a previous or future month are added to the account, charges must be transferred to the correct account for the month they're from and the claim from/thru dates would need to be corrected.

II. PROCESS:

A. Dialysis Consolidated Per Month Claims:
   1. Type of claim: 721
   2. The claim must be submitted as follows:
      a. Statement Covered Period from Date (UB-04 FL 6) equal to the earliest service date on line item Detail Charges.
      b. Statement Covered Period through Date (UB-04 FL 6) equal to the latest service date on line item Detail Charges.
      c. Dialysis Value Codes (UB-04 FL 39-41) should equal values from patient data.
         1) **VC 48**: Hemoglobin Reading
         2) **VC 49**: Hematocrit Reading
         3) **VC A8**: Patient Weight (kg)
         4) **VC A9**: Patient Height (cm)
         5) **VC D5**: Last KT/V Reading
         6) **VC 68**: Epoetin-Drug Units (use total ML for both 634 and 635 revenue codes)

d. Units (Epoetin Revenue Codes 0634 through 0635) (UB-04 FL 46) equal to **1 unit** per line.
e. Modifiers (Labs)
   1) Add AY modifiers to appropriate labs
f. Modifiers (Dialysis Treatment Revenue Code 0821) (UB-04 FL 44) to be added at the end of HCPCS code.
   1) Add appropriate Vascular Access for ESRD Hemodialysis Patients:
      a) **Modifier V5**: Any Vascular Catheter (alone or with any other vascular access)
      b) **Modifier V6:** Arteriovenos Graft (or other vascular access not including a vascular catheter)
      c) **Modifier V7**: Arteriovenous Fistula (AVF) Only (in use with two needles).
   2) Add appropriate G-modifier for patients that received seven or more dialysis treatments in a month:
      a) **Modifier G1**: Most recent URR of less than 60%
      b) **Modifier G2**: Most recent URR of 60% to 64.9%
      c) **Modifier G3**: Most recent URR of 65% to 69.9%
      d) **Modifier G4**: Most recent URR of 70% to 74.9%
      e) **Modifier G5**: Most recent URR of 75% or greater
      f) **Modifier G6**: For patients that have received dialysis 6 days or less in a month.

3. Include ALL diagnosis codes (UB-04 FL 66) from Statement Covered Period from Date to Statement Covered Period through Date.

REFERENCES: ESRD PPS Consolidated Billing | CMS

DEFINITIONS: **N/A**

ATTACHMENTS: **N/A**

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
11/23/2022	**Patient Safety and Quality Committee** Applicable Administrator, Hospital or Medical Committee
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	Board of Supervisors Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **7/1/2020**

REVISED: **N/A**

REVIEWED: **11/22/22**