



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

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TO: Hospice Providers for Action; MCOs for informational purposes

SUBJECT: Implementation of dual rates for Routine Home Care (T2042) and establishment of an add-on payment for services provided by a registered nurse (RN) or social worker during the last seven days of a beneficiary's life

EFFECTIVE: January 1, 2016

PURPOSE: The purpose of this Newsletter is to provide billing instructions to hospice providers to ensure appropriate reimbursement for routine care provided during the first 60 days of hospice care and for a visit by a RN or social worker during the last seven days of the beneficiary's life.

BACKGROUND: The final Medicare hospice rule, published on August 6, 2015 (CMS-1629-F), changes the payment methodology for Routine Home Care to implement two rates that will result in a higher base payment for the first 60 days of hospice care and a reduced base payment rate for days thereafter. It also establishes an add-on payment for services provided by a RN or social worker during the last seven days of a beneficiary's life. Both the dual Routine Home Care rates and the Service Intensity Add-On payment rate will be in effect on January 1, 2016.

ACTION: Fee-for-service claims for Routine Home Care (T2042) that are provided during the first 60 days of hospice care must be submitted to the fiscal agent using the procedure code modifier '22' in the first modifier position after the HCPCS procedure code (T2042 22). Claims that are not submitted with the '22' modifier will not receive the enhanced rate regardless of the number of days the person has been receiving hospice care. Claims that are received with the '22' modifier where a determination that more than 60 hospice days have been paid will pay at the lower rate and receive the new error code 1439 'Routine Home Care hospice with mod 22 priced at lower rate'. Unless there is a significant break in hospice care, the systemic calculation will take all hospice days into consideration when determining if the higher payment rate is appropriate.

Fee-for-service claims for the Service Intensity Add-On payment must be submitted to the fiscal agent using the procedure code 'T2043' and modifier '22' in the first modifier position after the HCPCS procedure code (T2043 22). This service is limited to 4 units and is only payable if the following requirements are met. The code 'T2043 22' should

be billed by hospice providers during the last 7 days of the beneficiary's life when a registered nurse or social worker provided services. The total number of hours used by the RN or social worker to fulfil the services must be reported in whole numbers in the 'days or units' position of the claim form and cannot exceed 4. The units should not be rounded up and the time reported should only include the actual visit time. Time spent preparing for the visit or completing paperwork after the visit should not be included when reporting the units/hours for the Service Intensity Add-On payment (T2043 22).

Because claims submitted to the fiscal agent are processed on a 'first come – first serve' basis, the Division is aware that, in some cases, the logic used to count the first 60 days of hospice care will not identify the appropriate claims. The Division strongly recommends that hospice providers submit all hospice claims to the fiscal agent on a monthly basis. Denied claims should be corrected and re-submitted as soon as possible. To ensure that the hospice days are correctly identified, the Division will instruct the fiscal agent to recycle all historical hospice claim records, verifying the days of hospice care per beneficiary.

Questions regarding this Newsletter should be directed to the State fiscal agent, Molina Medicaid Solutions. Their Provider Services telephone number is 1-800-776-6334.

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