



Related MLN Matters Article #: MM5567 **Revised**

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### *Reporting of Additional Data to Describe Services on Hospice Claims*

#### Key Words

MM5567, CR5567, R1447CP, Visits, Coding, Hospice

#### Provider Types Affected

Hospices billing Medicare Regional Home Health Intermediaries (RHHIs) for hospice services provided to Medicare beneficiaries

**Note:** MLN Matters article MM5567 was revised to reflect that the Centers for Medicare & Medicaid Services (CMS) revised Change Request (CR) 5567 to clarify that certain information discussed in the revised Section 30.3 of the *Medicare Claims Processing Manual* is collected for research purposes and will not affect reimbursement amounts. The CR transmittal date, transmittal number, and Web address for accessing CR5567 were also changed.

#### Key Points

- The mandatory reporting date for these changes is July 1, 2008. As of January 1, 2008, hospices have the option to begin reporting the data. These changes were made as CMS re-issued CR5567 on November 2.
- The implementation date is January 7, 2008.
- Historically, bills submitted by institutional providers to Medicare fiscal intermediaries contained limited service line information.
- Claim lines on a typical institutional claim in the 1980s or early 90s may have reported only a revenue code, a number of units, and a total charge amount.
- Over the last decade, legislated payment requirements have changed, and Medicare has implemented increasingly complex payment methods.
- These changes have required more line item detail on claims for most institutional provider types, such as line item dated services, reporting Healthcare Common Procedure Coding System (HCPCS) codes and modifiers, and submission of non-covered charges.

- This detail has supported the payment requirements of legislated payment systems and improved the quality and richness of Medicare analytic data files.
- Hospice claims have been an exception to this process.
- Since the inception of the hospice program in 1983, hospices have been required to submit only a small number of service lines to report the number of days at each of the four hospice levels of care on their Medicare claims.
- HCPCS coding was required only to report procedures performed by the beneficiary's attending physician (if that physician was employed by the hospice).
- CMS believes that this limited claims data has restricted Medicare's ability to ensure optimal payment accuracy in the hospice benefit and to analyze the services provided in this growing benefit.

### Key Points of CR5567

- Effective for service dates on or after January 1, 2008, hospice providers need to report data on their claims for Medicare payments that describe the services provided in the course of delivering each hospice level of care billed. **As of July 1, 2008, such reporting is mandatory.**
- Some specifics of these data include the following:
  - For each week, beginning on Sunday and ending on Saturday, hospice providers are to indicate the number of services/visits provided by nurses (registered, licensed, and/or nurse practitioner), home health aides, social workers, physicians, and nurse practitioners serving as the beneficiary's attending physician.
  - Each line should reflect the total number of direct patient care visits for each category and not as an aggregate total for all.
  - A service/visit constitutes direct care to the beneficiary. An entry in a medical record without a visit does not constitute a visit and is not counted.
  - Rounds in facilities do not constitute a visit and are not counted. Items and services provided within a visit are not counted as separate items.
  - Only the number of direct patient care visits are counted. All items and services within that visit are not separately counted.
  - If the site of service changes, a separate line will be required to reflect the site where the direct patient care visit was made.
  - To be counted, a service/visit must be medically reasonable and necessary. This applies for separate billing for the physician or nurse practitioner that serves as the attending physician.
  - For the nurse, home health aide, and social worker, the weekly total of services/visits by discipline are not for the purpose of separate payment but to provide transparency into the services that are being provided to beneficiaries who are electing the Medicare hospice benefit.

### Codes

- Effective on claims with dates of service on or after January 1, 2008, hospices may report the services (effective July 1, 2008, reporting is mandatory) that were provided to the beneficiary in the course of delivering the hospice levels of care billed with the codes listed below.

- Medicare systems will allow revenue codes 055X, 056X, and 057X on types of bill 81X and 82X.
- Medicare systems require 055X, 056X, and 057X revenue code lines reported on types of bill 81X and 82X to contain units and charges.
- Medicare systems will accept one or more 055X, 056X, or 057X revenue code lines associated with each hospice level of care revenue code (651, 652, 655, and 656).
- Medicare systems will accept for each hospice level of care revenue code that there is one or more 055X, 056X, or 057X:
  - Revenue code lines with a date of service equal to or later than the date of that level of care revenue code and
  - Prior to the date of the next level of care revenue code.
- Medicare systems will not make payment on 055X, 056X, or 057X revenue code lines.
- Medicare systems will reflect the charges associated with each 055X, 056X, or 057X revenue code as paid under the all-inclusive payment for the associated level of care revenue code line. Medicare systems will change any charges and units associated with each 055X, 056X, or 057X revenue code to be non-covered.
- Medicare systems will reflect bundling of services into level of care revenue codes on the remittance advice with reason code 97. Reason code 97 is defined as "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."
- Medicare systems will not allow reporting of V-codes as the principal diagnosis on hospice claims and will return claims to the provider if a V-code is reported as the principal diagnosis.

**Note:** The site of service code Q5003 is to be used for skilled nursing facility residents in a non-Medicare covered stay, while Q5004 is to be used for skilled nursing facility residents in a Medicare covered stay.

- The revised *Medicare Claims Processing Manual*, Chapter 11, Section 30.3 also contains clarification for the entry of other fields on the claim as well. Providers should review this revised section to assure accurate claims submission.

## Important Links

The related MLN Matters article can be found at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5567.pdf> on the CMS website.

The official instruction (CR5567) regarding this change may be viewed at

<http://www.cms.hhs.gov/Transmittals/downloads/R1447CP.pdf> on the CMS website.

The revised *Medicare Claims Processing Manual*, Chapter 11, Section 30.3 and be found at

<http://www.cms.hhs.gov/manuals/downloads/clm104c11.pdf> on the CMS website.

CR5245 (effective January 1, 2007) was implemented and represented a first phase in the expansion of line level detail information requirements on hospice claims. It required codes describing the location where hospice levels of care were delivered and created line item dating requirements for continuous home care level of care. The related MLN Matters article (MM5245) can be viewed at

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

If providers have questions regarding this issue, they may contact their Medicare RHHI at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.