
PROGRAM MEMORANDUM INTERMEDIARIES

Department of Health
and Human Services

Health Care Financing
Administration

Transmittal No. A-98-27

Date: SEPTEMBER 1998

Change Request #N/A

This Program Memorandum re-releases Program Memorandum A-97-11, dated September 1997. Changes are redlined.

SUBJECT: Hospice Provisions Enacted by the Balanced Budget Act (BBA) of 1997

The purpose of this Program Memorandum is to clarify recent legislation enacted by the BBA of 1997 as it applies to Medicare hospice services and provide guidance on billing instructions for these services.

Many of these provisions were effective upon enactment of the legislation; that is, August 5, 1997. These changes are a result of a Congressional mandate, and should be made immediately. Providers should be billing for those services based on the changes described below.

A. Payment For Home Hospice Care Based On Location Where Care Is Furnished.--The BBA of 1997 requires that hospices submit claims for payment for hospice care furnished in an individual's home (i.e., revenue codes 651 and 652) based on the geographic location at which the service is furnished (as opposed to the location of the hospice). HCFA is in the process of developing a pricing system that will be used by the fiscal intermediaries which will determine the rate for these services. Providers will be required to indicate the metropolitan statistical area (MSA)/rural state code number with value code 61 on the bill.

1. Fiscal Intermediary Instructions.--For dates of service beginning on or after October 1, 1997, reject hospice claims bill types 81X and 82X with revenue codes 651 (routine home care) and 652 (continuous home care) that do not contain value code 61 (where the service is delivered) and a MSA (Metropolitan Statistical Area) code/rural state code. A table identifying the appropriate MSA for each location is attached. Only revenue codes 651 and 652 require the value code and MSA for site of service.

Edit the claim for the presence and the validity of the MSA code. The MSA code for hospice claims is a 4 or 5 digit field. The common working file will also reject home care claims that do not contain value code 61 and a MSA beginning October 1 for revenue codes 651 and 652.

2. Coding Requirements.--

o Show value code 61 for home care revenue codes (651 and 652) and enter the MSA (a 4 or 5 digit numerical).

o On the UB92 rev. 4.1, show the value code and MSA in Record Type 41 fields 16 - 39. There can be up to 12 occurrences.

Since the value amount is a nine-position field, enter the 4-5 MSA code in the nine-position field in the following manner: Enter an MSA for Puerto Rico as 000994000 and the MSA for Abilene TX (0040) as 000004000. Note that the two characters to the right of the assumed decimal point (9999999V99) are always zeros.

- o To create parallel construction for the electronic X12 institutional claim transaction (837 Medicare version 3032 and 3051) and the electronic UB-92, use the HI segment to contain MSA data. For example, enter an MSA of 9940 as 000994000 on the electronic UB-92; this would be translated as HI*BE:61:::9940~. For the MSA of 0040, enter 000004000 on the electronic UB-92 and translate this as HI*BE:61:::40~. Note that this construction permits our current maps to work without change.

- o On the HCFA 1450, in field location 39 - 41, show value code 61 in the code area and the 4-5 position MSA in the amount area where a dollar amount could be entered. Do not extend the MSA into the cents area.

Send the above information to all hospices in your provider file, to hospice professional groups, and software support organizations.

B. Hospice Care Benefit Periods.--The BBA of 1997 restructured the hospice benefit periods available to Medicare beneficiaries as provided for under ' 1812 of the Social Security Act (the Act). Effective upon the date of enactment, August 5, 1997, the hospice benefit has two initial 90-day periods followed by an unlimited number of subsequent 60-day periods. Each period requires a physician to certify at the beginning of the period that the individual has a terminal illness with a prognosis that the individual's life expectancy is 6 months or less. 42 CFR 418.22(b) clarifies that a physician's certification specifies that the prognosis is for a life expectancy of 6 months or less, but qualifies it with the words "if the terminal illness runs its normal course," recognizing that such a prognosis is not entirely predictable. This provision of the regulation remains unchanged.

The change in the law affects certain beneficiaries in the former third period of 30 days and the fourth period of unlimited duration. On the date of enactment, these periods essentially disappeared. Consequently, beneficiaries in their third period will be automatically considered in their first subsequent period of 60 days. The period will be considered to have begun on the date of enactment. Recertification will be required at the beginning of the next 60-day period and for every 60-day period thereafter as may be indicated. Beneficiaries in their fourth period will be considered as having begun their first 60-day period as of the date of enactment (August 5, 1997) and the first recertification will be required at the beginning of the next 60-day period, and for every 60-day period thereafter as may be indicated.

Section 4449 of the BBA of 1997 indicated that the benefit period changes applied to the hospice benefit regardless of whether or not an individual had made an election of the benefit prior to the date of enactment. Therefore, a beneficiary who elected hospice prior to the BBA of 1997 and who may be discharged from hospice care at some future time because he or she is no longer terminally ill could avail themselves of the benefit at some later date if they should become terminally ill again and otherwise meet the requirements of the Medicare hospice benefit. If the beneficiary had been discharged during the initial 90-day period, he or she would enter the benefit in the second 90-day period. If the discharge took place during the final 90-day or any subsequent 60-day period, the beneficiary would enter the benefit in a new 60-day period. A beneficiary who had been discharged from hospice during the fourth benefit period prior to the enactment of the BBA of 1997 would be eligible for the benefit again and would begin it in a 60-day period. The 90-day periods would not be available as the amended ' 1812(d)(1) of the Act still only provides for two 90-day periods during an individual's lifetime. There is no limit on 60-day periods as long as the beneficiary meets the requirements for the hospice benefit.

With respect to the changes in the benefit period structure, HCFA will accept corrected certification statements in cases of billing errors. Other changes in physician certification requirements are discussed in another section below.

C. Other Items And Services.--A new item has been added to the list of covered services in ' 1861(dd)(1) of the Act. The new item AI explains that any other item or service which is specified in the plan and for which payment may otherwise be made under this title is a covered service under the Medicare hospice benefit. This new item is a clarification of past policy that the hospice is responsible for providing any and all services indicated as necessary for the palliation and management of the terminal illness and related conditions in the plan of care.

EXAMPLE: A hospice determines that a patient's condition has worsened and has become medically unstable. An inpatient stay will be necessary for proper palliation and management of the condition. The hospice adds this inpatient stay to the plan of care and decides that, due to the patient's fragile condition, the patient will need to be transported to the hospital by ambulance. In this case, the ambulance service becomes a covered hospice service.

This clarification becomes effective for items or services furnished on or after April 1, 1998.

D. Contracting With Physicians.--The BBA of 1997 also includes a provision that amends the core service requirement to allow hospices to contract for physician services. Effective August 5, 1997, ' 1861(dd)(2) of the Act is amended so that hospices will no longer be required to routinely provide all physician services directly.

Medical directors and physician members of the interdisciplinary group (IDG) are no longer required to be employed by the hospice. These physicians can now be under contract with the hospice. Although Congress did not specify what the terms of that contract must be, requirements at 42 CFR 418.56 and 418.86 are still applicable to hospice, as well as all other responsibilities under the hospice conditions of participation. Hospices retain professional management responsibilities for these services and must ensure that they are furnished in a safe and effective manner by qualified persons.

E. Waiver Of Certain Staffing Requirements.--Section 1861(dd)(5) of the Act has been modified to allow HCFA to permit certain waivers of the requirements that the hospice make physical therapy, occupational therapy, speech language pathology services, and dietary counseling available (as needed) on a 24-hour basis. HCFA is also now allowed to waive the requirement that hospices provide dietary counseling directly. These waivers are available only to an agency or organization that is located in an area which is not an urbanized area (as defined by the Bureau of Census) and that can demonstrate to HCFA that it has been unable, despite diligent efforts, to recruit appropriate personnel. Hospices will be required to submit evidence to establish diligent efforts. HCFA will apply the requirements for the nursing services waiver found at 42 CFR 418.83(a)(3) in determining that a hospice has made diligent efforts.

A waiver request will be deemed to be granted unless it is denied within 60 days after it is received. This change became effective upon enactment of the Balanced Budget Act, or August 5, 1997. Waiver applications should be sent to [your regional office](#).

F. Limitation On Liability Of Beneficiaries For Certain Hospice Coverage Denials--Section 1879 of the Act provides protections from liability for charges for certain denied claims to beneficiaries who, acting in good faith, receive inpatient or outpatient services from Medicare Part A providers, or items or services from Medicare Part B suppliers which accept assignment. Likewise, providers and suppliers may also be protected from liability under ' 1879 of the Act when it is determined that they did not know and could not reasonably have been expected to know that Medicare would deny payment. When the beneficiary is held not liable and the provider also is held to be not liable, payment may be made for a denied claim under ' 1879, as if the service were covered. Section 1879(g) of the Act has been amended by ' 4447 of the BBA of 1997 to extend limitation on liability protection to a beneficiary enrolled in a hospice when there is a denial of claims due to a determination that the individual is not terminally ill. Effective for services furnished on or after August 5, 1997, when a denial of payment for hospice services

is based upon a determination that the beneficiary is not terminally ill, apply the usual procedures of the limitation on liability provision under ' 3430ff of the Medicare Intermediary Manual (MIM), and (as appropriate) the indemnification procedures under ' 3446ff of the MIM, to determine whether or not the beneficiary is protected from liability, and whether or not the hospice is protected from liability, under ' 1879(g)(2) of the Act.

G. Extending The Period For Physician Certification Of An Individual's Terminal Illness.--The BBA of 1997 amended ' 1814(a)(7)(A)(i) of the Act by removing specific written and verbal time frames for physician certifications (that an individual is terminally ill) for the initial 90-day benefit period and requiring only that certification be done ~~at~~ at the beginning of the period. Certification by physicians for hospice care at the beginning of the initial benefit period will remain as they are currently, i.e., ~~at~~ beginning of the period continues to be not later than 2 days after hospice care begins, but written certification need only be on file in the patient's record prior to submission of a claim to the fiscal intermediary. An initial plan of care must be established at the start of care, prepared by the hospice physician or nurse, in consultation with the attending physician (if there is one) or the hospice physician if there is no attending physician and one other member of the IDG.

This requirement would apply to individuals who had been previously discharged during a fourth benefit period and were being certified for hospice care again to begin care in a 60-day benefit period. As had been discussed in a 1995 Bulletin For Hospice Providers, certifications of terminal illness must include specific clinical findings and other documentation supporting a life expectancy of 6 months or less.

For policy questions, contact Jennifer Carter (410) 786-4615, Tom Saltz (410) 786-4480, or Carol Blackford (410) 786-5909.

For questions relating to the conditions of participation, contact Lynn Merritt-Nixon (410) 786-4652 or Mary Vienna (410) 786-6940.

For questions relating to limitation on liability, contact Joan Collins (410) 786-4618 or Denis Garrison (410) 786-5643.

For questions concerning fiscal intermediary instructions and coding, contact Pat Williams (410) 786-6139

This Program Memorandum may be discarded after September 1, 1999.

These instructions should be implemented within our current operating budget.