



## Additional Data Collection on Hospice Claims – JA6440

**Note:** MLN Matters® article MM6440 was revised to clarify that the mandatory reporting requirement is effective for claims with dates of service on or after January 1, 2010.

Related CR Release Date: May 15, 2009 **Revised**

Date Job Aid Revised: January 7, 2010

Effective Date: October 1, 2009 (optional);  
January 1, 2010 (mandatory)

Implementation Date: October 5, 2009

**Key Words** MM6440, CR6440, R1738CP, Hospice

**Contractors Affected**

- Part A/B Medicare Administrative Contractors (A/B MACs)
- Regional Home Health Intermediaries (RHHIs)

**Provider Types Affected** Hospices billing RHHIs or A/B MACs for providing routine home care (RHC), continuous home care (CHC), or respite care to Medicare beneficiaries



CR6440 requires hospices to report additional detail for visits using the appropriate Revenue Codes (RCs) and Healthcare Common Procedure Coding System (HCPCS) codes, effective for claims with dates of service on or after January 1, 2010, **or their claims will be returned.**

### Reporting Requirements

**Provider Needs to Know...**

- Effective for claims with dates of service on or after January 1, 2010, hospices must report the following additional detail for visits on a separate line on their claims for all RHC, CHC and respite care billing:
  - Each visit performed by nurses, aides, and social workers, whom they employ, along with their associated time per visit (**in 15-minute increments**) with the time reported using the associated HCPCS G-code as follows:

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- RC 055x (nursing services) with HCPCS G0154,
  - RC 057x (aide services) with HCPCS G0156, or
  - RC 056x (medical social services) with HCPCS G0155;
  - Each RHC, CHC, and respite visit that physical therapists, occupational therapists, and speech-language therapists performed and their associated time per visit (**in 15-minute increments**) with the time reported using the associated HCPCS G-code as follows:
    - RC 042x (physical therapy) with HCPCS G0151,
    - RC 043x (occupational therapy) with HCPCS G0152, or
    - RC 044x (speech language therapy) with HCPCS G0153; and
  - Each telephone call that social workers made to the patient or the patient's family using RC 0569 and HCPCS G-code G0155 for the length of the call, with each call being a separate line item.

Only those telephone calls that are necessary for the palliation and management of the terminal illness and related conditions as described in the patient's plan of care (such as counseling or speaking with a patient's family or arranging for a placement) should be reported. Additionally, only social worker phone calls related to providing and or coordinating care to the patient and family, and documented as such in the clinical records should be reported.

- When recording any visit or social worker phone call time, hospices should:
  - Sum the time for each visit or call, **rounding to the nearest 15-minute increment**; and
  - Report in the unit field on the line level the units as a multiplier of the visit time defined in the HCPCS description.
- Travel time or documentation time should not be included for any visit or call. Additionally, interdisciplinary group time should not be included in time and visit reporting.
- The table on page 4 of MM6440 displays these new reporting requirements.

#### **Additional Key Points in CR6440**

- Charges associated with the reported RCs 42x, 43x, 44x, 55x, 56x, and 57x are covered under the hospice bundled payment and are reflected in the payment for the level of care billed on the claim.
  - No additional payment is made on the visit revenue lines.
  - These visit charges will be identified on the provider remittance advice notice with reason code 97 ("Payment adjusted because the benefit for this service is included in the payment / allowance for another service / procedure that has already been adjudicated.") and code CO (Contractual Obligation).
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- If a hospice patient is receiving respite care in a contract facility, visit and time data by **non-hospice** staff should not be reported.
  - Billing of physician visits to hospice patients is not changing, and is unaffected by CR6440.
  - Data on claims for chaplains/spiritual counselors or volunteers will not be collected at this time, but reporting of this data will be in a future phase of the data collection.
  - For General Inpatient (GIP) care, the reporting of visit intensity data is not required at this time. Providers should continue to report the number of GIP visits in accordance with CR5567.
  - Additionally, the units for visits under GIP level of care continue to reflect the number of visits per week, and visit reporting by non-hospice staff is exempted when hospice patients in a contract facility are receiving GIP.
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## Background

- Over the past several years the Medicare Payment Advisory Commission (MedPAC), the General Accounting Office, and the Office of the Inspector General have all recommended that the Centers for Medicare & Medicaid Services (CMS) collect more comprehensive data in order to better evaluate trends in the utilization of the Medicare hospice benefit.
  - In response, CMS began collecting additional data on hospice claims beginning in January 2007 with CR5245, which required the reporting of a HCPCS code on the claim to describe the location where services were provided.
  - CR5245 also required reporting of continuous home care time in 15-minute increments.
  - In April 2008, CMS issued CR5567, requiring Medicare hospices (effective July 2008) to provide detail on claims about the number of physician, nurse, aide, and social worker visits provided to beneficiaries.
  - MedPAC and industry representatives have informed CMS that the newly required claims information was not comprehensive enough to accurately reflect hospice care, and this restricts Medicare's ability to ensure optimal payment accuracy in the hospice benefit.
  - Of particular concern, was the fact that CMS was not requiring that visit intensity be reported.
  - Reporting visit intensity would improve Medicare's ability to analyze the services provided in this growing benefit.
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## Operational Impact

- Effective for claims with dates of service on or after January 1, 2010, Medicare contractors will:
    - Return claims that do not contain RCs 0655 and 0656, but DO contain one or more of visit RCs 042x, 043x, 044x, 055x, 056x, or 057x without the appropriate HCPCS
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code.

- Return claims containing RC 0569 when billed without HCPCS code G0155.
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Reference  
Materials

- The related MLN Matters® article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6440.pdf> on the CMS website.
  - The official instruction (CR6440) issued regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1738cp.pdfh> on the CMS website.
  - The MLN Matters® article related to CR5245 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5245.pdf> on the CMS website.
  - The MLN Matters® article related to CR5567 is available at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5567.pdf> on the CMS website.
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