



News Flash – It is not too late to start participating in the 2010 Physician Quality Reporting Initiative (PQRI) and potentially qualify to receive incentive payments. A new six month reporting period begins on July 1, 2010. The 2010 Physician Quality Reporting Initiative (PQRI) has two reporting periods: 12-months (January 1-December 31, 2010) and 6-months (July 1-December 31, 2010). For 2010, eligible professionals (EPs) who satisfactorily report PQRI measures for the 6-month reporting period will become eligible to receive a PQRI incentive equal to 2.0% of their total Medicare Part B allowed charges for services performed during the reporting period. To access all available educational resources on PQRI please visit, <http://www.cms.hhs.gov/PQRI/> on the CMS website.

MLN Matters® Number: MM6905

Related Change Request (CR) #: 6905

Related CR Release Date: April 28, 2010

Effective Date: October 1, 2010

Related CR Transmittal #: R1955CP

Implementation Date: October 4, 2010

New Hospice Site of Service Code

Provider Types Affected

This article is for hospice providers submitting claims to Medicare Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 6905, which states that:

1. Effective for claims with dates of service on or after October 1, 2010, **hospices will report HCPCS Q5010 when Routine Home Care (RHC) or Continuous Home Care (CHC) is provided at a hospice residential facility or a hospice facility which is also certified to provide inpatient care.**
2. Additionally, because Medicare regulations limit provision of general inpatient (GIP) or respite care to a Medicare or Medicaid certified facility, Medicare contractors will return to providers (RTP) any claims submitted for GIP or respite care, where the site of service is coded as Q5010. This is consistent with the instructions that were communicated in CR 6778, available at <http://www.cms.hhs.gov/Transmittals/downloads/R121BP.pdf>, that instructed contractors to RTP any claims submitted for GIP or respite where

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the site of service is a patient's home/residence, assisted living facility, or nursing long term care facility or non-skilled nursing facility.

3. Technical edits to assist hospices in correct usage of existing Healthcare Common Procedure Coding System (HCPCS) codes Q5003 and Q5004 are as follows:
 - a. The Centers for Medicare & Medicaid Services (CMS) is removing manual language which says, "Q5003 is to be used for skilled nursing facility residents in a non Medicare covered stay and nursing facility residents." and replacing it with **"Q5003 is to be used for hospice patients in an unskilled nursing facility (NF), or hospice patients in the NF portion of a dually certified nursing facility, who are receiving unskilled care from the facility staff."** Q5003 should be used for hospice patients located in a NF; many of these patients may also have Medicaid.
 - b. CMS is replacing manual language which says, "Q5004 is to be used for skilled nursing facility residents in a Medicare covered stay." and replacing it with **"Q5004 is to be used for hospice patients in a skilled nursing facility (SNF) or hospice patients in the SNF portion of a dually certified nursing facility, who are receiving skilled care from the facility staff."** Q5004 should be used when the hospice patient is in a SNF and receiving skilled care from the facility staff, such as would occur in a GIP stay. For Q5004 to be used, the facility would have to be certified as a SNF.
4. Some facilities are dually certified as a SNF and a NF; the hospice will have to determine what level of care the facility staff is providing (skilled or unskilled) in deciding which type of bed the patient is in, and therefore which code to use. When a patient is in the NF portion of a dually certified nursing facility, and receiving only unskilled care from the facility staff, Q5003 should be reported. Note that GIP care that is provided in a nursing facility can only be given in a SNF, because GIP requires a skilled level of care.
5. CMS is instructing contractors to RTP claims where the sum of the "Total Units" fields reported for the level of care revenue code lines does not equal the number of days in the billing period.
6. The following language is added to the hospice chapter of the Medicare Claims Processing Manual (Chapter 11, Section 90) to state longstanding policy regarding hospice billing on the day a hospice patient is discharged from one facility and admitted to another (for example, in the case of a transfer): ***"In cases where one hospice discharges a beneficiary and another hospice admits the same beneficiary on the same day, each***

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hospice is permitted to bill, and each will be reimbursed at the appropriate level of care for its respective day of discharge or admission.”

Be certain your billing staffs are aware of these Medicare changes.

Additional Information

If you have questions, please contact your Medicare MAC or RHHI at their toll-free number which may be found at

<http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction, CR6905, issued to your Medicare MAC or RHHI regarding this change may be viewed at

<http://www.cms.gov/Transmittals/downloads/R1955CP.pdf> on the CMS website.

For additional information regarding the Hospice Payment System see

http://www.cms.gov/MLNProducts/downloads/hospice_pay_sys_fs.pdf on the CMS website.

MM5245, *Instructions for Reporting Hospice Services in Greater Line Item Detail*, is available at

<http://www.cms.gov/MLNMattersArticles/downloads/MM5245.pdf> on the CMS website.

MM6778, *Medicare Systems Edit Refinements Related to Hospice Services*, is

available at <http://www.cms.gov/MLNMattersArticles/downloads/MM6778.pdf> on the CMS website.

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