Hospice Billing Overview

Overview

Use this overview as a general guide for hospice billing setup, claim preparation, per diem setup, and routine billing checks in Barnestorm.

Helpful Links

- Enter Hospice Per Diem Charges (Hospice, Per Diems)
- Home Health / Hospice Patient Locations By Date (Hospice Facility, Q codes)
- Hospice - Continuous Care Billing (Billing, Continuous Care, Hospice)
- Hospice Coverage Guidelines

Before Billing

- Verify Medicare or private insurance as usual.
- For Medicare hospice, confirm all prior hospice election periods.
- Hospice benefit periods are 90 days, 90 days, then unlimited 60-day periods.
- Face-to-Face is required before the 3rd benefit period and each later recertification period.
- For private insurance, verify whether the payer reimburses by per diem or by visit.

Important: Payer rules may vary. Always verify Medicare, Medicaid, managed care, or private insurance requirements before billing.

Hospice Revenue Codes and Per Diem Setup

Barnestorm hospice billing commonly uses hospice revenue codes such as:**0651** (Routine Home Care),**0652** (Continuous Home Care),**0655** (Inpatient Respite Care),**0656** (General Inpatient Care),**0658** and **0659** (Room and Board).

Hospice per diem setup is commonly configured using matching employee numbers, job codes, visit status codes, and revenue codes.

Hospice per diem rates are maintained from:**Codes > Rates > Hospice Per Diem Rates**.

See:Hospice Per Diem Billing Guidefor detailed setup instructions.

Admission and Election

- The patient signs the Notice of Election on or before the hospice admission date.
- For Medicare, NOE must be submitted and accepted within 5 days of admission.
  - NOE (81A) can be sent electronically through Barnestorm or keyed into DDE.
- Initial certification must be completed timely and supported by the attending physician and hospice medical director, as required.
- Complete the plan of care and document hospice orders as part of the admission workflow.
- Use the software to complete the first IDG meeting and updates within the required number of days set by payer.

Ongoing Hospice Tracking

- Track per diem days, visits, IDG meetings, facility stays, respite days, and discharge status.
- Document IDG meetings and plan of care updates according to hospice requirements.
- Document facility stays in Barnestorm when the patient is not in a private residence.
- Pre-arrange and document hospitalizations for non-hospice diagnoses when applicable.

Facility Stay and Location Reporting

When a hospice patient is not in a private residence, enter the appropriate facility stay dates and location (for Q-code) in Barnestorm.

Use **Billing > Other > Enter HH Location / Hospice Facility Stay Dates** to document facility stay information.

If the patient resides in a nursing facility long-term, agencies commonly enter an extended thru date to cover the expected stay period.

If the patient is in a hospital, you need to use the CBSA code of the county where the hospital is located on the claim.

Use **Referrals > Payers > Extra Billing Info**. Use the first day of the month or the admit date if the hospital stay is during the admission month. Enter a Value Code G8 with CBSA code of the county where the hospital is located.

Monthly Billing

- Hospice billing is generally completed by calendar month.
- Enter hospice per diem charges using **Billing > Other > Enter Hospice Per Diem Charges**.
- All visits except continuous care are entered as no-charge, including social worker phone calls 8 minutes or more.
- Most hospice routine visits are entered using visit status codes configured with: **Chargeable = No**.
- Although the visit may display as a no-charge visit within Visit Entry, Medicare hospice claims may still report the visit detail and usual/customary charge information on the electronic claim.
- Key medications into **Billing > Other > Enter Hospice Per Diem Charges > Hospice Medications**.
- A single line total for medication charges will show up on the claim but not in Accounts Receivable.

Continuous Home Care (CHC)

Continuous Home Care (CHC) is a higher level of hospice care provided during periods of short-term patient crisis to maintain the patient in the home setting.

- CHC is billed using revenue code **0652**.
- Continuous care hours are based on the total number of care hours provided during a

calendar day (midnight to midnight).

- A minimum of **8 hours** of care is required during the day to qualify as Continuous Home Care.
- More than half of the care hours must be provided by a nurse (RN, LPN, or LVN).
- Hospice aide services may count toward the total care hours.

Note: Continuous Home Care should only be billed during brief periods of crisis care as defined by Medicare hospice regulations.

Audit Before Claim Creation

Use **Billing > Other > Enter Hospice Per Diem Charges > Reports** to confirm that each active hospice patient has the correct number of per diem charges for the billing period.

Audit Tip: Review any message showing that the total number of per diem charges does not equal the number of active days before creating the claim.

Creating the Claim

- Create the hospice claim from **Billing > All Other Billing**.
- Check the applicable hospice billing options, including **Hospice**, **Visits**, and **HMB**.
- For non-Medicare hospice payers, confirm whether visit detail should be reported (HMB).

Claim Amounts and A/R

- The generated claim will include per diem charges and no-charge visit detail. Visit lines will show the agency’s usual and customary rate even when the visit was entered as no charge.
- The total claim amount is the sum of per diem and visit rates, not what is expected to pay.
- The amount that shows up in Barnestorm A/R may not match the claim. A/R will show per diem, continuous care, and medication charges.
    - It does NOT include the no-charge visit amount.

- Medicare claims are generally processed after acceptance (typical 14 days), but payment timing can vary based on edits, sequential billing, prior-month status, and payer processing.

Discharge, Revocation, or Death

- When a patient is discharged, revokes hospice, or dies, complete the required discharge billing steps timely.
- If required, submit the Notice of Termination/Revocation or final claim within the required timeframe.
  - The NOTR can be sent electronically through Barnestorm or keyed into DDE.
  - Sending medications may delay the claim - you may want to send the NOTR as soon as possible.
- If the patient died in a facility, enter the correct hospice facility stay information from **Billing > Other > Enter Hospice Facility Dates** before billing.
- Review discharge status and value code requirements before submitting the claim.

Medicare and Medicaid Room and Board

For patients who are dually eligible for Medicare and Medicaid and reside in a long-term care facility, the agency may be responsible for room and board billing arrangements. Contracts and payer setup should be reviewed before billing.

In this situation, Medicare may be billed for hospice routine home care per diems, while Medicaid room and board may be billed separately using the appropriate revenue codes such as **0658** or **0659**.

Sequential Billing Requirements

Medicare hospice claims must be billed and processed sequentially in date order. Hospice claims are billed monthly and generally limited to one claim per patient, per month.

The initial hospice claim cannot process until the Notice of Election (NOE) has been accepted by Medicare. After the first claim processes, the next consecutive monthly claim may then

process.

Claims submitted out of sequence may suspend or return with status codes until the prior billing period has completed processing. Claims may continue cycling through the Medicare system until earlier claims finalize.

Example: If a March claim has not completed processing, the April claim may suspend or remain pending until the March billing period finalizes.

Hospice Aggregate Cap

Medicare hospice payments are subject to an annual aggregate cap limit. The hospice cap is designed to limit the total Medicare payments a hospice agency receives each cap year.

The cap year runs from **October 1 through September 30**. Medicare calculates the hospice cap using the annual cap amount multiplied by the agency's Medicare beneficiary count.

CMS primarily uses a proportional methodology that allocates a portion of a beneficiary's cap amount based on the percentage of hospice care days provided by the agency during the cap year.

Hospices that exceed their aggregate cap amount may be required to repay Medicare overpayments.

Barnestorm agencies may monitor hospice cap trends using:**Reports > Hospice > 19.05 Tracking Hospice Cap**.

Knowledgebase
http://kb.barnestorm.biz/KnowledgebaseArticle50389.aspx