This is an overview of the Hospice billing process:

1. Verify Medicare/private insurance as normal. If Medicare, be sure to determine the dates of all prior election periods. The **Hospice Election Periods** are for 90 days, then 90 days, then all successive periods are 60 days, and require a prior Face-to-Face certification from the ordering physician. For private insurance Hospice, verify (from the insurance company) how they plan to pay the claim; *per diem* or *per visit*. Per diem billing expects the *actual visits* to be no charge; per visit billing will not have any per diems, and the visits are chargeable.
2. Patient signs the **Notice of Election (NOE)** on their admission visit (in the home). Write 485, consult with certifying doctor and medical director on orders, etc.
3. If Medicare, you will need to key the **NOE** into DDE by day 5 of the admission.
4. Track per diems, visits, IDG meetings. You have 5 days to do IDG meeting on new patient. There is no requirement that all participants be physically present (for example, consulting physician may attend by phone). Use software to document IDG meetings every 14 days. Number of respite days is limited.
5. Pre-arrange any hospitalizations for non-hospice diagnoses while patient is under hospice care. Any facility stays must be documented in Barnestorm for hospice patients.
6. Any day the patient is not in a private residence, a location Q-code must be assigned using **Billing** > **Other** > **Enter HH Location / Hospice Facility Stay Dates**. Also, if the patient is in a hospital, you must record the CBSA code of the county where the hospital is located to put 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) to enter a value code G8 with CBSA code of county where hospital is located.
7. Do calendar month billing. Key in per diems using **Billing** > **Other** > **Enter Hospice Per Diem Charges**. All visits except continuous care are entered as no-charge visits. All social worker phone calls of 8 minutes or more are also entered as no charge visits. All medications must be keyed into **Billing > Other > Enter Hospice Per Diem Charges > Hospice Medications**. A single line total for medication charges will show up on the claim but will not show up in the AR.

8. Audit Report: Use **Billing > Other > Enter Hospice Per Diem Charges > Reports** to print Per Diem Charges to search for patients that do not have the appropriate number of per diems keyed. A message will display "total number of per diem charges does not = number of days active".
9. When creating the claim from All Other Billing, check the Hospice, Visits, and Report HMB Visits checkbox. For non Medicare Hospice payers you do not need to check the Report HMB Visits.
10. The generated claim will have all the per diem charges and the detail of all no charge visits for each discipline, and those visits will have the agency usual and customary rate on them (even though they were entered as no charge). Total dollar amount is the sum of per diem and rates, but this does not reflect the amount that will be paid, which is per diem charges only. The total dollar amount is not the amount that will show up in the A/R as amount billed, it only includes the per diem, continuous care and medication charges.
11. Medicare claims will be paid in 14 days.
12. Patients that are discharged, revocation or death must have the 81B created OR the claim sent and accepted within five days after discharge. If the patient receives medications, that may delay the claim from going out - you will want to create the 81B as soon as possible.
13. If the patient died in a facility, be sure to add the correct entry from **Billing** > **Other** > **Enter Hospice Facility Dates**. This will add correct value codes to claims as needed.
14. Many agencies establish a per diem rate charge larger than the Medicare per diem as their usual and customary rate, to allow for a reasonable opportunity for Medicare Secondary when a private insurance is primary.
15. If you have a patient dually eligible (Medicare and Medicaid), and they are in a long-term care facility paid by Medicaid, and they want to elect their Hospice Medicare Benefit with you, you are responsible for the room and board charges. The contract to define these arrangements should be in place prior to this occurrence. In this case, the primary payer is Medicare (for the routine home care per diems) and the secondary payer is Medicaid Room + Board (for the 0658 or 0659 per diems).
16. Medicare has a sequential billing rule which requires that all previous monthly claims must be paid before the next consecutive

month will be processed. You can send a claim before the previous one has been paid, and it will cycle through their system 4 times before being marked with T status.

17. The Medicare hospice cap rules set limits on the total amount of hospice income for an agency each year. This amount is determined by the number of patients who have their first hospice election period with your agency, and a prorated amount of patients who do not have their first hospice election period with your agency during that medicare year. This can be tracked using **Reports** > **Hospice** > 19.05 Tracking Hospice Cap.
18. Be sure to run hospice/billing reports regularly. There are several other articles related to Hospice/Billing in our Knowledgebase. Access that link, and type in "Hospice" in the Search field. A host of articles will be available for you to review.

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