



Provider Inquiry Assistance

Associating Hospice Visits to the Level of Care – JA6791

Related CR Release Date: January 29, 2010

Date Job Aid Revised: February 2, 2010

Effective Date: April 29, 2010

Implementation Date: April 29, 2010

Key Words MM6791, CR6791, R1897CP, Hospice, Visit

Contractors Affected

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

Provider Types Affected Provider types affected are hospice providers submitting claims to A/B MACs and/or RHHIs for services provided to Medicare hospice beneficiaries.



Change Request (CR) 6791 will require hospice agencies to report a separate line item for each time the level of care changes.

- For hospice claims submitted on or after April 29, 2010, hospices should report separate line items for the level of care, each time the level of care changes. This includes revenue codes 0651 (Routine Home Care), 0655 (Inpatient Respite Care) and 0656 (General Inpatient Care).

Provider Needs to Know...

For example, if a patient begins the month receiving routine home care, followed by a period of general inpatient care, and then later returns to routine home care all in the same month, in addition to the one line reporting the general inpatient care days, there should be two separate line items for routine home care.

- Each routine home care line reports a line item date of service to indicate the first date that level of care began for that consecutive period.
- This will ensure visits and calls reported on the claim will be associated with the level of

care being billed with minimal administrative demands on providers.

- However, should providers not adhere to this policy the Centers for Medicare & Medicaid Services (CMS) may consider implementing a line item date of service billing requirement for hospice level of care revenue codes.
- This would require reporting a separate line for the level of care for each day billed on the hospice claim.
- CMS realizes this is an additional burden in reporting, but this level of reporting will ensure that each level of care is reported with a line item date of service. Therefore, each visit and call is appropriately associated with the level of care during the time of visit.

Background

- With implementation of CR6440 on January 1, 2010, hospice providers are required to report visits, certain phone calls, and visit or call intensity for nearly all hospice days billed, according to line item date of service.
- These visit data will better reflect the services provided to Medicare hospice beneficiaries and may be used in research conducted for possible future payment reform. For the data to fully serve their purposes, it is necessary that the visit or call always be associated with the level of care being billed.
- Currently, when a hospice patient has different levels of care within a given month, it is sometimes not clear from the claim which visits or calls are associated with each level of care reported on the claim.
- This is because each level of care is only required to be reported once on the claim for the location it was provided and all days associated with that level of care are billed on one claim line, even when the days being billed on that line are not consecutive.

Operational Impact N/A

Reference Materials

The related MLN Matters® article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6791.pdf> on the CMS website.

The official instruction (CR6791) issued regarding this change may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R1897CP.pdf> on the CMS website.

Providers can review the MLN Matters® related article for CR6440 at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6440.pdf> on the CMS website.