CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1292	**Date: JULY 13, 2007**
	Change Request 5670

Subject: Payment for Hospice Care Based on Location Where Care is Furnished

I. SUMMARY OF CHANGES: This transmittal revises Medicare systems to wage adjust payments for hospice inpatient levels of care based on the location where the services are delivered.

New / Revised Material
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

Unless otherwise specified, the effective date is the date of service.

Attachment - One-Time Notification

Pub. 100-04	Transmittal: 1292	Date: July 13, 2007	Change Request: 5670

SUBJECT: Payment for Hospice Care Based on Location Where Care is Furnished

Effective Date: **January 1, 2008**

Implementation Date: January 7, 2008

I. GENERAL INFORMATION

A. Background: Currently, all Medicare payments for hospice services are not wage adjusted based on the location where the service is furnished. For Routine Home Care (RHC) and Continuous Home Care (CHC) levels of care (revenue code 651 and 652), Medicare uses the CBSA for the beneficiary's residence as the basis for wage adjustment. There may be circumstances where RHC and CHC are provided in inpatient settings, as these settings may serve as the beneficiary's place of residence. The CBSA for the beneficiary's residence, whether or not it is an inpatient setting, is reported on the claim using value code 61. This code is currently defined by the National Uniform Billing Committee (NUBC) as "Location Where Service is Furnished (HHA and Hospice)."

For inpatient hospice levels of care, Medicare currently uses the CBSA on provider file for the hospice facility as the basis for wage adjustment. This assumes that any inpatient levels of care are provided at an inpatient facility either at the hospice itself or under arrangements with a facility within the same CBSA. As hospice services may be provided in multiple locations, including a hospice facility, these assumptions may not be accurate.

The FY 2008 Hospice Wage Index Notice of Proposed Rulemaking proposes, effective January 1, 2008, using the CBSA of the location where hospice care is provided for all levels of care, including inpatient levels of care. The current definition of value code 61 is broad enough to include this use, as the code itself does not distinguish between home and facility locations. However, hospice providers frequently bill both home and inpatient levels of care on the same claim. If multiple instances of value code 61 were reported, the claim would not distinguish which CBSA code corresponded to which level of care.

It would be possible to resolve this problem without a code change by requiring hospices to bill separately for home vs. inpatient levels of care. While this would meet Medicare's need in terms of making accurate payment, it could create unnecessary administrative burden on hospices. Also, by artificially increasing the number of hospice claims, it would increase administrative costs for the Medicare program.

To avoid these impacts, CMS requested the NUBC approve a new value code to distinguish a facility CBSA from the currently reported residence CBSA. Such a code allows hospices to continue the current practice of billing all hospice services on a single monthly claim while allowing the Medicare program to wage adjust the services on that claim accurately under the new regulation. The NUBC approved this new code, value code G8, effective January 1, 2008. The NUBC has also redefined value 61 to make clear that it applies to residence locations only. Similar to CBSA code reporting for home levels of care, if multiple inpatient locations with differing CBSAs are used in a billing period, the last CBSA shall be reported for payment.

B. Policy: Medicare claims for all levels of hospice care, including inpatient hospice levels of care, shall be wage adjusted using the CBSA for the location where services are furnished. The CBSA for

inpatient levels of care shall be reported in value code G8, for services provided on or after January 1, 2008.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5670.1	Medicare systems shall use the CBSA code reported with value code G8 to wage adjust payments on service lines for inpatient levels of care.						X	X				Hospice Pricer
5670.1.1	Medicare systems shall add a new field to the input record into the hospice Pricer to carry the CBSA code to apply to inpatient levels of care.							X				Hospice Pricer
5670.1.2	Medicare systems shall populate the new field for the inpatient level of care CBSA with the value associated with value code G8.							X				
5670.1.3	Medicare systems shall apply the wage index associated with the CBSA code in the new field to payment calculations for revenue code 655 and 656.											Hospice Pricer

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	None.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5670.1	Value code G8 is defined as follows: Short definition: “Facility where Inpatient Hospice Service is Delivered.” Long definition: “MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the facility where inpatient hospice service is delivered.” Value code 61 has been revised as follows: Short definition: “Place of Residence where Service is Furnished (HHA and Hospice)” Long definition: “MSA or Core Based Statistical Area (CBSA) number (or rural state code) of the place of residence where the home health or hospice service is delivered.”
5670.1.3	The CBSA code on the hospice provider file will no longer be used in payment calculations. Payment calculations for revenue codes 651 and 652 are not changed by this instruction, as these levels of care are currently wage adjusted by the location where services are furnished.

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, 410-786-6148, wilfried.gehne@cms.hhs.gov or Wendy Tucker, 410-786-3004 for claims processing issues; Terri Deutsch, 410-786-9462, terri.deutsch@cms.hhs.gov or Katie Lucas, 410-786-7723 for policy issues

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 operating budgets.